



EFFECTIVE DIFFUSION AND ADOPTION OF HEALTHY WORKING PRACTICES: A FEASIBILITY STUDY

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1. Executive summary

This feasibility study was commissioned by the Glasgow Centre for Population Health as a response to initial work carried out by the Glasgow Healthy Working Lives (GHWL) steering group towards its aim of more effectively diffusing healthy working principles and good practice amongst Glasgow's businesses. The initial work suggested that there may be an opportunity to progress this agenda beyond initial short term actions, through a comprehensive investigation of the key drivers which bring about adoption of innovations / new practices in general and how this might be applied to the health improvement arena with specific reference to healthy working practices within the workplace. The feasibility study's two stated objectives were:

- To establish the parameters of a potential healthy working practices demonstration and research project;
- To ensure that the right questions to be answered are at the heart of the research.

These objectives have been explored through a combination of reviewing relevant theory and practice in the fields of healthy working and health promotion more generally, whilst reflecting on the employer's perspective through a small sample of case studies and focus groups.

What does our feasibility research suggest?

- a) The characteristics of 'late mover' employers (those which are only likely to adopt new practices at a very late stage) are very different from 'innovators' and that the 'product' to be effectively promoted to organisations needs to be determined based on thorough investigation of distinct characteristics of different groups of employers (or 'customers segments' in marketing terms);
- b) In order to influence the extent and nature of the diffusion process, policy makers and practitioners will need to have a 'mixed strategy' which is closely aligned to the interests of the category(s) needing to be most influenced at a particular point in time, but is flexible enough to move on to meeting the needs of other categories over time;

- c) The traditional 'business case' for Healthy Working Lives (HWL) is not as important to early movers as might have been first thought; BUT
- d) Robust evidence is required to convince late adopters, which can only be provided through further research and evaluation of the impact of HWL programmes by organisations which are adopting them;
- e) Reducing sickness absence and job retention are key drivers for organisations;
- f) Adoption theory when linked to social marketing processes could provide a robust framework for approaching further employer related research;
- g) A number of assumptions are made by employers about the motivation and values of their staff, for which there is not necessarily robust evidence (difference between perception and reality).

These findings point towards a number of key questions for future research (which might be explored in conjunction with one another or as distinct project/s):

- 1. How does an employer defined as a 'late adopter' differ from an 'early adopter' in its approach towards the same set of HWL services?**
- 2. What would make late adopters move earlier?**
- 3. Given the organisational characteristics of 'early movers', which employers should be adopting earlier and aren't?**
- 4. To what extent do wellbeing policies impact on employee motivation to work for and remain with their employer?**

Further consideration of strategic priorities by potential key partners, such as the Scottish Centre for Healthy Working Lives, the Partnership for Health and Safety in Scotland, City Council / enterprise company and Department of Work and Pensions initiatives will be necessary to produce a detailed proposal which is capable of strengthening the evidence base in this field and providing practical examples of how change can be made to happen voluntarily.

2. Introduction

The May 2006 issue of Health at Work (online healthy working newsletter produced by NHS Greater Glasgow and Clyde) made the following comment:

“Health at Work is pleased to announce that 200 organisations are now signed up for Scotland’s Health at Work Award (SHAW) Programme. Employer Direct, a part of JobCentrePlus recently became the 200th registered workplace... This takes the number of employees reached by SHAW in (Greater¹) Glasgow to over 150,000, representing 47% of the working population. Nationally over 1,600 workplaces have signed up to the programme and these companies range in size from 2 employees to 38,000 employees.”

(NHS Greater Glasgow and Clyde 2006; 4)

There is obviously much to celebrate in these figures, but they also raise a number of important questions. For instance, what about the 53% of the working population in Glasgow that is not currently covered? Is there a realistic likelihood that a sizeable proportion will become covered in the not so distant future? Furthermore, much of the current coverage statistic of 47% is heavily influenced by the participation of a relatively small number of large sized public and not-for-profit sector organisations (for example, Glasgow City Council accounts for 38,000 employees; Glasgow Housing Association for over 2000). Given that 74% of Glasgow’s businesses employ fewer than ten people, coverage among small (and medium sized) organisations is rather more limited, which suggests that the nearly one in two coverage of the working population in Glasgow is not particularly representative of the overall distribution or pattern of employers there.

2.1 The key research questions and approach

It is these sorts of questions and issues that prompted the study undertaken here. Specifically, we sought to make a start (in this feasibility study phase) in shedding some light on the following sorts of questions:

1. What considerations and sources of information have motivated individual workplaces at the present time to introduce voluntarily healthy working lives programmes?

¹ Statistics are provided by Health at Work for the NHS Greater Glasgow area and include several outlying local authority areas. They also relate to the ‘business unit’ which is participating, resulting in several large UK wide companies as presenting as only SME sized businesses.

2. Conversely, what sorts of barriers and obstacles are impeding other workplaces from adopting similar sorts of programmes?
3. If some of the workplaces currently without such programmes were to introduce them at some stage in the future would similar considerations and influences (as identified for question 1 above) have played such a role?
4. What are the criteria of success that workplaces use in evaluating such programmes, and what proportion of programmes are deemed to be successful in this regard?
5. Within individual workplaces, what proportion (and types) of employees utilise such programmes, value them and appear to gain some tangible health and work related benefit from them?

2.2 What are 'healthy working lives' and what do programmes which encourage them hope to achieve?

It is helpful to define what we mean by 'healthy working lives' or 'wellbeing' programmes. The Scottish Centre for Healthy Working Lives describes its mission as being to provide *"support and opportunities to enable individuals to maximise their functional capacity throughout their working lives"* (NHS Health Scotland 2006, 5) with both an economic and health rationale for their approach. For this feasibility study we have defined such support and opportunities as: policies and practices which aim to protect and promote good health and wellbeing, as well as addressing the determinants of ill health within the workplace setting.

This is a deliberately broad definition, recognising the impact that more general HR policies such as 'family friendly policies' can have on workplace wellbeing. It is interesting to note that even within these two definitions, there are some distinct emphases in terms of the core objectives of HWL interventions. For the Scottish Centre the emphasis is more on *supporting employment and economic efficiency* as an end in itself, perhaps a reflection of public policy focus on employability, demographic change and economic imperatives to keep people working longer. To put it crudely, the rationale for HWL interventions here is about *'stopping work making you sick'*. Our own definition perhaps reflects a more traditional health promotion stance, which sees the workplace as an important setting *through which to reach the population with health improvement messages*. These two complementary, but distinct, objectives are important to recognise as this study considers areas for further development and research. Both approaches recognise the potential of wider

measures, such as good management and occupational health and safety, to impact upon healthy working, rather than purely traditional health promotion programmes.

2.3 Methodology

To begin the longer term process of gathering the necessary information to help answer our research questions, this study reports the leading information and insights that we have obtained from:

- a (partial) review of the literature concerning organisational change, and the adoption and diffusion of organisational innovations;
- a brief look at making behavioural change happen in the context of social marketing;
- a case study of an individual organisation;
- the result of two focus group exercises; and
- brief analysis of three projects currently engaged in making change happen within health promotion and healthy working lives.

