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Exploring the feasibility of evaluating workplace health and wellbeing initiatives that are free at the point of use for workplaces (WHISPAs)

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Research Article

Keywords: Workplace Health, Evaluation, Implementation, Health Inequalities

Posted Date: November 3rd, 2026

DOI: https://doi.org/10.21203/rs.3.rs-11594406/v1

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Additional Declarations: The authors declare no competing interests.

Abstract

Background

Workplace health and wellbeing initiatives that are free at the point of use for employers (WHISPAs) are increasingly used to improve employee health and reduce health inequalities. Despite investment in workplace health programmes, evidence of effectiveness remains limited, and there is little consensus on how to evaluate these initiatives. This study explored stakeholder perspectives on the feasibility and design of future evaluations of WHISPAs across the UK.

Methods

A qualitative study used semi-structured online interviews with stakeholders involved in the development, delivery, commissioning and evaluation of WHISPAs. Participants were recruited through a national WHISPA network. Interviews were conducted between March and April 2024, transcribed verbatim and analysed using framework analysis informed by current guidance for evaluating complex interventions.

Results

Sixteen stakeholders participated. Five overarching themes were identified: support for evaluation; practical barriers to implementation and evaluation; outcomes for employers, employees and providers; workplace culture; and socio-economic inequalities. Participants supported mixed-methods evaluations and valued qualitative evidence alongside quantitative outcomes. Recruitment of employers and employees, particularly within small businesses and routine/manual occupations, was considered challenging. Standardised organisational outcomes, such as sickness absence and staff turnover, were viewed as important but difficult to measure consistently. Stakeholders highlighted workplace culture as a key determinant of intervention success and expressed concern that workplace health initiatives may inadvertently widen inequalities by preferentially engaging more advantaged organisations and workers.

Conclusions

Stakeholders considered evaluation of WHISPAs necessary but highlighted methodological and practical challenges. Future evaluations should use mixed-methods designs, equity-focused recruitment strategies, and account for organisational context and workplace culture. Developing robust evaluation frameworks is essential to strengthen the evidence base for workplace health interventions and support equitable implementation. These findings have informed the development of a new NIHR-funded workplace health evaluation, including outcome selection, evaluation methods and strategies to address equity and implementation challenges.

Introduction

Working and workplaces affect people's health and directly impact health inequalities(1). The cost of mental ill health alone to UK employers, estimated from the combined costs of absenteeism, presenteeism, and labour turnover, was £102 billion in 2023(2). In 2024, the number of people who were inactive in the labour market due to long-term sickness reached a record high of 7% of the working-age population in the UK(3).

One approach to improving health through workplaces and promoting a healthy workforce is the implementation of publicly provided workplace health and wellbeing initiatives that are free at the point of use to workplaces (WHISPAs)(4). A defining characteristic of WHISPAs is that they are free for employers, although they may recommend paid services. These publicly funded initiatives may have advantages over private workplace health services that can widen inequalities by reducing inclusivity and charging fees(5, 6).

We define WHISPAs as providing employers with a multi-component menu of options to support staff health and wellbeing https://whispas.co.uk/. The content of WHISPAs can vary and may include information, advice and activities related to mental health, lifestyle health, or musculoskeletal (MSK) health(7, 8). Specific advice may be given on topics such as conducting staff needs assessments, return to work, policies on sickness and absence, and campaigns promoted throughout the workplace that encourage healthy eating or walking. WHISPAs may suggest that workplaces identify a staff member to champion workplace health and wellbeing projects. Some WHISPAs offer workplace accreditation to incentivise progress (such as gold, silver, or bronze-level accreditation) by achieving milestones on their health and wellbeing journey.

Global evidence shows that workplace health and wellbeing programmes often demonstrate inconsistent effectiveness and can unintentionally reinforce inequalities when not designed with equity in mind. Large-scale international studies, such as the Illinois Workplace Wellness Study, have shown that programme participants tend to be healthier and have lower medical expenditure prior to enrolment, indicating strong selection effects that limit causal inference and risk disproportionately benefiting already advantaged workers(9). This aligns with global scoping evidence from 72 countries, where wage disparities, discrimination, and unequal exposure to occupational hazards were found to shape engagement with and benefits from workplace interventions, particularly disadvantaging marginalised groups(10). Moreover, international analyses highlight that programmes focusing narrowly on individual-level behaviour change, such as digital wellbeing tools or stress-management apps, frequently overlook structural determinants of health, thereby limiting their effectiveness and increasing the risk of exacerbating disparities(11).

