

## BENEFIT STAFF WELLNESS PROGRAMME YEAR 1 REPORT

### 1.0 Purpose

Year 1 report on progress of BENEFIT Staff Wellness programme with recommendations for its continuance and development.



### 2.0 Introduction

One of NHS Birmingham East and North's key goals is to be the employer of choice, and a sign of its commitment to its staff was the introduction of the innovative BENEFIT Staff Wellness programme.

In 2008 the staff survey identified a number of areas of dissatisfaction. There were a number of possible explanations for this but it was recognised that there was a need to provide staff with support and benefits which both motivated and fulfilled them at work and ensured they continue to maintain their own health and well-being. The development of the Pilot Wellness Programme was set-up with this in mind. It has two objectives:-

- To create an opportunity for staff to get involved in a wellness programme which empowers them with support to look after their own health and well-being, particularly in relation to lifestyle, e.g. healthy eating. In doing this it is hoped that staff who are participants will encourage patients and public who they come into contact with to think about their own lifestyles and make changes that will increase their health and well-being.
- To test the potential of the use of Incentive Schemes to support staff to achieve their own personal health goals, prior to launching any incentive schemes with the whole population.

### 3.0 Evidence



There is a growing body of evidence to demonstrate the effectiveness of interventions to tackle obesity. A recent meta-analysis of nine pedometer-based walking studies without dietary interventions showed a significant overall reduction in weight of 1.27kg (*Annals of Family Medicine* 6:69-77 (2008)).

Similarly a meta-analysis of 26 studies showed a 27 percent increase in activity (especially if goals on number of steps to be walked were agreed in

advance) and average and significant decreases in both BMI (0.38kg/m<sup>2</sup>) and systolic blood pressure (3.8mm Hg) (*JAMA* 298 (19); Nov 2007).

Other studies show that pedometers can increase physical activity, independent of starting BMI (*Preventive Medicine* Volume 39, Issue 6, Dec 2004) and that almost twice as many sedentary, obese people using pedometers reported sustained increases in exercise over a six-month period compared with controls (*JABFM* 19:524-525 (2006)).

A 2005 meta-analysis of 72 randomised controlled trials of motivational interviewing demonstrated a significant effect for body mass index, total blood cholesterol, systolic blood pressure, blood alcohol concentration and standard ethanol content. About three quarters of studies reviewed demonstrated significant effects on both physical and psychological illnesses and 64% showed an effect for a series of brief 15 minute interventions (*Br J General Practitioner*. 2005 April 1; 55(513): 305–312).

Further supporting evidence can be found locally in the Birmingham OwnHealth® service. Whilst the target group for this service is different the OwnHealth® service is underpinned by the same approach to health behaviour coaching and supporting individuals to make positive lifestyle changes, such as:

- 67% of members were exercising regularly at the end of Year 2 compared with 39% at the time of their initial assessment.
- 90% of people were non-smokers, had stopped or were actively trying to stop smoking at the end of Year 2 compared with 73% at the time of their baseline assessment.
- For members with BMI measurements considered to be in the obese range, there was a significant reduction in BMI, with the greatest weight loss (3.14kg) occurring in the group with BMI >45kg/m<sup>2</sup>.
- Members with diabetes, cardiovascular disease or hypertension all achieved significant reductions in their total cholesterol concentrations . The greatest reduction was seen in members whose total cholesterol was more than 7mmol/l; the average loss in this group was 2.08mmol/l.  
(Birmingham OwnHealth®, 2009)

The roll-out of Health Trainers as specified in the DH white paper “*Choosing Health*” provides further support for the use of health behaviour change coaching based on psychological techniques to help people improve motivation and make desirable health behaviour changes. As “*Choosing Health*” explains, “*providing information and persuasive messages can increase people’s knowledge of health risks and what action to take to deal with them*”. This is an essential framework for changing our way of life, but it is rarely enough on its own. There is good evidence that a range of approaches grounded in psychological science can help people change habits and behaviour, for example, setting goals and planning how to achieve them and building confidence to make the changes that they want.

## 4.0 Programme Initiation and Implementation

### 4.1 Programme Set-up



Commencing in February 2008, a combined team from the then Birmingham East and North Primary Care Trust (BEN PCT), Pfizer Health Solutions, and Humana Europe designed a multi-faceted workplace wellness programme. For the next five months, the design came together to deliver BENeFIT.

BENeFIT is a customised workplace wellness programme designed to meet the detailed specification set forth by the Trust. During the set-up period, the combined teams worked together to deliver all the different elements of the programme: face to face screening, telephonic health coaching, web-enabled pedometers, online health assessment, programme website, and a programme promotion & awareness campaign.

In reviewing the set-up effort, key elements deserve attention. First, the programme governance structure was very effective at managing and coordinating the work of dozens of resources across three main entities (Trust, PHS, and Humana Europe). Meeting more frequently and comprised of the resources closest to the work taking place was the Operations Group chaired by Andrew Bull. Providing oversight for this group and ensuring the programme headed in the right strategic direction was the Programme Board chaired by Nicola Benge.

BENeFIT is a sophisticated programme that makes a lot of use of technology, and as such, there are a number of key pieces of equipment that have to work together. It required a great deal of cooperation and coordination amongst the technical teams from the respective organisations.

The level of information handled and shared was governed through the introduction and use of an Information Sharing Protocol; the third set-up element to recognise. Participant information needs to be shared across multiple platforms and parties in order for BENeFIT to perform as required, and the Information Sharing Protocol clearly states who has access to what information, how information will be shared, transferred, stored, and secured, and how this information will be used.