PART ONE:
RELATING EMPLOYER ADOPTION TO CHANGE AND
DIFFUSION THEORY

3. A (partial) review of the organisational change literature

3.1 A general introduction

There is a voluminous literature on organisational change which is primarily concerned with the following themes:

1. identifying the key triggers for change;
2. outlining different types of change which are being sought; and
3. seeking to identify the most effective types of change process, given the different triggers for change and difference in the nature of the change.

For present purposes it is important to recall exactly what type of change we are seeking to understand and explain: it is the **voluntary** (not legally required) decision of the management of a work organisation to introduce a set of policies and procedures designed to improve the health and wellbeing of the workforce. Health promotion, smoking cessation support, stress advice, opportunities for exercise and nutritious food options are typically central to such physical/mental health awareness raising programmes. These types of interventions would at first suggest that HWL programmes are generally concerned with small, discrete, planned types of change (Senior 2002). However, a great deal of the existing literature on organisational change is concerned with large scale, organisation wide structural change in the face of poor performance which requires strong leadership to drive through major changes in strategies and structures in the face of potential internal opposition. Such concerns tend to reflect wider, more fundamental organisational health issues, such as poor health performance resulting in thorough-going review of sickness absence management (to which we return later in this chapter).

It is this latter sort of perspective, which involves the so-called 'ten commandments' (essential truths) of change listed in Figure 1 below.

Figure 1	
The Ten Commandments of Organisational Change	
1.	Analyse the organisation and the need for change
2.	Create a shared vision and common direction
3.	Separate from the past
4.	Create a sense of urgency
5.	Support a strong leader role
6.	Line up political sponsorship
7.	Craft an implementation plan
8.	Develop enabling structures
9.	Communicate, involve people and be honest
10.	Reinforce and institutionalise change
<u>Source:</u> R M Kanter, B A Stein, and T D Jick, <u>The Challenge of Organizational Change</u> , Free Press: New York, 1992	

However, evaluations of change programmes show that the messages of the ten commandments have not worked terribly effectively in practice. Experts in organisational change frequently cite around only one in five change programmes (typically involving attempted changes in structures and strategies) as being 'successful' in practice².

There have been a number of responses to such a relatively high level of failure among conventional change programmes. One response, has been to argue that the model is fine (Figure 1), but the failure stems ultimately from a *poor implementation process* (Kotter 1995). A second, very different response has been to argue that the model is flawed, being essentially too top level driven (Beer et al 1990); according to proponents of this view successful change needs to be initiated in a *'bottom up way' in a small, relatively isolated part of the organisation*. A third view is that the Figure 1 approach concentrates too much on strategies and structures, and *too little on people* whose attitudes and behaviour need to change. This view has resulted in the big emphasis (post the 1990s) on seeking to change the culture of the organisation via cultural ('hearts and minds') change programmes (Senior 2002).

² This figure emerged through interviews with a number of organisation change experts.

3.2 The particular theme of organisational culture

This emphasis on the importance and nature of **organisational culture** is particularly important for our purposes. This is because of the increasingly popular argument in recent years that whether the workplace is a solution (or problem) for employee health is a function of whether there is a good (poor) fit between the employee and:

1. the job and
2. (increasingly) the organisation's culture (Jones 2006).

Figure 2 lists features of both the job and the organisational culture where a good (poor) fit with the employee can be a source of good (poor) wellbeing.

Figure 2	
Employee Wellbeing and Key Job and Organisation Culture Characteristics	
<p>Key Job Characteristics</p> <ul style="list-style-type: none"> - Job demands - Opportunity for Personal Control - Opportunity for Skill Use - Externally Generated Goals - Variety - Role Clarity - Availability of Money - Physical Security - Opportunity for Interpersonal Contact - Valued Social Position - Quality of Supervision 	<p>Key Characteristics of Organisational Culture</p> <ul style="list-style-type: none"> - Organisation-Person Fit - Environmental Clarity - Existence of Discrimination - Decision Making Climate - Occupational Stress Factors - Nature of Relationships at Work - Participation Change Management - Supporting Management and Colleagues - Social-Organisational Environment - Values of Organisations - Internal Politics of Organisations
<p><u>Source:</u> Warr, P. 'The Study of Wellbeing, Behaviour and Attitudes', <u>Psychology at Work</u>, Penguin 5th edition.</p>	

The values of the organisation cited in Figure 2 have been of particular interest in recent years. This is because a number of employee questionnaire-based studies have widely reported that strong bottom line pressure on management quite widely leads to a culture of 'limited respect' and 'fault finding', which involves poorly given criticism, limited praise, the use of command/control practices when bottom line pressure is on, and which can easily slide into bullying and harassment of employees (People Management 2006). The costs in terms of employee wellbeing, productivity and employee retention are being increasingly discussed by human resources specialists. In marked contrast, discussions with individual organisations with health and safety records well in advance of their particular industry average(s), frequently attribute a good deal of their success to their attempts to encourage and establish organisational cultures characterised by "*no blame and respect*".

3.3 The trigger for change: sickness absence?

Formal models of organisational change invariably embody a process consisting of three sequential stages (Kanter et al 1992). The precise terminology used for the stages may vary between individual models, but in essence they involve recognising the existence of a problem (stage one); experimenting with new approaches (and monitoring their progress) to deal with the problem (stage two); and institutionalising the successful approach as the new way of doing things (stage three).

For present purposes, it is stage one with which we are particularly interested, as a problem-centred stage in which the organisation concerned must have an "*internally generated, felt need to change*" (Lewin 1951). This might be described as the initial 'trigger' for change. In seeking to explain the adoption of employee wellbeing programmes a question of particular interest is whether there is one leading problem that has driven that adoption process, or whether the nature of the problem tends to vary considerably between individual organisations? This is a question that we return to in various sections of the report, but here we suggest that if there is a leading 'trigger' for the introduction of such programmes, the most obvious (single) candidate is likely to be the level (and causes) of sickness absence.

For example, the Chartered Institute of Personnel Development's (CIPD) absence survey for 2005 reported an average level of sickness absence of 3.7% or 8.4 days per employee per year; in the public sector the latter figure reached 10.3 days. Furthermore, *"stress and mental ill health are the leading causes of long term absence among non-manual workers..."* (CIPD 2005; 22); in the public sector nearly half of the respondents identified stress as the number one reason for long-term absence among non-manual employees.

There are a number of existing case studies of individual organisations, which have identified sickness absence levels as the trigger for the introduction of employee wellbeing programmes (Bushfield, Beaumont and Stewart, 2006; CIPD, 2005). This suggests that a business case, involving a short run, direct impact on the bottom line of the organisation, has been important in motivating **some** organisations to introduce such wellbeing programmes. However, whether a business case is important in motivating all employers to introduce such programmes is a question that we return to in other sections of this report.

4. Studies of the diffusion process amongst employers: key insights

At present there is no large scale, representative data sets that can tell us the proportion of employment organisations in Glasgow, Scotland or the UK, which have introduced employee wellbeing programmes. The most relevant national ‘proxy’ statistics available relate to the ‘reach’ of the Scotland’s Health at Work (SHAW) scheme in 2002, which indicated that 0.4% of organisations were registered with the scheme, representing some 12.1% of the workforce (NHS Health Scotland 2002). Case study based evidence also makes it abundantly clear that some organisations have in place some programmes. What – among other things – remains unclear is how many other organisations will introduce such programmes in the future, when this will occur and whether the considerations that influence such future introduction will be the same as influenced those who have already introduced such programmes.