In the UK, research similarly shows that workplace health initiatives are not delivered optimally across regions, and the evidence base underpinning them remains limited. Public Health England (now replaced by the Office for Health Improvement and Disparities) and University College London (UCL) evidence reviews note insufficient high-quality evidence for widespread implementation, with significant inconsistencies across intervention types, delivery mechanisms, and outcome measures(12). Recent regional reviews also show substantial geographical inequalities: a 2025 scoping review found that only 21% of local authorities offered free workplace health programmes, with marked regional disparities in availability and access(5). Furthermore, qualitative studies reveal persistent barriers to effective implementation in small and medium-sized enterprises (SMEs), including limited resources, poor employee

involvement in programme design, and uneven employer capacity to engage with wellbeing initiatives, reducing the likelihood that such schemes meet the needs of the most disadvantaged workers(13).

Adding to these concerns, systematic assessments demonstrate that the quality of evidence supporting many specific components of workplace interventions is inconsistent and frequently low. For example, evaluations of topics commonly included in workplace health programmes, such as standing desks and anti-bullying interventions, show mixed and often weak evidence, with Cochrane-level reviews indicating methodological limitations and insufficient certainty regarding effectiveness(12). Collectively, this global and UK evidence indicates that while workplace health initiatives hold potential, their impact is constrained by unequal delivery, variable evidence quality, insufficient worker participation, and a general lack of robust evaluation. Without greater focus on structural determinants, high-quality evidence generation, and equity-centred design, such programmes risk limited effectiveness and may inadvertently deepen rather than reduce workplace health inequalities.

Ongoing research examines how workplace health interventions function in practice. Two mixed-methods cluster randomised controlled trials conducted in the West Midlands have explored the effectiveness of specific behavioural strategies. In the first, 100 SMEs were allocated organisational-level financial incentives to encourage engagement with a workplace health programme. While employers subsequently offered more health-related information, advice and activities, employees did not report improvements in health or health behaviours, indicating a gap between organisational provision and individual outcomes(14). In a second trial involving roughly 30 workplaces, a goal-setting intervention aimed at supporting staff progress on health and well-being goals was tested; findings showed that workplace-based goal-directed behaviour change is challenging and can at times be counterproductive, highlighting the need for better alignment between programme design and employee needs(15). Additionally, a realist evaluation of the Better Health at Work Award in the North East and Cumbria has developed a programme theory to clarify how contexts and mechanisms shape the outcomes of workplace health initiatives with the aim of guiding future implementation(16).

Appropriately designed research is needed to grow this evidence base so that employers can select from the most effective aspects of WHISPAs for their workplaces(17). In the initial stages of complex intervention evaluation design and development, the Medical Research Council (MRC) and National Institute for Health (NIHR) guidance(18) recommends an evaluability assessment that involves stakeholder collaboration to explore different methodological considerations. These include expected outcomes (such as whether there will be a national standard or cost-effectiveness outcomes), consideration of data that could be collected (such as sickness and absence or productivity), and identifying options for designing the evaluation (such as individual or workplace-level interventions).

Research aim

The aim of this study was to understand the views of stakeholders involved in WHISPAs to reach agreement on the expected outcomes of these interventions, the data that could be collected to assess processes and outcomes, and the options for designing the evaluation. Stakeholders include participants (employees and employers) and those responsible for delivering WHISPAs, and that can be at different levels, such as planning, delivery and integration at a local, regional or national level.

Methods

Study design and ethical approval

The study followed a qualitative design, and data were collected through semi-structured interviews conducted using the Microsoft Teams online meeting function. The study received ethical approval from Newcastle University Ethics Committee (ref: 42039/2023).

Recruitment

Participants were identified through an existing national network of stakeholders involved in the development, delivery or evaluation of WHISPAs(19). Invitations to participate were circulated through routine communication with network members (newsletters received via email) containing a link to an online expression of interest form, which collected contact details and a summary of WHISPA involvement. The research team contacted all potential participants, providing full details of the study and participant involvement. Once a member agreed to participate, they were sent a link to an electronic consent form, and a suitable time was arranged for an interview with a researcher. All interviews were carried out in March – April 2024. In addition, verbal consent was obtained at the beginning of each interview.