The most prominent component of the programme during the set-up phase was the promotion campaign developed by Humana Europe and the PCT communications team. After creating the programme identity for BENeFIT, the team designed the promotion campaign using posters,



emails, intranet pages, on-site promotions with the health coaches and programme coordinator and payslip inserts.

## **4.2 Programme Implementation**

BENeFIT's implementation started with staff at Waterlinks House on 1 July 2008. Much like the set-up, the implementation was closely managed and coordinated through an 8-week phased launch period covering the Trust's eight localities. On each Tuesday for 8 weeks, Trust staff at the selected localities received an email inviting them to join the BENeFIT programme by enrolling through the Programme website. At first, performance was monitored hourly with detailed implementation metrics produced by the Humana team. This eventually relaxed to daily monitoring and status meetings for the combined team focusing primarily on any technical issues with the system or for users as well as recognising any changes required to the promotion campaign.

Also introduced at this point was the team from NHS Direct that provided the health coaching and face to face screening for BENeFIT members. For many participants, the helpful voice from one of the BENeFIT coaches was the first human contact from the programme, and was very effective at distinguishing the programme and ensuring its success.



## **5.0 Participation**

### **5.1 Enrolment**

In total 869 employees have expressed an interest in BENeFIT (March 31 2009). 686 have gone on to complete the Health Risk Assessment, and 611 pedometers have been registered. The initial aim was to engage 680 staff (40% of workforce). This has been achieved at two of the three key stages – see table 1. This total includes everyone who has since opted out of the programme, which is currently 28 (23 of whom were removed from the programme as they had left the Trust). There has been sustained interest in the programme and each week there are new enrolments. The sharp rises around challenge registration are apparent but the continued increase in participants throughout the year is strong also.

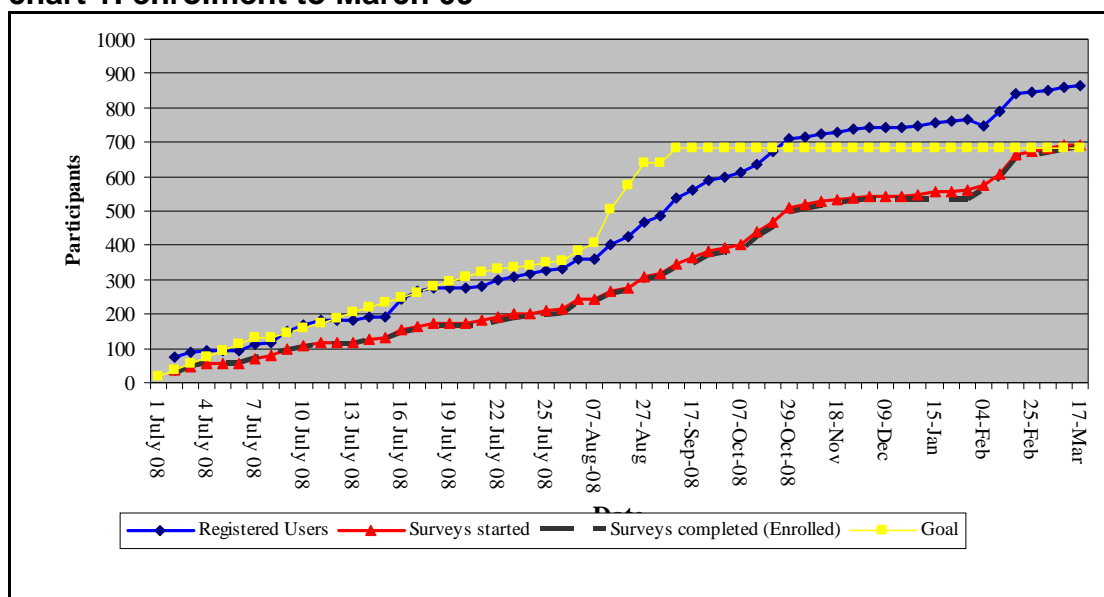
Throughout the programme, there has been a gap between those that have expressed an interest and those that have fully signed up. At present this gap is 183. We know from user feedback that some people haven't been able to register first time and have not tried again. Others simply did not get around to registering. Part of the on-site coordinators role is to identify non-completers and attempt to remedy any problems they have.

**table 1: enrolment**

Total Expressions of Interest	869
Total HRA Surveys Completed	686
Total Pedometers Registered	611

Chart 1 shows recruitment into the programme until March 24 2009. 461 have registered their reward card.

**chart 1: enrolment to March 09**



Initial enrolment was phased over eight weeks. The majority of participants are based at Waterlinks – a figure which is reflected in flu vaccinations uptake amongst staff– see table 2. The on site coordinator and Health Coaches regularly visit clinical teams to promote BENEfit and answer queries.

**table 2: participants by locality**

Locality	Total Participants
3S's	19
Birmingham SSA	125
BNE	108
BSA	22
Kingstanding	108
Sutton	46
Waterlinks (HQ)	255
WWH	14

**5.2 Demographics**

Participation by job role reflects the location of staff, the majority being Administrative, Clerical or in Management – see table 3. As stated above the on site coordinator regularly meets with clinical teams. Beyond IT difficulties, we do not fully understand the reasons why clinical staff are not engaging as well. The health Coaches and on-site coordinator will work with clinical teams to understand better the motivators and barriers to engagement and motivation. We will investigate whether the Trust’s expertise in social marketing can be employed to engage better with clinical groups.

**table 3: participants by job role**

Job Role	Total Participants
Administrative, Clerical & Management	317
Clinical Qualified Staff (AHP - Allied Health Professionals)	69
Clinical Support Staff - (Unqualified Support Staff)	29
Estates and Ancillary	20
Medical and Dental	7
Other	124
Professional Scientific & Technical	34
Registered/Qualified Nurse (Nursing & Midwifery Registered)	92
Students	5

Gender distribution is in-line with PCT make-up (536 females: 161 Males), while the age distribution favours the younger employees –see table 4.