4.1 Lessons from diffusion theory

To answer these sorts of questions, one needs to turn to some of the leading studies on the diffusion process, which show how and why an idea, product or innovation is adopted by a given population over a period of time. A popular, recent book provides a useful summary of the underlying analytical framework of such studies:

“One of the most famous diffusion studies is Bruce Ryan and Neal Gross’s analysis of the spread of hybrid seed corn in Greene County, Iowa, in the 1930s. The new corn seed was introduced in Iowa in 1928, and it was superior in every respect to the seed that had been used by farmers for decades before. But it wasn’t adopted all at once. Of the 259 farmers studied by Ryan and Gross, only a handful had started planting the new seed by 1932 and 1933. In 1934, 16 took the plunge. In 1935, 21 followed, then 36, and the year after that a whopping 61, and then 46, 36, 14 and 3, until by 1941, all but two of the 259 farmers studied were using the new seeds. In the language of diffusion research, the handful of farmers who started trying hybrid corn at the very beginning of the 1930s were the Innovators, the adventurous ones. The slightly larger group who were infected by them were the Early Adopters. They were the opinion leaders in the community, the respected, thoughtful people who watched and analyzed what those wild Innovators were doing and then followed suit. Then came the big bulge of farmers in 1936, 1937 and 1938, the Early Majority and the Late Majority, the deliberate and sceptical mass, who would never try anything until the most respected of farmers had tried it first. They caught the seed virus and passed it on, finally, to the Laggards, the most traditional of all, who see no urgent

reason to change. If you plot that procession in a graph, it forms a perfect epidemic curve – starting slowly, tipping just as the Early Adopters start using the seed, then rising sharply as the Majority catches on, and falling away at the end when the Laggards come straggling in.”

(Gladwell 2000; 196-197)

This framework (innovators; early adopters, early majority; late majority; laggard) has been tested and found useful in explanatory terms in relation to other types of innovation, and in more recent periods of time (Rogers 1995). Figure 3 summarises some of the leading characteristics of these five sub-groups.

Figure 3	
Characteristics of Adopter Categories	
Category	Characteristics
Innovators	Venturesome, educated, multiple information services, greater propensity to take risk, act without hard data backing the initiative, motivated by the prestige of being the first to adopt an innovation.
Early Adopters	Social leaders, popular, educated, look beyond their peers at outside sources for information, act without hard data backing the initiative, do more research than innovators but still motivated by potential positive outcomes, in terms of reputation both internally and externally.
Early Majority	Deliberate, many informal social contacts, motivated by harder bottom line outcomes.
Late Majority	Sceptical, traditional, lower socioeconomic status, motivated by peer pressure and bottom line elements.
Laggards	Neighbours and friends are main information sources, fear of debt, may only adopt innovations when it becomes legally necessary.
Source: based on Rogers, E.M. <u>Diffusion of Innovations</u> , New York 4 th edition, The Free Press, 1995.	

The framework can be (and indeed has been) utilised to try and account for the pattern of diffusion among populations variously based on **individual persons** or **organisations** as the unit of analysis. Moreover, some commentators have modified the framework by reducing the number of categories from five to a smaller number, such as two or three (see Figure 4 below).

Figure 4	
Characteristics of Early Movers versus Late Movers	
<p>Early Movers</p> <ul style="list-style-type: none"> • not interested in the bottom line numbers • evaluate it in terms of ‘feel good’ factors • mainly motivated by view that employees will value it (which is not necessarily the same as will benefit from it) • will ensure that the underlying budget is highly controlled • big debate often about which particular item will be most valued/appreciated by employees 	<p>Late Movers</p> <ul style="list-style-type: none"> • will do the numbers (as more to employees means less to the customers) • believe that not of high interest to employees relative to traditional terms and conditions of employment • believe that any initial positive valuation by employees will fade time quickly • any gains to the organisation will only come about via an enhanced general commitment to work (‘better morale’) which is similar to effect from staff Christmas party/social event
<p><u>Source:</u> Interview with Former CEO</p>	

However, the essentials of the framework, with their predictions and implications remain basically the same. These may be summarised in terms of the following three propositions.

4.2 Three propositions for understanding voluntary adoption of health and wellbeing programmes

1. At any point in time the characteristics of adopters will not be representative of the population at large.
2. The motivation of, information sources used by, and expected gains of the 'early movers' (innovators and early adopters) will be very different to those who follow them (early majority, late majority, laggards).
3. Specifically, the former will be less influenced by peer group information sources and will be less bottom line orientated than those who follow them.

The implication of these three predictions is that policy makers seeking to influence the extent and nature of the diffusion process will need to have a '***mixed strategy***' which is closely aligned to the interests of the category(s) needing to be most influenced at a particular point in time, but is flexible enough to move on to meeting the needs of other categories over time. Figure 5 provides a recent illustrative approach to mixed diffusion strategy to introduce ergonomic innovations, with occupational health benefits, to earlier movers (with levels of diffusion penetration up to 30%) within the US construction sector.

Figure 5	
Level of Use of Ergonomic Initiative and Strategy for Diffusion	
Level of Penetration	Strategy for Diffusion
Minimal (less than 2.5%)	<p>Target Innovators</p> <ul style="list-style-type: none"> - present workshops to firms that have previously been in the forefront of ergonomic improvements - create opportunities for experimentation through collaboration with suppliers - collaborate with external and internal groupings of innovators - document experiences with new ergonomic improvements - collaborate with firms and individuals to achieve innovation
Low (between 2.5% & 15%)	<p>Target Early Adopters</p> <ul style="list-style-type: none"> - develop and lead workshops and conferences for training and safety professionals and trade contractors, using innovators, vendors and researchers as presenters - develop fact sheets and brochures concerning innovation industry data on relative advantage - act as liaison between suppliers and potential users
Moderate (between 15% and 30%)	<p>Target Early Majority</p> <ul style="list-style-type: none"> - facilitate peer-to-peer information sharing through unions, contractor associations, trade shows - develop fact sheets and brochures concerning innovation emphasising data on relative advantage and bottom line - promote ergonomic marketing of tools by suppliers through peer network - promote ergonomic improvements through joint training centres
<u>Source:</u>	M. Weinstein et al (2005) 'There is Nothing So Practical as a Good Theory: A Roadmap to Diffuse Ergonomic Innovations in the Construction Industry,' Labour Education and Research Center, University of Oregon, Mimeo graphic Paper

4.3 Surveys of the voluntary adoption (or not) of HR policies

Much of the literature reviewed here emphasises the importance of human resource (HR) policies and practitioners in implementing healthy working policies (such as sickness absence management or work life balance programmes), whatever the initial rationale for their adoption. To further test our first proposition (Section 4.2) – that at any given time the characteristics of adopters will not be representative of the population at large – it is worth looking at the statistical literature relating to voluntary adoption of particular human resource management policies and practices designed to be of some substantive or procedural benefit to their workforce.

In such studies, the particular nature of the innovation being adopted has varied quite considerably in practice, but the overwhelming findings from these types of studies is that such point of time adoption decisions are not randomly distributed throughout the population of organisations at that point in time. In other words, the organisations which have adopted them are not representative of the full population of organisations. An excellent illustration of this key finding comes from a recent study of the distribution of ‘family-friendly management’ in Britain

“Management in the average British workplace is not practising family friendly flexible management. Those managements that do are likely to be in large organisations that have personnel departments, an equal-opportunity approach, or a high proportion of female, well-educated employee managers among their workforces. Such managements are also more likely to provide child care assistance, although child care is more likely to be found in large workplaces (not necessarily organizations) and where management does value a healthy family-work balance and have a quality strategy (as proxied by Total Quality Management).”