Data collection and processing

Interview questioning was guided by the study's semi-structured interview schedule, developed in advance of all data collection. Interviews were audio recorded and transcribed using the automated transcription function in Microsoft Teams. All files were saved on password-protected, secure electronic file storage networks of Newcastle University and Teesside University. Transcripts were anonymised and checked for accuracy by the researcher who conducted the interview and edited where appropriate. Audio recordings were deleted after data analysis was completed.

Data analysis

Data was analysed using a framework analysis approach(20, 21), which consists of five stages of analysis: familiarisation with the data, developing the framework to help sort and examine the data, indexing to apply the framework to the data, charting to be able to collecting all the selected sections under a particular theme and viewing the data as a whole for each theme and finally mapping and interpretation to bring the key themes within the data set together and pulling together the findings of the analysis as a whole to address the aims and objectives of the research. The framework approach allows both deductive and inductive coding. The MRC/NIHR guidance(18) was used a as a deductive framework allowing us to draw on a priori themes based on key feasibility concepts such as; recruitment, data collection, retention, outcomes and analysis. In addition, relevant inductive codes generated from the data were also compiled and included in the final data synthesis, such as motivation for taking part in an evaluation.

Results

Sixteen interviews were conducted with WHISPA participants, commissioners and providers of WHISPAs, senior leaders of civil society organisations, and researchers with experience of evaluating WHISPAs across the UK. Themes generated from the analytical framework included: 1) support for evaluation; 2) practical barriers to WHISPAs and their evaluation, and 3) outcomes for employers, employees, and WHISPA commissioners and providers. Additional themes of 4) workplace culture and 5) employees' socio-economic contexts were inductively identified.

Theme 1: Support for evaluation

The effectiveness and impact of WHISPAs were recognised by participants as a longstanding knowledge gap, and the potential for evaluation was welcomed by providers, commissioners and researchers who believed evaluation was important for allocating resources and making commissioning decisions. Pre and post intervention evaluations were viewed favourably by commissioners and providers, and were sometimes an aspiration, but resource constraints had prevented these studies from taking place.

If we don't have that research to share, we don't have anything to share to say this is the business case for local authorities to invest in this. And I think if Dame Carol Black 1 *was here right now. She would still say we still don't know what works. (ID2)*

Even if it's free at the point of use there's always a cost. It might not be monetary, but you know, time someone's spent designing something; if it is a flyer, the cost of printing it, the cost of designing it, the person's time. So even in trivial things, I think there's always opportunity cost like what else you could have you have done. (ID7)

Having the capacity to do like an observational design or a controlled evaluation where we compare an organisation that isn't on the programme with one on the programme or like a pre and post that we just haven't had the ability to do that yet. (ID16)

Several participants considered evaluation evidence as a tool to strengthen the case for continued investment in WHISPA interventions they perceived were effective, but this did not necessarily lead to employer buy-in to WHISPAs.

If there's any way to sort of put a case together, put forward ideas of why they're working how they're working, what they're doing, anything that strengthens our case to make sure that they continue. (ID10)

If you had data that was statistically significant then that helped, you know, that's that is going to strengthen our case, but sometimes even employers aren't like… really interested in the evidence base…even case studies and things like with a human story we've sometimes struggled to engage employers (ID8)

Whilst participants generally welcomed observational designs such as pre and post intervention evaluations, randomised controlled trials were considered less practical, and not always necessary. Participants supported mixed-methods approaches to evaluation, citing the power of stories and case studies.

The RCT is kind of like the gold standard in the evaluation tool kit. So, I mean, you know, if you had all the money in the world, why not? I think in reality, no, it's kind of overkill, you know, it's a bit too much. (ID7)

Actually, stories also can be the most powerful thing. So curiously, qualitative can trump quantitative the story, the story of that patient or that person that sums up the issue. (ID02)

think it's really hard to measure impact when we're just looking at the numbers in general because it's not always the case. It's the anecdotal stuff I think is really where we get the value of what's been going on. (ID12)

Additionally, participants highlighted how certain measures were often burdensome, which WHISPA providers thought were overused.

We live and die by surveys and questionnaires. People in life don't like filling out surveys really. (ID16)

Theme 2: Practical barriers to WHISPAs and their evaluation

Theme 2a: Recruitment

Most participants raised recruitment as a challenge both to employer participation in WHISPAS, and for evaluation. The feasibility of recruiting an employer not participating in a WHISPA as a control group was considered challenging. At the individual employee level, one provider had attempted a study with a

control group but encountered difficulties recruiting eligible participants. Several participants felt the employers and employees who would participate in a WHISPA intervention or trial were already those who prioritised health and wellbeing.