**table 4: age distribution (yrs.)**

< 18	18 – 35	36 – 45	46 – 55	> 55
8	264	200	165	60

Monthly activity reports show a continued engagement with the programme throughout the year and through the winter months, and peaks in activity are seen during event periods. The Birmingham to Paris challenge was held over two weeks in November and as a result, November was the best month for total steps achieved, mean participant steps per day and % of participants achieving 7,000 steps a day.

**5.3 Body Mass Index (BMI)**

The Health Survey for England (HSE) data shows that in 2007, 60.8% of adults (aged 16 or over) in England were overweight or obese, out of these 24% were obese. 53% of participants were overweight/obese, and 21% were obese – see table 5.

**table 5: participants' BMI**

BMI <= 20	20 < BMI <= 25	25 < BMI <= 30	BMI > 30
62	264	219	151

## 5.4 Ethnicity

The ethnic mix of the BENEfIT programme is broadly aligned with that of the Trust.

Table 6: ethnicity BENEfIT compared to Trust pops.

Ethnic Category	Ethnicity	BENEfIT %	BEN %
White	British	69.29	71.96
Asian or Asian British	Indian	7.321	4.23
Asian or Asian British	Pakistan	6.06	4.07
Black or Black British	Caribbean	4.88	6.36
White	Any other white background	2.58	1.72
White	Irish	2.15	2.51
Choose not to disclose		2.01	2.35
Asian or Asian British	Bangladesh	1.29	0.8
Black or Black British	African	1.29	1.03
Asian or Asian British	Any other Asian background	0.86	0.75
Mixed	Any other mixed background	0.72	0.29
Mixed	White and Black Caribbean	0.72	1.03
Chinese or other ethnic group	Any other	0.43	0.4
Chinese or other ethnic group	Chinese	0.28	0.28
Mixed	White and Asian	0.14	0.17

## 6.0 On-site Programme Coordinator



The programme coordinator is based on site at BEN and is the first point of contact for programme participants. The programme coordinator is responsible for dealing with user queries, the distribution of pedometer welcome kits, troubleshooting technical issues, the collecting and reporting of operational metrics, producing copy for documents and communications and other clerical duties.

As a Humana employee, he acts as a point of contact for the PCT to Humana and works with IT and operational colleagues to feedback and provide solutions to any on-site issues or programme developments.

At the start of the programme, the coordinator worked to promote BENEfit around the PCT with on-site visits and email communications. Once fully implemented the focus of his work changed to more technical support work, assisting with registration and helping users get the most out of the hardware and software. There is a continuous flow of information from the coordinator to the operations group, identifying issues and opportunities and developing strategies to meet them.

During the two events the coordinator focused on making the user experience as straight forward as possible. There is much work done in the background around communicating rules to participants, organising teams and dealing with peaks in enrolment. The on-site coordinator managed a multi-disciplinary team in Humana to design and deliver the challenge.

As a result of analysing the operational metrics that are produced weekly and monthly, areas and job groups of low enrolment were identified. Strategies were put in place to address this which included face-to-face drop-in sessions on-site with a health coach, talking to the staff there and dealing with questions and technical issues. This led to an increase in enrolment from these groups and specifically the enrolment target set for nurses was met.

## **7.0 Health Coaches**



The main role of a Health Coach (HC) is to:

- Support and motivate members towards a healthier lifestyle, agreeing on safe achievable goals set by the member.
- Promote wellness, fitness and self care within a defined group of people and make appropriate suggests aiding a member in lifestyle changes.
- Undertake assessment, planning, implementation, coordination, review of health action plans and encourages the appropriate utilisation of services to reduce health risk and improve wellbeing.

Health coaching works on the philosophy of enabling and promoting wellness, self care and reducing health risk. HCs endeavour to engage individuals in active participation in their own health and encourage them to be proactive in their efforts surrounding health, fitness and wellbeing.

### **7.1 Health Coach Utilisation**

HCs are based at NHS Direct making and receiving phone calls to members. By working collaboratively with the member the HCs develop a health action plan and set goals around an individuals needs, particularly relating to areas of physical activity, diet and nutrition, pedometer use, stress, alcohol, depression and any health concerns. The main topics have been:

- physical activity 42%
- pedometer use 15%
- weight reduction 13.6%

Cardiovascular screening session is also available to members >40yrs- 237 screenings have been conducted to date. Recently 4 members of BoH staff have been trained as HCs to provide support and cover for the two full-time staff.

Currently both BENEFIT Health Coaches are working at full capacity and have 200 members each. These members each have different coaching levels assigned, which means that some maybe called every week other every 3 months. The majority of members have fortnightly or monthly calls.

On average HCs make 15 calls per day to members and also take inbound calls. E-mails are received from members on a daily basis; these can cover a variety of topics including booking appointments to speak to their health coach or to book a screening appointment.

A Health Coach participates in the weekly BENEFIT implementation telephone conference call. These calls allow any immediate concerns to be addressed and to update other partners on planned activities. In addition HCs attend the monthly Operational group.

The HCs have also undertaken drop in sessions at various sites across the PCT to encourage more staff members to join BENEFIT and take part in events and different activities to support their health and wellbeing.