(Wood et al 2003; p246).

This sort of finding could be reproduced from many such studies of the adoption (or not) of various HR policies and practices (Osterman 1994). At present we lack a nationally representative data set which can usefully document and track over time the time profile of the adoption of healthy working lives programmes. However, what we do know is that their introduction is a relatively recent phenomenon, being concentrated in the last five to ten years or so as the concern about sickness absence levels has received more and more media and government attention. Moreover, we also have some existing case studies of a number of these individual programmes. Accordingly, in the next Sections we briefly review some of the findings of these case studies in order to provide a preliminary perspective on the second and third of our propositions relating to the importance of different motivational factors including the relative importance (or not) of peer influence and bottom-line performance for different employers.

4.4 A review of the case study evidence concerning healthy working lives programmes

Given the relatively recent history of healthy working lives programmes (as we understand the term now) one might not unreasonably assume that, in time scale terms, we would be talking about the ‘innovators’ and the ‘early adopters’ stage of the process. However, surveys of HR executives and reviews of the existing Government advice to encourage the adoption of such policies overwhelmingly involve a business case being made. That is, they believe that a direct, short run positive effect on the organisation’s bottom line performance will result from the introduction of such programmes.

Our review of the existing case study literature, including those conducted by the authors of this report, suggests that the strong business case, such as that summarised in Figure 6, is the exception rather than the rule.

Figure 6 The Case of AstraZeneca
<ul style="list-style-type: none"> • Between 2002 and 2003 there was, globally, a 50% reduction in the number of staff reporting stress-related illness. • There was also a significant reduction in claims for psychological support from the company's health insurance scheme. • The company have calculated that improved productivity, as a result of counselling, adds up to £700,000 annually to the bottom line, which reduced time off contributing a further £600,000. • 88% of employees believe that AstraZeneca demonstrates commitment to the health and wellbeing of its employees.
<p><u>Source: CIPD (2005), Making CSR Happen: The Contribution of People Management, London, p16-17</u></p>

What makes this case relatively unusual was the following: there was a clear explicit driver for the introduction of the programme (a reported rise in stress symptoms among the workforce) and the programme was formally monitored and evaluated with hard data being gathered to assess the immediate organisational, bottom line benefits. These sort of features were relatively absent from many of the case studies we have conducted or reviewed. Arguably, the most typical case was along the lines suggested in the traditional diffusion studies (Figure 4): 'innovators' and 'early adopters' are less bottom line orientated, and more concerned with enhancing their reputation among their existing employees and potential future employees. That is, they view the adoption of healthy working lives programmes as:

1. A natural outgrowth of the larger organisational culture they have long aspired to create (*"we encourage an open culture... a community spirit"*)
2. Enhancing their claim to be an 'employer of choice' (*"we take good care of our employees"*) in a tight labour market where the recruitment and retention of good employees is all-important.

This 'reputational' motivation for the adoption of healthy working lives programmes was certainly not indifferent to the business advantages of having such programmes. However, they tended to view such benefits as being more longer term and indirect in nature, and tended to rely more on perceptual, rather than hard data to make this case. These findings find resonance with SHAW's impact evaluation in 2002, which found that whilst organisations attributed health-related workforce improvements to SHAW, there was virtually no evidence available to support those perceptions (NHS Health Scotland 2002).

There was also a third category of cases, which we have labelled the 'investment' approach (Bushfield et al 2006). These tended to be seeking both business and reputational benefits from the adoption of such programmes, with sickness absence levels and costs being frequently the most common, initial driver for their introduction. Typically for them such programmes were viewed as 'successful' if:

1. Sickness absence levels, and associated costs, were coming down over time;
and
2. Employee attitude surveys indicated that the majority of their workforce value and appreciate the programme.

In Part Two of this report, we investigate this 'investment' perspective further, through a case study based on a health working intervention recognising the importance of a multi-faceted approach to tackling one specific 'problem' issue. First however, Chapter 5 will investigate the potential of social marketing – an emerging tool in the health improvement field – to provide a framework for understanding employer motivation and achieving diffusion of healthy working messages.

5. Making behavioural change happen: insights from social marketing

In Chapter 3, one of the reasons cited for the lack of success in conventional organisational change programmes, was the lack of attention paid to the *people* whose attitudes and behaviour need to change (page 9). The recognition of the differing characteristics of adopters (seen in Chapter 4's adopter categories) responds to this criticism, suggesting that a 'mixed strategy' is needed to bring about diffusion of new practices on a whole-population level. This is beginning to be recognised in both the UK Government's and Scottish Executive's developing approach towards health improvement strategy, using what is known as a '**social marketing**' approach.

5.1 A tool for influencing behavioural change

Social marketing is a tool for influencing behavioural change which recognises the value of commercial marketing techniques in understanding and influencing human motivation and behaviour. It is a distinctly consumer-centred approach to affecting changes in lifestyle and diverse socially important behaviours such as drug use, smoking, sexual behaviour (Andreasen 1995). A growing recognition of the effectiveness of the social marketing approach has led the UK Government to recently produce a public health white paper highlighting its potential impact on building public awareness and changing behaviour, whilst the Scottish Executive will imminently publish its 'Social Marketing Strategy for Health Improvement'³ (Hastings and McDermott 2006).

This focus on values and motivation of individuals is not new, in terms of existing organisational, cognitive behavioural, environmental or any number of behavioural change models. Is it not a 'theory' in itself, but instead draws upon learning from the most appropriate models: a recent review of social marketing interventions which focused on nutrition identified no less than 11 models utilised by a total of 23 different interventions (National Social Marketing Strategy for Health 2006).

Is the report referred to in the footnote now published?

³ NHS Health Scotland hope to publish this before the end of 2006, having commissioned The Institute of Social Marketing to investigate this area.

What it does offer is a framework and a process for how to understand people's behaviour and how to use this understanding to make change happen or *influence voluntary behaviour* change (Andreasen, 2003).

5.2 Market segmentation and understanding the target audience

As a concept first developed in the 70s to harness commercial marketing tools and processes to affect lifestyle change (Kotler and Zaltman 1971), social marketing specifically recognises the importance of segmenting the target population and the need to make any intervention's starting point understand *where the person is at now* rather than *where we might think they are or should be*. The differences in these approaches can be seen in the way in which a key health concern – cancer – has been approached by early health educators to the present day. It was originally assumed that provision of factual information about the benefits of adopting preventive health advice would be sufficient for 'logical processing' of that information and behaviour change (Hill 2006). When this did not happen, the health promotion discipline broadened out the scope of influences that shaped health related behaviour and today there is an increasing focus on how individuals' perceptions of and response to risk (of cancer) are affected by experience – and increasingly sophisticated marketing campaigns focused on specific target populations.

For example, an analysis of public orientation smoking, exercise, nutrition, weight control and alcohol in the United States (Figure 7 below) identified seven 'health styles' audience segments comprising:

Figure 7: The Health Styles Segmentation System

- 1/ Decent Dolittles (24% of adult population)
- 2/ Active Attractives (13%)
- 3/ Hard-Living Hedonists (6%)
- 4/ Tense but Trying (10%)
- 5/ Noninterested Nihilists (7%)
- 6/ Physical Fantastics (24%)
- 7/ Passively Healthy (15%).