One of the big challenges for us was actual engagement with employers as well. So, trying to find them and recruit them and interest them in our programme was hugely time consuming and difficult and we didn't think it would be because we thought people would bite our hands off. (ID8)

We did actually try to do a sort of movement at your desk study with the Council. And to be honest, we just struggled to get participants. The plan was to have a control group and an intervention group but unfortunately, I think we just ended up with about 15 individuals. So, we just got them all doing the intervention. We wanted those that were sedentary and inactive, so we actually had a lot of people. But then when we went through the eligibility criteria, it turned out that they were kind of too active for it. (ID13)

Participant incentives at the employee level were considered important for encouraging recruitment but were not supported at the employer level. Shopping vouchers were typically suggested as incentives; however, some participants felt that the intervention itself, time with an expert, or a more enduring incentive, such as an education workshop, was most valued.

Those that wanted to get involved with the active desk study were really interested in getting a cholesterol test and that experience with an academic that they could ask a couple of questions about physical activity. (ID13)

A colleague of mine that didn't work in public health did some kind of work that wasn't directly health and well-being related, but they gave the employer a free bike shelter and that obviously encouraged people to cycle and use active travel so that you know, there's something almost about providing the employer with something that benefits the whole good. (ID8)

Theme 2b: Accessing WHISPAs

Participants recognised that it tended to be easier to engage larger, professional employers in office-based settings in WHISPAs, for practical reasons such as digital access, having English speaking staff, and not needing to release employees from a production process. Whilst participants primarily identified barriers to employers' participation in WHISPAs, these factors were highlighted as important for researchers to consider during an evaluation.

In the workplaces where we really wanted to be, so like the routine and manual-dominated ones, a lot of the staff didn't have access to a computer. The huge amount of languages as well, the practicalities of getting so much translated material was sometimes a huge barrier. (ID8)

If you're taking people out of like the manufacturing environment, you cannot account for there being a crisis. And I'm sorry, I need all hands-on deck down here. You can't talk to anybody you've come in and planned to talk to 20 people. There's 20 people today because we've got to get on. We've got an urgent order to go out or something. A big organisation is easier because you can get more people to talk to. (ID4)

Tailoring WHISPAs to accommodate different types of organisations was important but was achieved with varying success and it was more challenging to implement WHISPAs in small and medium sized (SME) businesses, or when staff were dispersed or field-based.

A domiciliary care organisation, say they came under a large organisation because they had loads of care staff on their books. But in terms of the office staff, they had about eight employees, as in the office, and they didn't really have a sophisticated HR department and it just felt like it was quite they sort of feedback that was quite burdensome for them because we haven't really adapted the programme for the specific needs. (ID6)

Despite reported difficulties implementing WHISPAs in SMEs, participants reported it being similarly challenging to recruit very large multinational companies to WHISPAs, as they are considered prestigious employers with good terms and conditions.

Theme 3: outcomes for employers, employees and WHISPA commissioner and providers

Providers and commissioners found it easier to articulate individual level outcomes for WHISPA participants than for employees as a whole; in particular, participants reported positive impacts for individual employees who had participated in health checks or screening interventions which they could act on.

We asked them to forward issues as part of our programme. It was a male dominated environment, there was only one female working there and she decided to do something about prostate, and she had somebody come in. It's a little blood test… One of them had a problem with prostate and obviously that was preventative then for them and they could go and get that sorted. And that's one person. But that's significant change. (ID12)

Participants acknowledged the complexity of measuring outcomes when many factors in and beyond workplaces influence health and wellbeing and recognised it could be challenging to go beyond reporting outputs from WHISPA projects.

We would just be looking at outputs with things like NHS health checks. But even then, we can only say all right, so that we referred this number of people to their GP as a result of the NHS health check, we can't really measure how that long term has impacted their health (ID8)

It's really difficult to say that that intervention was the one that made the difference because there's so many influences on a person's life and their mental health. So, for me that's the real challenge is how can we say that this particular intervention was the one that changed the outcome for the individual. (ID8).