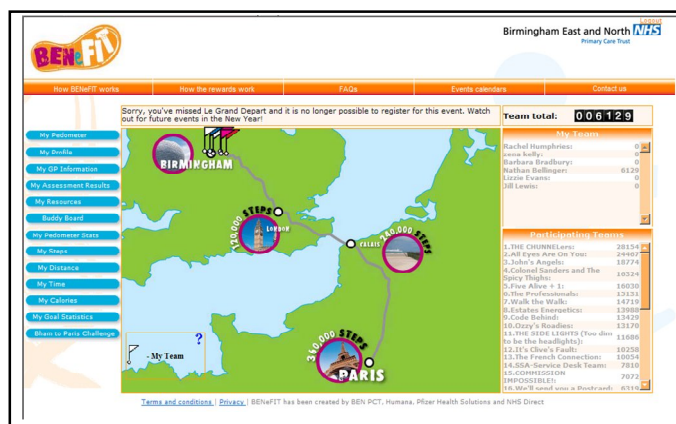
## **7.2 Cardiovascular Check**

Cardiovascular screening consists of a variety of health tests, including a capillary blood test for total cholesterol, High Density Lipid (HDL) levels, non-HDL levels and random blood glucose levels. Blood pressure and BMI are calculated and in collaboration with their cholesterol results a cardiovascular risk score is established. These results are discussed and recommendations made for changes to lifestyle. Where appropriate members may be advised to contact their GP.

The screening component of this programme contributes to the national policy requirements for delivering systemic Health Checks for our population aged 40-74 yr s. The West Midlands SHA has recently recommended that commercial and alternative providers for NHS Health Checks should be encouraged. Therefore, the BENEFIT screening programme could significantly contribute to a successful delivery of this national agenda.

**8.0 Events**

**8.1 Birmingham – Paris Challenge**



The Birmingham to Paris Challenge consisted of a promotion and enrolment campaign that took place over three weeks (3 – 27 Oct 08) and the actual challenge which occurred over two weeks (3 – 14 Nov 08). It was open to all BENEFIT participants who were asked to form teams of 4 – 6 people who were then

challenged to walk the virtual distance of 360,000 steps from Birmingham to Paris.

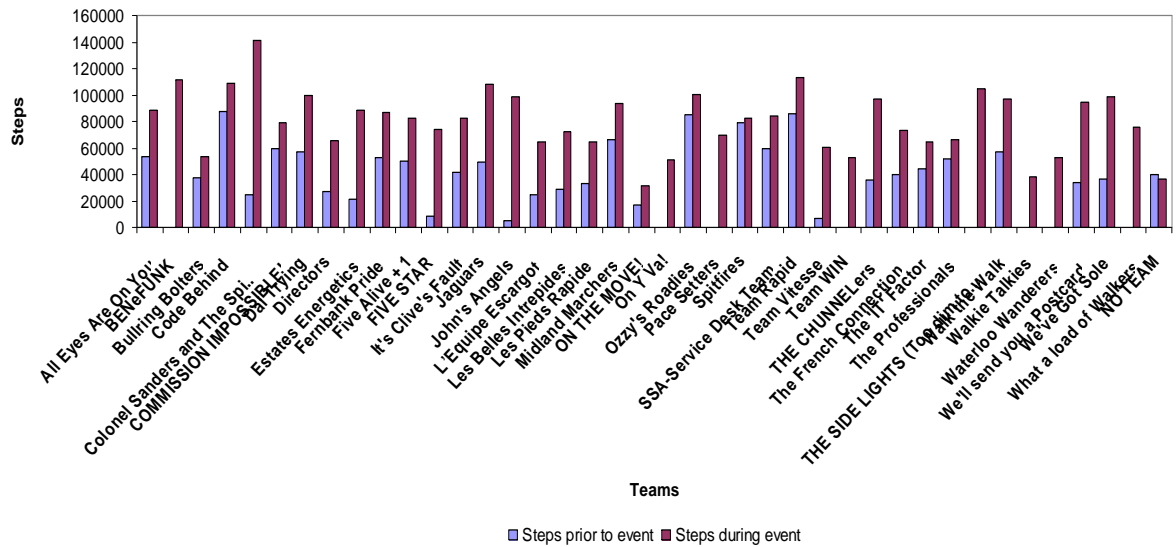
After the three week promotion and sign-up period, 215 BENEFIT participants (43%) had signed up for the Birmingham to Paris Challenge. These participants were formed of 39 teams with a large majority of teams consisting of six people.

The event was not meant to be a race, but there was hope that a competition would develop between teams (which was the case). Teams were rewarded with additional Boots Rewards points for reaching the three milestones along their route to Paris (London, Calais, and Paris). The first team to each milestone or to reach Paris did not receive any additional rewards, but the team that was the first to reach Paris has had their photo taken and included in an article in the forth-coming staff newsletter.

Enrolment figures during the promotion period and through to the end of the event were compared to the month before. The results showed an increase in participants enrolling with an increase to 135 from 84 people. This equates to a 61% increase.

It was interesting to compare the marked difference in the average number of steps walked by participants in a 2 week period prior to the event compared to the number of steps taken during the event period. Chart 2 below illustrates the dramatic increase in the average number of steps taken by individuals grouped in their event teams. Of note, it also appears that the team aspect of the event may have been an impetus for people to enrol, since around a quarter of teams prior to the event had 0 steps registered.

**chart 2: steps taken pre-event and during event**



**Comments about the Challenge**

- “Competitive element. Good fun. Great to see how far a certain amount of steps can get you. The fitness element – it encouraged me to walk more everyday – Loved it !!”
- “It improved my fitness but the competition also added to the challenge and gave me an incentive to meet the number of steps required.”
- “It was good bonding with other members of the team.”
- “It made me realise how little I did walk.”

**8.2 The Great Australian Walkabout**



The Great Australian Walkabout was organised like the first event but took place over 29 days (23 February – 23 March 09), and participants were challenged to walk up to 2 million steps, a virtual trip from Lake Eyre to Uluru. The increased distance was introduced because of feedback from the previous event. It was suggested to

participants that they pick one of the six different destinations (Sydney, Great

Barrier Reef, Arnhem Land, Karijini National Park, Margaret Lake or Uluru) and, with their team mates, aim for their personal targets.