Malbach, Maxfield, Ladin and Slater, (1996), 'Translating Health Psychology into Effective Health Communication: The American Lifestyles Audience Segmentation Project,' Journal of Health Psychology 1: 261-77.

5.3 People don't behave or think rationally

Of all seven categories identified in Figure 7, only the health oriented motivation of 'physical fantastics' might be described as a result of 'logical information processing' and represent what adoption theory calls the 'innovators' or early movers. This recognition of what policy makers might call the majority's 'irrational' behaviour is also being recognised in enterprise and development circles as 'behavioural economics', a contrast to standard neo-classical economics which assumes that humans are rational and behave in a way which maximises their self-interest. The New Economics Foundation (NEC) recently published its 'Seven Principles of Behavioural Economics', which they argue must be acknowledged in economic policy making, if unrealistic economic analysis is to be avoided. Principles include such behavioural observation as "*Habits are important: it is not easy for a person to change, even if they want to*" (NEC 2006,5) that people's self expectations influence how they behave and that people need to feel involved and effective to make change: just giving people information and incentives is not always enough.

In the health promotion arena, human's 'irrational' behaviour has long been understood, with most programmes attempting to assess 'user needs', identifying and filling information gaps and establishing collaborative structures through research, consultation mechanisms and partnership engagement with stakeholders. But social marketing is about more than this: it is about embedding a consistent framework and process for tackling specific health/social 'problems', recognising motivation of individual segments of the target population and delivering services in response to them. It also starts and finishes with *research*, which is conducted throughout to inform the development of the strategy (McFadyen et al 1999). Andreasen's six benchmark criteria for defining social marketing projects, developed from commercial marketing tools, are widely used in the field and provide a baseline upon which, social marketers argue, all public health campaigns' design and delivery should be based. Figure 8 describes the six criteria, demonstrating clear synergies with diffusion theory relating to the concept of 'Exchange' and 'Segmentation and Targeting'.

Figure 8	
Andreasen's Benchmark Criteria	
Benchmark	Explanation
1. Behaviour change	Intervention seeks to change behaviour and has special measurable objectives.
2. Consumer research	Formative research is conducted to identify target consumer characteristics and needs. Intervention elements are pre-tested with the target group.
3. Segmentation and targeting	Different segmentation variables are considered when selecting the intervention target group. Intervention strategy is tailored for selected segment/s.
4. Marketing mix	Intervention consists of promotion (communications) plus at least one other marketing 'P' ('product', 'price', 'place'). Other Ps might include 'policy change' or 'people' (e.g. training is provided to intervention delivery agents).
5. Exchange	Intervention considers what will motivate people to engage voluntarily with the intervention and offers them something beneficial in return. The offered benefit may be intangible (e.g. personal satisfaction) or tangible (e.g. rewards for participating in a programme and making behavioural changes).
6. Competition	Intervention considers the appeal of competing behaviours (including current behaviour). Intervention uses strategies that seek to minimise the competition.
Andreasen A (2001), Ethics in Social Marketing, Georgetown University Press	

This brief literature review could find no evidence of a healthy working lives initiative specifically utilising a social marketing approach, although it should be acknowledged that some projects may contain all these principles but may not be 'labelled' social marketing, whilst others, despite their label, are poor examples of social marketing (National Social Marketing Strategy for Health 2006). Many health promotion programmes contain some, but not all of these criteria: for example, most health campaigns will have a well established marketing strategy offering a mix of interventions.

5.4 Achieving results through social marketing

It is perhaps not surprising that many programmes fall short of the six criteria: there are pressures for health programmes to respond (and be seen to respond) with speed to nationally set targets (which may not be based on a segmented approach to understanding different population groups' motivation) through delivering programmes which have little opportunity for pre-testing (consumer research) nor enable the level of resources required for rigorous monitoring and developmental evaluation. In fact, these shortcomings reflect some of the same barriers to success as organisational change programmes have identified (Section 3.2 of this report): lack of people focus, poor implementation and a top down approach.

This is unfortunate, for where the process of social marketing has been applied to traditionally 'hard to reach' populations, the results have been impressive. Figure 9 provides a brief case study synopsis of the West of Scotland Cancer Awareness Project, regarded as a model of social marketing good practice.

Figure 9	
West of Scotland Cancer Awareness Project	
<p>The Project: began in 2002, implemented in five Scottish NHS Board areas.</p> <p>Advertising campaign: to encourage people, particularly those in deprived communities to present earlier with signs / symptoms of bowel or mouth cancer.</p> <p>Research and evaluation: target audience initial knowledge and attitudes, monitoring change in awareness, impact on NHS services.</p> <p>Impact on Services: appropriate engagement with NHS staff; training needs assessment and delivery of training; influencing local and national agenda.</p>	<p>The Process: long term planning</p> <ul style="list-style-type: none"> • Understanding target audience's knowledge, attitudes and perceptions of mouth and bowel cancer; • Convincing primary and secondary healthcare experts of campaign approach (understanding fears and attitudes); • Getting to know the media; • Piloting and tracking advertising messages; • Training professionals: increasing knowledge.
Outcomes	
<ul style="list-style-type: none"> • A high proportion of patients who were aware of the campaigns admitted that seeing them had encouraged them to seek advice more quickly (62% for bowel cancer, 68% mouth cancer). • Those who attended did have symptoms. • For mouth cancer, one third of malignant conditions and nearly half of pre-malignant conditions were detected in people who came forward as a result of the campaign. 	
<p><u>Cited in:</u> Hastings and McDermott (2006), 'Putting social marketing into practice', <u>British Medical Journal</u> 332, p1210-1212.</p>	

Whilst the WoSCAP project used advertising to target low income groups, Figure 9 shows how it was about much more than purely advertising (described as merely 'the tip of the iceberg' in the group's report). Its success was not only in understanding the target audience (the individual consumer), but also the agents on which the project was dependent for long term success (the stakeholders): what were their concerns about awareness raising? (e.g. demand exceeding capacity, a stampede of the 'worried well'), working with those professionals to address such issues and provide the capacity to address increased demand (the 'Exchange'). At the outset, the project asked 'whose behaviour / attitudes need to change' for this to succeed and what is more, 'who influences who' in making this happen? Hastings sees such an 'Exchange' approach as not so much a series of transactions, but rather in terms of *relationships*: with suppliers, stakeholders, competitors and employees (Hastings 2003).

5.5 Upstream social marketing and the healthy working lives agenda

This is not dissimilar to the circumstances which face healthy working lives: the Scottish strategy focuses on the relationship with both *individuals* (as employees or potential employees) and *employers* who can be encouraged to create healthy workplaces. This broader acknowledgement of the impact of the immediate and wider 'environments' – from local community and friends to organisations, structures and policies – on our behaviour, and the need to address 'change' at these levels is described as '*upstream*' social marketing (as opposed to 'downstream' consumer orientation). In other words, it is marketing which tackles the influencers' behaviour.