We'll come and run a health check event or come and talk and do a marketplace and promote services. But actually, how much of that translates into improvement in employee well-being? And I suppose it depends how you're defining employee well-being because is it about their health? So, I suppose a health check could pick up someone's got high blood pressure and they could get on tablets. So that is a positive health intervention for that person. But actually, is employee well-being more than that? Is it about kind of satisfaction and well-being at work and feeling secure in your job and having a job that you enjoy? (ID9)

Participants emphasised that evidence of positive outcomes from WHISPAs was central to securing employer buy-in, which was viewed as essential for successful implementation across diverse organisational contexts. While WHISPAs were described as broad and adaptable interventions applied within varied workplace cultures, this diversity also created challenges for evaluation. Participants identified reduced sickness absence, improved productivity, and enhanced staff retention as key employer-level outcomes likely to motivate engagement, alongside reputational benefits such as being recognised as a socially responsible employer. However, they noted that data to evidence these outcomes, such as sickness absence records, staff turnover metrics, or qualitative insights from exit interviews, were often inconsistently collected, incomplete, or unavailable, limiting the ability to robustly demonstrate impact across organisations.

It's improved our productivity. We don't get as much sickness and substance use because people feel they can come and talk about an issue. There was somebody that they got, they actually employed somebody to be fair. But that was their choice, who people could go and talk to and because they'd had that conversation, it stopped people going off sick because they felt they couldn't talk to anybody. (ID10)

We had a large construction business that when they did their analysis of their sickness absence, the highest reason for sickness was just the word sick. Well, that doesn't tell you anything. (ID10)

The thing we'd like to tie stuff to that most people routinely collect is sickness absence data. But what I found in my journey was employers collect that all, collect that all different ways. So, some of them measure different things, some of them categorise things differently. Often, they've got different sickness absence triggers in the system, which then changes how something's collected. So yeah, I would say the only thing I know that probably all employers collect, but actually not all of them do. (ID8)

Some participants expressed a desire to access public administrative, medical and Human Resource demographic data for more sophisticated evaluation of WHISPA outcomes, but they recognised accessing this information in an employment context would be very challenging.

Obviously, they [employers] have their address, but obviously that's confidential information. So, I don't really know how we would get that. I can't think of anything else that would be particularly linked to health inequalities really. Again, if you're thinking about prior medical history, but again, you're never gonna get that. (ID6)

Theme 4: workplace culture

The importance of workplace culture for engagement in WHISPAs and the role workplace culture plays in employee wellbeing beyond individual WHISPA interventions was repeatedly emphasised by participants. In its simplest sense, workplace culture was fundamental to successful employer buy-in to WHISPAs. However, workplace cultures were found to be highly variable and, to an extent, contingent on sector and job type.

I think I had a misconception that most employers would have the same drivers, but actually what I found was each employer is its own different culture with its own drivers it its own kind of health and well-being perspective and it and I couldn't apply what I'd learnt somewhere else always to even a similar type of employer because there were so many cultural aspects to that particular employer. (ID8)

Some of it just depends on the organisation and the sector to, to be honest, you know, what they're like as an organisation and I guess how much they value their workforce. (ID2)

Participants noted that in some organisations, especially when work was considered low-status or unskilled, employers were not receptive to WHISPAs because employees could easily be replaced.

The new starters are put on worse terms. So, it's to some extent in the [employer's] interest to have some attrition. (ID15)

There's a lot of zero hours contract work in our in our disadvantaged areas and they would have people just turning up at the factories queuing to see what work they could get that day. So why would you need to invest if you've got multiple migrant workers just waiting for work you know? (ID8)

Even in workplaces that adopted WHISPAs, participants felt interventions were unlikely to be effective unless supported by more structural organisational approaches to good work.

You could have an NHS health check at work, but if your terms and conditions aren't very good. That probably isn't gonna motivate you to make a behavioural change in any way. (ID8)

it's almost kind of looking slightly beyond WHISPAs as well and saying what are employers doing around the good work agenda. So, there's all those other aspects, the things like equality, good pay, dignity at work. WHISPAs can be, you know, such a vital part of the health and well-being aspect of that. But if you just put a WHISPA in place yet people's pay and conditions aren't there, you know, it's got to be part of a bigger picture. (ID8)

Participants also felt there could be a gap between policy and practice in organisations and that it was difficult for organisations to implement WHISPAs without an existing positive corporate culture, including and extending beyond senior leadership.