After the two week promotion and sign-up period (this was extended by two working days because of demand), 328 BENEFIT participants (49% of BENEFIT participants at the time) had signed up for the Walkabout. These participants were formed of 55 teams with all but two teams consisting of six people. 53 of these teams were formed by the participants themselves.

The further participants walked the more money they raised for WaterAid – a charity that run clean water projects in Asia and Africa. Based on feedback from the first challenge, it was thought that raising and donating money to charity rather than crediting the participant's Boots points would be more motivating. The total raised for WaterAid was £721 (£661 raised in the challenge and £60 donated for guessing the mystery word)..

Full analysis of the challenge has yet to be undertaken but the total step count for all teams during the Walkabout period was 66,204,000. The step count for all BENEFIT participants over the entire month of February was 36,355,000 and the total for November (during which the first event took place) was 34,626,000.

### **Comments about the Challenge**

- “Team work is a culture at John Taylor Hospice and we affirmed and encouraged each .... We also had friendly competition between each other to increase our steps.”
- “As for how I managed it; getting on and off the bus earlier than what I needed to, walking of a lunchtime and evening...and each weekend walking with friends or my parents' Welsh border collie.”
- “Team motivation is also a good thing; a shared goal and encouragement to aim that little bit higher.”

## **9.0 Evaluation**



The majority of programme participants continue to be members of staff based at Waterlinks House, while the gender split is 86% female and 14% male.

The ethnic mix of the participants, as can be seen from the accompanying pie chart, is predominantly British (72%) with the remaining 28% being split, including those from African, Bangaledshi, Caribbean, Chinese, Indian, Irish and Pakistani backgrounds amongst others.

Many staff groups are represented, although the majority of staff are administrative and clerical (61%), clinical staff, both qualified and unqualified, make up 12% of the total.

## **9.1 Staff Satisfaction Questionnaire (SSQ)**

Overall the data collected and evaluated demonstrates that the programme is achieving positive benefits for the participants.

The SSQ exemplifies this – 101 participants. Participants overwhelmingly report their appreciation for being able to take part and that time is available for them to consider and take action upon their health and wellbeing. When asked to comment on the statement “I appreciate being given the time to think about my own well being” 100% either agreed or strongly agreed, the majority being the latter category – see appendix 1.

The website and pedometer ease of use were all commented upon favourably by participants (93% of respondents for example reported that they “like having a pedometer” and 80% reported that having a pedometer helped motivate them to be physically active).

85% of respondents commented favourably when asked about being incentivised with reward points to increase their physical activity and 99% stated that they would recommend the programme to new colleagues.

The intervention of Health Coaches overall received positive comment. 83% commented that they were appreciative of the opportunity for face to face screening, 86% felt the discussions with Health Coaches are pitched at the right level and almost 70% reported that they had made changes to their lifestyle as a result. Health Coach call frequency, duration and pace all attracted positive comment while service hours were felt to be right by 84% and overall service quality was to the satisfaction of 85% of respondents.

## **9.2 Health Risk Assessment**

In respect of the Health Risk Assessment (HRA) 667 participants took part in the original baseline assessment. Of that cohort 85 responded to the 6 month follow up. All demographic statistics that follow relate to the “follow up” cohort. Clinical statistics have been drawn from the entire membership.

Comparing between the initial assessment and 6 month follow-up of the members in a paired test, the HRA value has been reduced with the mean of 0.221 units and standard deviation of 1.91.

Because the values were not normally distributed (Kolmogorov-Smirnov Test Significance of 0.000), we used Wilcoxon signed rank (a non-parametric test). The P value of this test was 0.042.

This shows that BENEfit project has significantly reduced HRA value in the members who responded to the follow-up.

Responses concerning alcohol consumption appear to indicate the frequency of drinking has declined slightly, and the heavier users of alcohol appear to decreasing average levels of consumption.

The clinical measurements clearly demonstrate that a measurable impact is being experienced. Participants mean weight, waist measurement and BMI can be seen to be falling by statistically significant proportions – see appendix 2.

**9.3 Participant Activity**

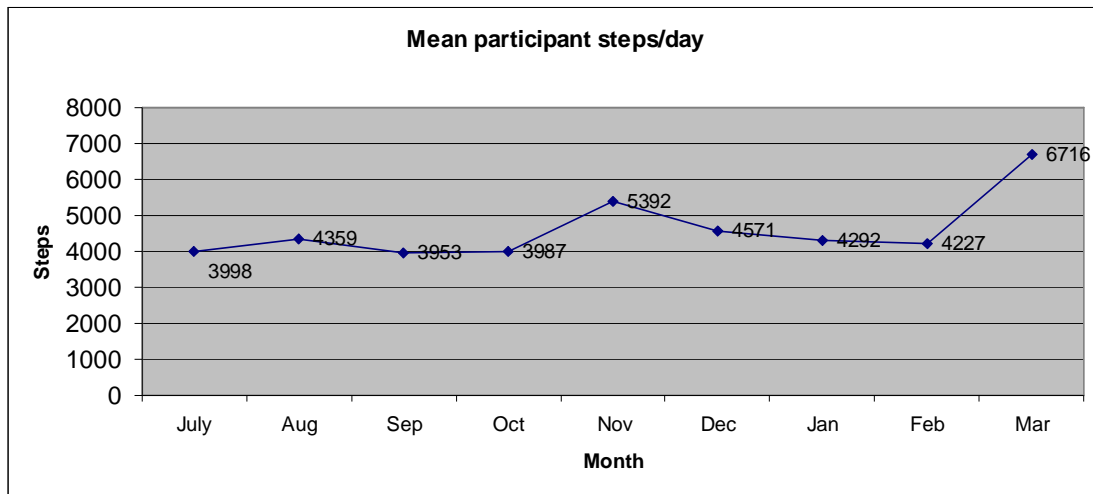
The following charts from the March monthly report show the impact the Walkabout had on participant activity. Chart 3 below shows the total number of steps achieved for all participants in March. It is twice the number achieved in November during which time we held the 2-week Birmingham to Paris Challenge.