Upstream social marketing not only integrates external influences within its planning structures, but also recognises the increased efficiency that moving upstream can deliver and the interacting forces which may form part of the solution or issue to be addressed. In the North East of England, upstream social marketing has, for example, successfully encouraged general practitioners to prescribe sugar-free medicines (Lowry et al 2004), alongside dental health programmes targeted directly at children. For new programmes, such as Health Promoting Schools (about which more later) and Healthy Working Lives, upstream social marketing approaches offer an opportunity to influence the policies and culture of whole organisations (the school, the employer) which will bring about improved health and wellbeing throughout life (not just in the school or workplace).

However, there is a challenge for the application of social marketing in the healthy working lives arena. Social marketing tends to be applied – like stage one of an organisational change process – in response to an identified ‘problem’ or ‘trigger’ (for example, reducing sickness absence). Yet we have already seen that the motivation of individual segments of employers is far more complex and nuanced than a ‘problem’ centred approach suggests. The whole field of ‘healthy working lives’ (and health promotion activity in general) is deliberately broad and holistic, aimed at addressing a whole gamut of healthy and safe workplace issues: the challenge is in identifying, developing and selling a social product which employers want.

Social marketing offers a systematic and practical approach to applying adoption and diffusion theory to workplace health and a set of benchmark criteria for the development of future healthy working lives campaigns. It supports our proposition that all employers are not the same in their responses and are motivated by very different factors and not necessarily a single trigger. It also recognises the importance of wider ‘environmental’ or ‘cultural’ considerations which must be addressed to maximise behaviour change. It asks:

- What don’t we understand about our target audience? (and not ‘what is wrong with these people, why don’t they understand’!)
- Where is the person / organisation at now?
- Whose behaviour do we need to change? (the broader environment: upstream).
- What product (or message) are we trying to sell and what benefits are our target audience really interested in?

When these questions are answered, using the framework of consistent planning and implementation described in this Chapter, healthy working lives policy makers and practitioners may be nearer to achieving their objective of making change happen at employer (and employee) level.

PART TWO: LEARNING FROM THREE QUALITATIVE RESEARCH EXERCISES

Introduction

To help further illustrate and flesh out the diffusion and behavioural change propositions outlined through our literature review in Part One of this report, the following Chapters focus on the findings of a number of short-run qualitative research exercises comprising:

- A case study of a major financial services company engaged in a multi-faceted change programme (focusing on health and wellbeing) to tackle one specific 'problem' issue;
- A review of the experiences of three current health promotion / workplace health programmes/ pilots; and
- An analysis of two focus groups of employers conducted in Glasgow and the Scottish Borders.

6. Tackling sickness absence: a case study

6.1 Introduction

Morgan Stanley, an international investment bank and credit card company, provides a number of healthy working provisions for its employees within the UK (e.g. health care, dental plan and pensions). Moreover, within its Glasgow, Cumbernauld and Atlantic Quay operations centres, it has introduced a multifaceted wellness programme complemented by participation in the SHAW awards programme. These locations face different issues and employ different types of workers. Hence, this case study is split into two parts, the first concentrates on the Glasgow Institutional Securities office, whilst the second deals with the company's credit card operations centres.

6.2 Glasgow institutional securities

The Glasgow city centre office currently employs some 600 staff, a figure projected to continue to rise. The Glasgow office employs a very young (average age 25), professional workforce with a roughly 50/50 split between men and women. Some 90% of employees are graduates, with more than half having post-graduate level qualifications.

The Scottish office opened in 2000, with six functional areas being relocated from London. The office grew substantially in 2001 and in 2002 it moved to its current location in Glasgow, with around 200 staff and with a dedicated HR function being created for the office. From its inception the following arrangements existed:

- Private health care for all staff from day one of their appointment;
- Life insurance;
- Employee assistance programme which includes a 24-hour counselling service;
- Disability earnings protection – short term (26 weeks full pay) and long term (75% of pre-sickness salary until able to return to full time work or for life if unable to return);
- Gymnasium facilities within the premises;
- On site occupational health service.

The current Vice President of HR joined the Glasgow office in the summer of 2003. At that time the HR team had started to address absence levels, introducing a recording process in January 2003. Whilst producing the *People Strategy* for the office, the Managing Director expressed considerable interest (not to say concern) about Glasgow's reputation as the sick city of Europe (there was high profile media coverage of this issue at the time). In this context the Vice President of HR conducted a review of the absence data collated to date which revealed that over a one-month period some 22% of total working days available to the company were being lost through absence. The concern caused by these figures resulted in a more systematic process being established in order to track absence over time. In essence this involved the following:

- Educating the workforce to appreciate the importance of work attendance, but with the assurance of help and support if they needed it;
- Establishing a colour coding system for tracking employee absence:
 - Green** (Fine)
 - Amber** (Cause for concern: three spells in 12 months)
HR discusses with manager of employee concerned and the next level of management, followed by discussion with employee.
 - Red** (Action required: four spells in 12 months)
As Amber plus automatic referral to Occupational Health.
- Establishing a system of return to work interviews. This involved welcoming an employee back, questions concerning why he/she has been absent, fitness for work, offer of support if necessary (Occupational Health being particularly important in this regard), updating the employee on what had happened in their absence and the setting of a timetable to follow up matters;
- Systematic collation of absence figures (including the salary costs) on a monthly basis; these figures are discussed for each cost centre by the Senior Management Team, with relevant managers being held accountable for results and action plans being set for each relevant individual employee;
- Setting a target figure for absence levels within the Glasgow office at 3%.

The actual figure achieved in the last two years of operation has been between 2.6% and 2.8%. What explains this successful turnaround in the absence figures?

In summary, the following all appear to have played a contributory part:

- Regular monitoring, in itself produced some notable changes in the prior pattern of absence;
- All new employees and new managers now receive training in coaching techniques (initially there was one trainer, now there are five in the Glasgow office);
- High absence was shown to be linked to limited one-to-one time with the relevant manager. Now all employees in the Glasgow office have a minimum of six face-to-face meetings per year with their manager, a figure that can and is frequently increased by a mutual agreement;
- Face-to-face performance review interviews now occur twice per year for all staff;
- Each employee has a personal development plan drawn up on an annual basis.

Alongside these HR management interventions sits the employee wellbeing programme which has a number of elements, the first of which is a 24-hour phone and online employee assistance programme. This is an information service designed largely to help employees cope with problems in their personal life, which may affect their job performance. Secondly, the office participates in the SHAW awards programme (currently a Bronze holder and is working towards a Silver) through its associated Wellness Committee. This Committee is concerned with health awareness raising matters such as occupational health, the gym and the staff restaurant. For instance no fried foods are served in the restaurant, low-fat options are always available, blood pressure checks are provided to gym members every six months and health promotion talks and materials are sporadically provided about topical health issues. (Current figures indicate that 65% of staff have gym membership, with 65% of these being active members using the gym at least twice per week). Although sickness absence figures are the key measure of the wellbeing programme's success, the positive staff views regarding the office's provisions are also relevant.

6.3 Morgan Stanley operations centres

Morgan Stanley's credit card business is spread over three locations: Cumbernauld, Atlantic Quay in Glasgow and London. More than 1,000 people are employed in their two operations centres in Scotland while approximately 70 employees are based in their London office. The majority of employees are customer service agents working within the operations centre environment, dealing with customer enquiries. Approximately 25% of those employed work behind the scenes in roles within IT, HR and Finance. Female employees account for 65% of the workforce and the age breakdown of staff shows that 30% are under 25; 41% are aged between 25 and 34; 18% are aged between 35 and 44; and 11% are aged 45 or over. For the purpose of this case study we will focus on the Cumbernauld site, which was custom built for the organisation approximately six years ago.