It's all very well saying you're doing it and the policy side, but actually how do you make sure it's put into practice and people are given the time and space to go and do these things. And often I think I suppose as an employee in my local authority we constantly get emails saying like don't work over lunch and make sure you have short meetings and you have a gap between meetings. But the reality of it is it isn't there. (ID9)

It needs to be a company directive and it needs to be something that's brought in from the senior leadership team and they need to get people that are outside of that little remit involved as well. It can't just be a one-man band approach because it just doesn't work. (ID12)

Theme 5: importance of socio-economic inequalities

Theme 5a: potential of WHISPAs to widen inequalities

Participants recognised that WHISPA interventions tended to be targeted towards office workers for practical reasons identified in themes 2b (access to WHISPAs) and theme 4 (organisational culture) and several participants were concerned this had the potential to widen health inequalities, though this was typically accepted, especially in the broader context of WHISPAs having positive individual health outcomes such as health screening providing information individuals could act on.

Some workplace health initiatives are biased towards office workers. (ID3)

It [WHISPAs] perpetuates inequalities, 'cause people who are more likely to access a lot of these interventions are, you know, middle class office-based employers who then you know, they have health insurance so they're in better health and they're more engaged in in, in looking for interventions. (ID7)

Occasionally, participants questioned the impact of focusing interventions on the working population compared with other groups with poorer health status, such as people not in employment.

It seems completely perverse that we put the focus on employers and we're trying to support people in the workplace at the expense of someone without a job and not trying to improve their health. Because once someone had fallen out of work due to ill health, we'd lost interest in them. (ID2)

Given that you're dealing with the working population. If anything, you know, we'll sort of call that healthy population, not unimportant, you know, say, depressed or physically unwell. They're not unemployed. Generally, they're not middle age. They're not, you know at the end of their lives. So generally, you know they you would expect these people to be pretty well as it is. (ID1)

Theme 5b: Impact of wider social inequalities on employee health

Participants noted that workplaces were only one setting in employees' lives, and they questioned how influential this setting was compared with other factors. This was considered in relation to both structural factors that affected health behaviours, for example, the built environment, as well as individual factors, such as early life experiences.

What are the factors in people's lives which determine their behaviours? And their health? And where does come from? My suspicion is that they don't come from people's workplace, particularly. Lots of them are patterned quite early in their lives. (ID1)

I thought active travel would be something everyone would want to do. But then we had things like employers saying, no, we can't encourage our staff to use active travel for our night shift because we haven't got any cycle lanes. There's no lighting, we're out in the middle of nowhere. (ID8)

Participants were increasingly aware of employees' difficult socio-economic circumstances since the Covid-19 pandemic, particularly regarding income, debt, and housing conditions. Financial issues and housing conditions were linked with poor mental health in the workplace, and mental health was considered of paramount importance for employees, especially since the Covid-19 pandemic. Several participants reported that they had re-focused their WHISPA activity to place a greater focus on finances and debt, even though these issues were less explicitly focused on health. Participants believed populations most exposed to Covid-19 at work were also likely to be those generally most at risk of ill health at work due to their working conditions, such as in call centres or meat-processing industries.

We did know that there are issues around existing debt as we went into it. But I think we became more aware with people on furlough and with the stresses around mental health. The debt issue became a little bit larger and obviously what's followed is you know stuff around the cost of living, energy, etc. And it's that sort of stuff that's made us think. (ID2)

Coupled with increased focus on mental health and financial wellbeing was a recognition that WHISPA worked as part of an integrated approach to workplace health, and there was a role for promoting access to other forms of support, as well as WHISPA interventions.

Don't underestimate what is already available and using the workplace as a as a vehicle to kind of advertise that. So, if somebody is struggling with that and financial issues, well, actually just somebody within the organisation knowing about the money and pension service, knowing about Citizens Advice. (ID13)

We were approached by the joint work and health unit nationally and given a small amount of kind of pump priming [funding] to look at developing a health and work strategy across our whole system. So rather than having a kind of discrete small contract that looked at WHISPAs we've now got a strategy in place that encompasses that whole journey from health, overcoming health barriers into employment. It includes benefits, includes employers. (ID8)

Discussion

This study explored stakeholder perspectives on the implementation and evaluation of WHISPAs, identifying strong support for workplace health initiatives alongside persistent structural, methodological and socio-economic constraints. The findings suggest that while WHISPAs are perceived as beneficial, particularly at the individual level, their broader effectiveness is influenced by organisational culture, recruitment dynamics, data limitations and wider inequalities. Future research in this area has the potential to influence workplace and employees' health and wellbeing positively. However, ways to demonstrate impact, both in terms of practicality and evaluation, will prove challenging given the heterogeneity of organisational drive, resources and context.