Chart 4 shows the average number of steps taken per participant which includes those that do not upload steps – there is an 89% increase on the previous month which had been the best month so far.

**chart 3: Total Steps Taken July – March**



**chart 4: Mean Participant Steps**



## 10.0 Summary



As stated in the introduction an impetus for setting-up BENEFIT was the Trust's performance in the Staff Satisfaction Survey. The results of the 2009 survey have recently been released, in which a record 65% of staff took part. It shows an overall improvement in satisfaction, which puts NHS Birmingham East and North amongst the top 20% of Trusts for being recommended as a place to work. We believe that the BENEFIT programme has significantly contributed to our staff health and wellbeing, contributing to our prestigious ranking.

The results of the Staff Satisfaction Questionnaire attest to BENEFIT's positive impact and perception of the programme. Participants are overwhelmingly positive about the programme and having time at work to consider their health and wellbeing. The clinical measurements, mean weight, waist measurement and BMI, also show statistically significant change.

There has been a statistically significant reduction in the HRA score, a decline in members' at risk scores. Waist, weight and BMI scores were also reduced significantly. Whilst not statistically significant a decline in alcohol consumption has been observed.

At the programme's inception a 40% sign-up was set. This has been achieved on two of the three key indicators: Expressions of Interest and HRA surveys completed. Whilst 686 pedometers have been issued to date 611 are registered, i.e. in use. The on-site coordinator and the HCs continually try to

close that gap. Feedback suggests that the main reasons for this is lack of time and technical issues, e.g. poor IT skills.

The two events: Birmingham – Paris and The Great Australian Walkabout have been very successful, and have acted as excellent tools for recruitment into the programme. There has been a noticeable “buzz” when they are running and we feel they make a significant contribution to the life of the organisation and its culture.

The screening component of this programme could contribute to the national policy requirements for delivering systemic Health Checks for our population aged 40-74 yr s.

## **11.0 Recommendations**



NHS Birmingham East and North has invested £250,000 in the BENeFIT staff wellness programme – 40p per day for all staff, £1 per day for staff enrolled in the programme (50% of our staff lives within the Trust’s area). In view of the successful outcomes outlined above and the overwhelmingly positive response identified in the SSQ it is recommended that the programme is continued.

There is much scope for developing the project. Possible areas are:

- Further develop the website to make it more dynamic and interactive
- Further develop links with Birmingham OwnHealth®
- Review on-site coordinator and HC roles to establish right mix of skills and activities
- Explore links and learning with Young Foundation to identify opportunities applying learning from BENeFIT to the population we serve
- Understand better the needs of under-subscribed groups, e.g. nurses, and develop appropriate marketing strategy
- Screenings could contribute to the national policy requirements for delivering systemic Health Checks for our population aged 40-74 yr s.
- Feedback suggests staff may see BENeFIT as a work time only activity. Market programme as a whole life activity. Develop specific programmes of physical activity, e.g. walking clubs, under the BENeFIT/Team BEN brand.
- Develop actual programmes of activity, e.g. weight loss, as well as general lifestyle advice
- Better understand how HCs can be used in the maintenance of lifestyle change, e.g. motivational coaching techniques
- User feedbacks suggest the events are valued. Identify the nature and frequency of future events. Whilst the pedometers may always be used, there is probably a shelf-life for them as the main focus