"The business supports employees in establishing a happy and healthy working and personal life."

(Head of HR, Cumbernauld)

The culture within Morgan Stanley is one that encourages both 'work-life balance' and 'community-work balance'. The open-plan, bright and airy nature of the office is designed to promote both productive and healthy working. Each employee has their own space whilst being part of a wider community. On the same floor is a management suite, which has an open-door policy allowing employees to discuss any issues/concerns they might have.

Within the Cumbernauld site, many of the policies and procedures that relate to healthy working are comparable with those found in the administration office. For example, there is a managed gym onsite, and an in-house occupational health service. Similar to the Glasgow office, employees also have 24-hour access to an employee assistance programme. There is also a voluntary employee committee to promote well being called 'HealthWorks'. This committee is managed by employees and thereby encourages and empowers them to take ownership of health issues. For example, the committee recently organised a 'smoothie day', preparing and distributing healthy fruit shakes to their colleagues throughout the day – an activity that has since resulted in the canteen offering these as part of the breakfast menu. Collectively the range of on-site services provides staff with holistic health and fitness provisions.

Sickness absence is also managed stringently within the operations centre. There are predetermined trigger points, 'return to work' interviews and systematic tracking / analysis of absence figures (they have seen a reduction of 8% in the last three years).

Nonetheless, there are three key differences between the operations centre and the administration office. Firstly, the operations centre has a different working environment from that of the administration office – the majority of employees work in customer service roles within a target driven environment. Secondly, the operations centre employs a diverse workforce unlike the administration office where 90% of employees are graduates. Finally, the operations centre's out-of-town location provides an additional dimension. Within the operations centre, it is these differences that have led to increased emphasis being placed on: recruitment and retention, work-life balance and employee recognition. Consequently:

- The company has invested a great deal in its recruitment strategy; the fundamental message being that although the operations centre represents a challenging working environment, Morgan Stanley can provide rewards and recognition to match;
- Recruitment is channelled to attract the right people with the right approach. The company realises that to recruit the best people they have to offer more than just a competitive compensation package. Thus, its health and wellbeing programme is crucial to achieving 'employer of choice' status;
- When the organisation runs recruitment open-days and assessment centres, feedback from potential employees is very positive – they can see first hand that if they work well they will be supported.

In a similar manner the health and wellbeing initiatives assist the business in creating a positive reputation with their existing employees. To retain good employees the company runs a number of extra initiatives that promote work-life balance and show employees that they are valued. As the site is located out-of-town, the company provides a number of additional services to make life easier for employees. These include:

- A shuttle bus from the local train station and surrounding area for employees who do not have their own transport;
- A large, free car park that is open to all employees – a benefit which could not be provided in a city location;
- Two lounges for relaxation and a learning/development area – employees can get away from their desk and its associated activities, either socialising or self-learning;
- An ATM is located onsite;
- External services visit the site on a regular basis (including dry cleaning, car valet and beauty and massage therapists).

The company also offers several tangible incentives including:

- A comprehensive reward and recognition scheme. The business invests in its people, rewarding and encouraging high achievement at all levels throughout the organisation. Monthly and quarterly business awards are presented to staff at department meetings and quarterly business update sessions with the managing director. Prizes are of a high quality and winners of the monthly awards are entered into an annual draw for a week's trip to Chicago. This is seen as a very good motivational tool as employees can see that their hard work is being recognised.
- Regular events. For example, the business recently organised a World Cup incentive, an ice hockey tournament and an on-site barbecue. All of these events aimed to encourage socialising and promote positive wellbeing.
- Learning and development support: the company states that it believes in providing career opportunities and support for its people, offering ongoing training and structured career pathways.

Although these incentives may not be directly associated with employee health and wellbeing, when combined with the progressive culture at Morgan Stanley, a quality working life may be established. Moreover, the company sees a return in its investment through high retention levels, with turnover figures at the Cumbernauld site being below the national average for operations centres, which is particularly good for an out-of-town location. When employees do leave it tends to be because they are going on to do something different, such as a college or university course, rather than moving to another operations centre, i.e. a competitor.

6.4 Comment

To conclude, the important message from the case is as follows:

1. Tracking and dealing with sickness absence requires a multi-pronged approach rather than any single magic bullet.
2. Within the multi-pronged approach different parts of the organisation need to tailor their approach by emphasising different elements and policies depending on their operating circumstances, i.e. the type of workers and working environment.
3. Management policies focused on promoting positive and supportive organisational cultures may have played as significant a part in reducing sickness absence and turnover as more traditional health promotion policies.

7. Lessons on diffusion: policy-led health promotion and healthy working lives interventions

7.1 Introduction

The Morgan Stanley case study offers a useful insight into a company's efforts to address a specific problem through a programme which it voluntarily adopted. How does this fit with policy driven health promotion initiatives, such as Healthy Working Lives? As part of this study, three projects were explored to provide further insight, including a number of interviews with stakeholders from Health Scotland, Health at Work and the Institute of Occupational Medicine (IOM) which is conducting an evaluation of the Bovis (major construction company) pilot. The three interventions are:

- Health Promoting Schools initiative (2002-07) as an example of a nationally driven behavioural change initiative, which seeks to ensure that every Scottish School is health promoting by 2007;
- BOVIS Construction Site HWL pilot (2005-06) as a recent example of a sector specific initiative with significant safety issues, which brought a multi-disciplined team of HWL health (and safety) professionals 'on site' in partnership with a larger construction management company;
- The Glasgow Fort Health Group, Greater Easterhouse Health Project (from 2004): as an example of an integrated regeneration and health improvement project focused on working with new retailers as major local employers, which offers specific health promotion and healthy returns services to employers and their staff in the development.

There is some commonality between all three initiatives, despite their differing focus and objectives:

- They all seek to engage their target audience through influencing behaviour rather than compulsory adoption as a result of legislation (although Health Promoting Schools will eventually be covered in new legislation);
- They all seek to maximise collaborative approaches between public agencies targeting the same 'audience';
- They all seek to minimise duplication of effort and avoid competition between agents for the attention of that audience.

7.2 Health Promoting Schools (HPS) initiative

HPS is a large scale, Scottish Executive driven intervention to make every Scottish School 'Health Promoting' by 2007. This policy initiative set out to combine formerly disparate education and health service attempts to improve the physical, social and emotional health of school aged children in a coherent single strategy for engagement with schools. HPS soon recognised the need to take a 'whole school approach' to the issue, through weaving healthy messages into the curriculum and mainstreaming rather than creating yet another 'add on' initiative to head teachers' workload. Initial barriers to implementing HPS were lack of time, heavy workload, staff resistance (as a result of the former producing low morale) and lack of funding for implementation (although discrete funding for specific elements of a HPS, such as Active Schools funding, was available). How were schools influenced to overcome these barriers? Project Leader, Wendy Halliday, reflects the language of a social marketing 'Exchange' when she says that her key message to influence and lobby teaching staff (and their stakeholders) was around the benefit which the programme will bring school learning environments since *"unhealthy, absent children cannot learn effectively"*.