Support for and feasibility of evaluation

Across participants, there was clear recognition that the effectiveness of WHISPAs remains insufficiently evidenced. Evaluation was widely viewed as essential for strengthening commissioning decisions and sustaining investment in this area. However, few organisations had the capacity to conduct such evaluative research, particularly that which is deemed robust in terms of design. Resource constraints such as time, funding, staffing, and expertise were cited as barriers to conducting controlled or longitudinal evaluations.

Participants favoured practical approaches, particularly pre–post designs and mixed-methods methodologies. Randomised controlled trials (RCTs) were regarded as methodologically ideal but unrealistic. This reflects broader debates in public health and implementation research regarding the transferability of experimental hierarchies to complex social interventions(18, 22, 23). In organisational environments characterised by variable cultures, shifting work demands and recruitment challenges, tightly controlled designs may lack feasibility and ecological validity.

Importantly, participants emphasised the value of qualitative narratives and case studies. Individual stories, particularly when re-screening identified preventable health conditions, were perceived as powerful forms of evidence. Yet even statistically significant findings or compelling case studies did not consistently translate into employer engagement. This suggests that the presence of evidence alone, as identified in other workplace evaluations, may be insufficient to shift organisational priorities, particularly where wellbeing competes with productivity demands(9).

Taken together, these findings suggest a recurring challenge in the evaluation of workplace interventions, where the generation of evidence is contingent on investment that is difficult to secure without prior evidence. In the absence of dedicated funding mechanisms and context-sensitive evaluation approaches, this dynamic may continue to impede the development of robust and transferable evidence for workplace interventions.

Recruitment, Selection Bias and Feasibility

Recruitment emerged as a central challenge in the implementation and evaluation. Employers were often difficult to engage, and those who did participate were frequently organisations already committed to employee wellbeing. Similarly, employees who volunteered for interventions tended to be those already motivated or health-conscious, therefore raising concerns about selection bias and generalisability. Recent evidence suggests that WHISPAs may primarily reach employers and employees predisposed to engage, potentially reinforcing existing organisational cultures rather than transforming less health-oriented environments and individuals(5). Moreover, the feasibility of recruiting control groups was particularly problematic, undermining the practicality of experimental evaluation designs, which is synonymous within the implementation science arena(24). Recruitment and data collection methods therefore need to be equitable with financial/other incentivisation to allow for participation across diverse job roles and working patterns. At the employee level, incentives such as health checks or expert consultations were perceived as effective motivators. At the employer level, however, incentives appeared more complex; organisational benefits (e.g., infrastructure improvements) were sometimes more persuasive than financial or reputational arguments. These findings suggest that engagement strategies must align with organisational interests and sector-specific constraints rather than relying solely on evidence-based appeals, a point which is frequently noted within the evaluative literature(17, 25).

Measuring Outcomes in Complex Systems

Participants found it easier to articulate individual-level impacts, particularly those linked to clinical screening or referrals rather than organisational-level outcomes. However, translating outputs (e.g., number of health checks delivered) into meaningful measures of sustained health improvement proved challenging. Attribution was frequently described as problematic, particularly for mental health outcomes influenced by multiple life domains, something which is reported to be persistently challenging(26).

Sickness absence and staff turnover were commonly cited as desirable metrics. Yet substantial variation in how employers collect and categorise data limited comparability and reliability. Often, inconsistent recording practices, differing absence triggers and incomplete datasets are reported to constrain meaningful and robust analysis of outcome data(13). Although some participants expressed interest in linking administrative or health data to enhance evaluation quality, whilst citing barriers such as confidentiality and workplace governance.

Conceptual ambiguity further complicates measurement in practice. The term “employee wellbeing” was interpreted inconsistently, referring variously to clinical indicators, job satisfaction, psychological safety and broader aspects of the work experience. In the absence of clearer alignment between intervention objectives and outcome measures, evaluation risks either reducing complex impacts to overly simplistic indicators or diffusing attention across poorly specified constructs.