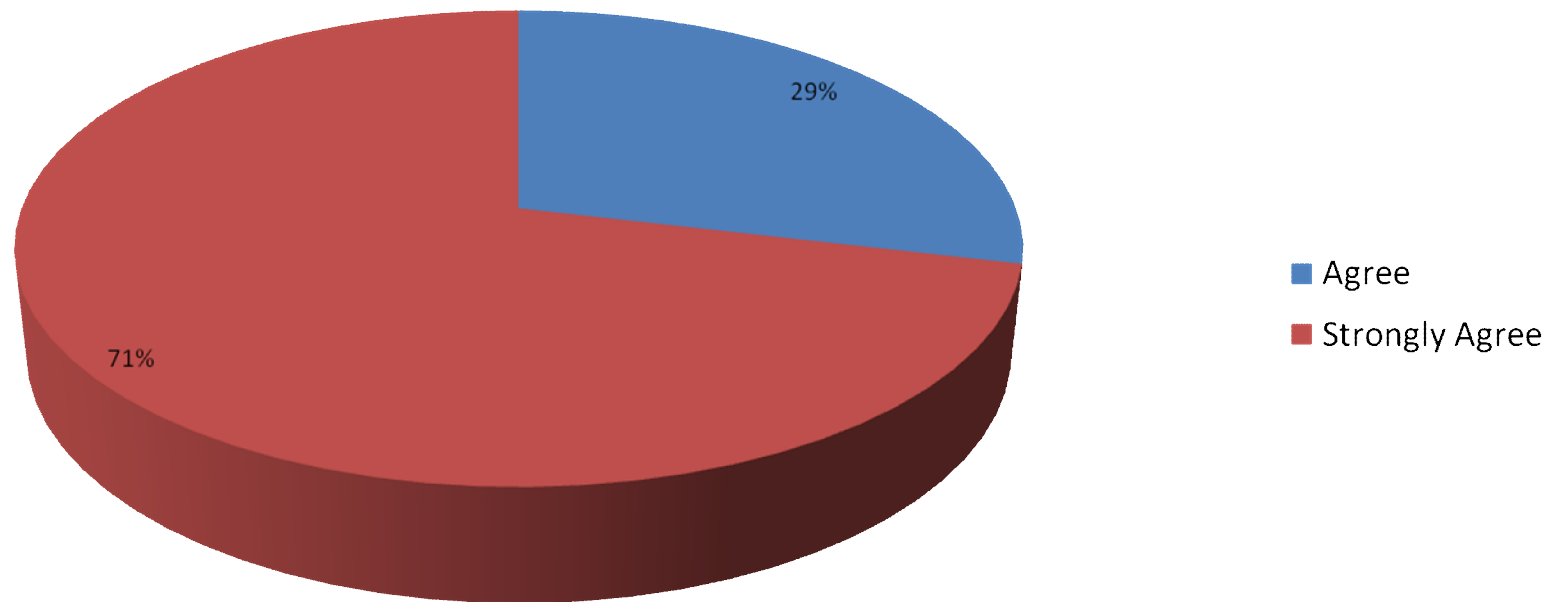
Appendix 1

# Evaluation Report

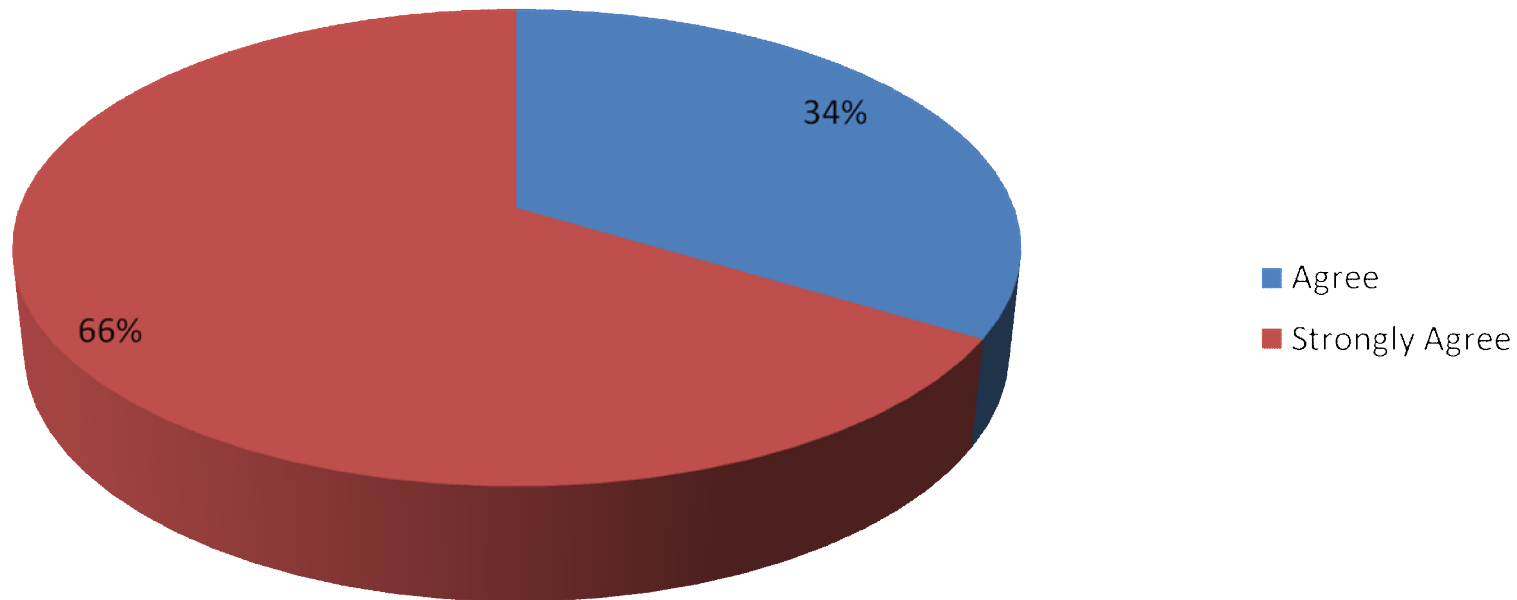
## 6 Month Report

### Staff Satisfaction Questionnaire

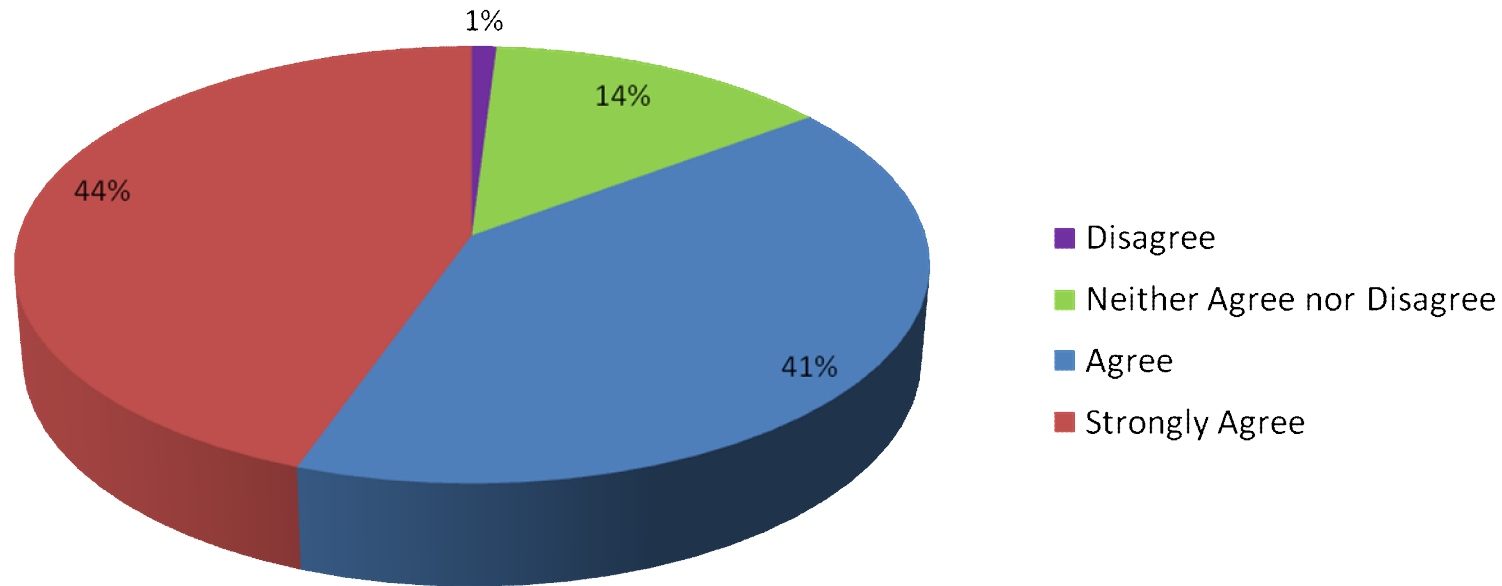
## I like the concept of a wellbeing programme being provided for staff



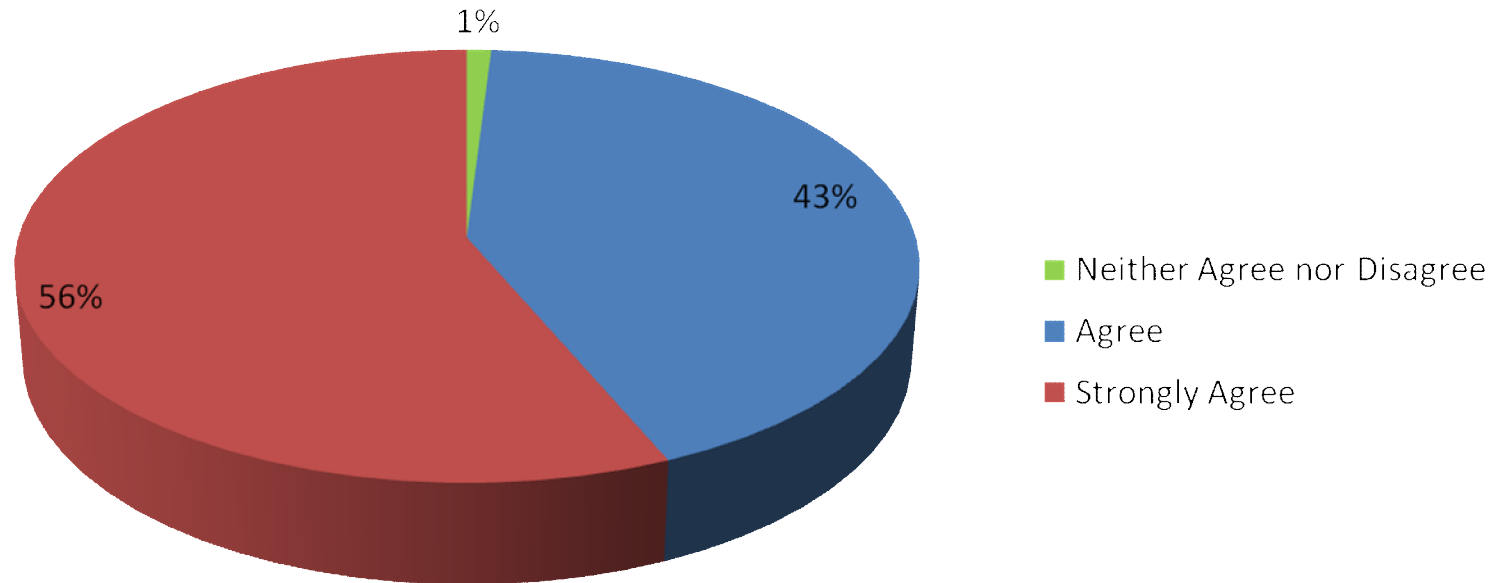
## I appreciate being given time to think about my own wellbeing



## **I like the idea of incentive points for improving my physical activity and weight management**



## I would recommend joining the programme to new staff



Appendix 2

# HRA Assessment

About HRA Assessment:

667 members participated in the baseline assessment. 85 members responded to 6 month follow-up.

## HRA Questionnaire

Comparing between the initial assessment and 6 month follow-up of the members in a paired test of the HRA value has been reduced with the mean of 0.221 units and standard deviation of 1.91.

Because the values were not normally distributed (Kolmogorov-Smirnov Test Significance of 0.000), we used Wilcoxon signed rank (a non-parametric test). The P value of this test was **0.042**.

This shows that BENEFIT project has significantly reduced HRA value in the members who responded to the follow-up.

<b>BENeFIT members with two clinical measurements</b>		<b>Count: 482 members</b>
<b>Clinical Test</b>	<b>Mean Difference ± SD</b>	<b>Significance (2-tailed)</b>
Weight (kg)	-0.044 ± 1.64	<b>0.049</b>
Waist Circumference (cm)	-0.097 ± 2.46	<b>0.014</b>
BMI	-0.037 ± 0.396	<b>0.021</b>