Overall, the findings reinforce the difficulty of evaluating complex workplace interventions within dynamic organisational systems, where multiple interacting factors influence health and productivity.

Workplace Culture as a Mediating Context

Workplace culture emerged as a central determinant of both engagement and impact. Participants described significant heterogeneity between organisations, even within similar sectors. It was reported that culture influenced employer buy-in, the prioritisation of wellbeing, and whether employees were genuinely supported to engage with interventions.

In some employment contexts, particularly those characterised by precarious contracts or high labour replaceability, employers were perceived as having limited incentive to invest in workforce health.

Where attrition aligned with organisational interests, WHISPAs could conflict with prevailing economic logics. This finding aligns with wider evidence linking insecure employment and poor job quality to adverse health outcomes(27).

Even in organisations that adopted WHISPAs, participants questioned whether individual-level interventions could meaningfully influence wellbeing in the absence of supportive structural conditions. Poor terms and conditions, high workloads and limited autonomy were perceived as undermining behavioural change initiatives(28). A recurrent theme was the gap between formal policy commitments and lived organisational practice. Senior leadership endorsement and integration into organisational strategy were considered essential for sustainability.

These findings suggest that workplace culture serves as a mediating mechanism between intervention and outcome. WHISPAs may have a limited impact where underlying organisational conditions remain unaddressed.

Inequalities and the Limits of Workplace-Based Approaches

Concerns were raised regarding the potential for WHISPAs to widen health inequalities. Interventions were more readily implemented in office-based and professional settings, where digital access, stable employment and established HR systems facilitated participation. Routine and manual sectors faced structural barriers, including language diversity, production pressures and limited flexibility.

This pattern reflects the “healthy worker effect”, whereby employed populations are systematically healthier than those excluded from the labour market(29, 30). Some participants questioned whether focusing resources on the working population risks diverting attention from individuals with greater health needs who are not in employment, a concern echoed in the wider public health literature on work, selection and health inequalities(31).

At the same time, participants emphasised that employee health is shaped by broader socio-economic determinants beyond the workplace, including housing, income security and debt. Since the COVID-19 pandemic, financial stress and mental health concerns have become increasingly prominent(32). In response, some WHISPA activity has broadened to incorporate financial wellbeing and signposting to external support services.

These findings highlight both the potential and limitations of workplace-based interventions. While the workplace offers a valuable setting for reaching adults, it cannot be considered in isolation from wider structural determinants of health. Without deliberate equity-oriented design, WHISPAs risk primarily benefiting relatively advantaged employees.

Strengths and Limitations

This study draws on diverse stakeholder perspectives, including commissioners, providers, senior leaders and researchers, enabling a multi-level understanding of implementation challenges. However, the findings reflect self-reported perceptions rather than objective outcome data. Additionally, participating stakeholders may have been more engaged in workplace health than non-participants, potentially leading to the underrepresentation of more critical or disengaged viewpoints.

Implications for Policy and Research

These findings have several implications for policy and research. First, there is a need for proportionate evaluation frameworks that balance methodological rigour with feasibility in real-world organisational settings. Greater standardisation of core employer-level metrics, particularly definitions of sickness absence and staff turnover, would also improve comparability across studies and contexts. To avoid reinforcing existing inequalities, equity-focused implementation strategies are required to support engagement within routine and manual sectors, where participation has historically been lower. In addition, WHISPAs are likely to be most effective when embedded within broader strategies that address job quality and socio-economic conditions, rather than relying solely on individual behaviour change approaches. Future research should therefore explore hybrid implementation–effectiveness designs and examine how workplace culture and organisational context moderate the intervention’s impact.

Conclusion

WHISPAs are widely valued and perceived to generate meaningful individual-level benefits. However, their impact is shaped by recruitment challenges, organisational culture, evaluation constraints and socio-economic context. Without structural investment in evaluation capacity and greater attention to employment conditions and inequalities, workplace health interventions are unlikely to thrive. A shift toward integrated, equity-sensitive and contextually grounded approaches may be necessary to strengthen both effectiveness and impact.

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Footnotes

1. Dame Carol Black's *Working for a Healthier Tomorrow* review (2008) was a landmark report that shaped UK policy on workplace health, wellbeing and occupational health.

Black, C. (2008) *Working for a Healthier Tomorrow: Dame Carol Black's Review of the Health of Britain's Working Age Population*. London: Department for Work and Pensions and Department of Health
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