Some of the best examples of schools embracing the HPS concept holistically are those which recognise the importance of incorporating the health and welfare of staff within their approach to their school environment (such as in Edinburgh). These examples we would classically call 'early adopters'. Figure 10 briefly outlines how schools might be perceived in terms of adoption theory.

Figure 10	
Health Promoting Schools: Adopter characteristics	
Early adopters: Early movers	<ul style="list-style-type: none"> • Courageous leadership: head teachers can work outside the 'comfort' zone • Understand the message and the benefit • Acceptance that partnership can be part of the solution (shed the workload) and not just the problem • Extend links to wider community to maximise effectiveness
Mid term adopters	<ul style="list-style-type: none"> • Influenced by peer engagement and mentoring: 'it worked for us'; • Seek help in 'where to start' • Build on existing practices once they knew how.
Late adopters	<ul style="list-style-type: none"> • A 'go it alone' ethos (no buy-in to local authority wide or learning community groups) • Lack of leadership • Low staff morale • Will resist until last minute
Interview with Wendy Halliday , Scottish Health Promoting Schools Unit	

Such characteristics are in keeping with our earlier propositions regarding adoption theory. Although HPS has not consciously sought to segment schools and their approach to 'selling the benefit', it has had to adjust its messages (for example, mentoring in 'how this can be done' for mid term adopters) as the intervention has progressed.

However, HPS differs from our two HWL pilots in one significant area. As well as 'the carrot' (the benefits), it also has 'the stick': legislation is planned to ensure HPS are embedded within Scotland's education service during 2007. Working with employers, there is obviously no such carrot and the challenges in motivating companies to participate have been immense for both the BOVIS construction and Fort retail pilot initiatives.

7.3 BOVIS construction site HWL pilot⁴

Using a holistic multidisciplinary approach, one of the original BOVIS/BBC pilot's aim, amongst other things, was to develop a construction industry based intervention model for effective healthy working lives, whilst assessing the impact of construction work on health. A range of health promotion, health and safety and occupational health services were delivered and uptake monitored through an on-site occupational health nurse recruited by BOVIS, as the managing contractor.

Observations made here are based on brief interviews with IOM and Health Scotland staff. The pilot encountered some significant barriers in its attempts to offer an integrated service and in retrospect, the original aims were perhaps over ambitious but nevertheless worthwhile attempting and learning from:

- Sector characteristics: a sector dominated by complex sub-contractual relationships: this is a classic 'hard to reach' sector.
- Inadequate time to prepare integrated approach: this took longer than anticipated and workers were 'on-site' before the final project specification, roles and responsibilities were agreed by the steering group and key stakeholders.
- Some confusion over responsibility for 'ownership', "management" and monitoring of the day to day activities of the project
- An initial imbalance in the model of integrated services towards health promotion rather than occupational health surveillance, due to the skills set of the health professionals working on site in the early phase of the pilot. This led to concerns over:
 - The need to continue to meet statutory health and safety requirements within a model of interventions with broader health improvement objectives;
 - Inadequate time to put more sophisticated impact evaluation into place, including a comparator 'control study': statistics collated are more about 'reach': number of people completing lifestyle questionnaires, picking up leaflets.

The completed evaluation of this pilot will examine these issues in greater depth, utilising available statistics and drawing conclusions for future construction sector developments.

⁴ *It should be noted that limited information was available on the construction pilot due to the project evaluation being in the early stages of delivery in Autumn 2006. A full evaluation report is expected to be published towards the end of 2007.*

7.4 The Glasgow Fort health improvement initiative

The Glasgow Fort Health Group comprises a number of local partners and agencies together which have a role in health improvement, to create and sustain employment in the area and improve the individual health of employees and members of the public visiting the retail outlets. This is delivered through a number of co-ordinated pre-employment, training, employee support and health promotion activities. An award winning initiative, the most successful of these have been those aimed at the public (sun awareness, nutrition and alcohol and drugs), access to employment (for example, Equal Access programme) and health information delivered through pre-employment training by John Wheatley College. Despite significant efforts to ensure a consistent, co-ordinated approach towards employers, however, significant barriers have been encountered by the Health at Work team in engaging retailers in healthy working lives activities. There was virtually no uptake of free occupational health support for employees on long term sick leave ('Healthy Returns' service). Perceived reasons focus on characteristics of large retail sector companies:

- Lack of delegated authority at local level for managers of national companies, to develop local HR solutions (or at least managers do not feel empowered to act);
- Retail HR policies strictly controlled and top-down (head office) decision making;
- Problems are around short-term sickness absence and not long-term sickness.

7.5 Comment

Both pilots offer useful feedback on the design and delivery of policy driven healthy working lives activity. Lessons gleaned from these experiences suggest a need for:

- Rigorous initial research and consumer orientation at the outset of any project to scope sector characteristics and attitudes;
- Engagement with the sector to define what the 'exchange' might be for these companies and evidence (business case) of benefit;
- A clear planning framework and roles for the development and delivery of the project;
- Flexibility in delivering services which are tailored to the sector's needs, rather than attempting to deliver existing service packages (cf. Healthy Returns at the Fort).

Many of these comments resonate with the perspectives of barriers to successful organisational or behavioural change programmes identified in Chapters 3 to 5 of this report, relating to implementation process, consumer focus and orientation and delivering a mixed marketing strategy which recognises the distinct characteristics of those employers whose behaviour we seek to influence. The experiences of all three programmes highlighted here provide an excellent basis on which to reflect on future developments of employer adoption strategies, to which we will return in the concluding Chapter (Chapter 9).

In contrast to the service provider's perspective, the next Chapter further explores the motivation and attitudes of **employers** towards adopting wellbeing policies, through the findings of two focus groups of employers.

8. Focus groups: exploring employer attitudes towards workforce health and wellbeing

8.1 Introduction

Two focus groups were held in support of the feasibility research, one in Glasgow (2 October 2006) and a larger forum for discussion held in the Scottish Borders (1 September). Both focus groups explored the same questions and were intentionally recruited to ensure involvement by a variety of public, private and voluntary sector businesses/ organisations, of varying sizes (from SMEs to international enterprises). They were also recruited to ensure a mix of organisations in relation to the question of the development and implementation of employee wellbeing programmes: some were SHAW award winners; others had not yet introduced any such, or few such programmes. A deliberately broad definition of employer 'wellbeing' programmes was used in the focus groups, as representing any policies or programmes which aimed to promote healthy lifestyles or prevent ill-health (including mental health and stress) and could typically involve anything from family friendly flexible working policies to promoting physical exercise in employee lunch hours.

8.2 Membership of the focus groups

Membership of the Glasgow Employers Focus Group

Five employers attended the Glasgow Focus Group (from a total of eight employers who confirmed attendance, one of whom provided information after the event). Employers were drawn from the hospitality sector (a sector characterised by high turnover of staff) and represented business units as part of much larger UK or international hospitality companies. As such these were large employers, with one attendee representing the management of human resources at pan-Scotland level. Another large employer (employing 900 in Greater Glasgow) from financial services was represented, which was also a SHAW Gold award winner. Two voluntary sector organisations from the health and housing sectors were represented, as SMEs, one of which was a SHAW award winner. The remaining participants were not involved with any Government/NHS led Healthy Working Lives services. A further small and growing IT services business which was unable to attend on the day also provided subsequent information on motivation to engage with the HWL agenda for the benefit of employees. The post holders representing their employers ranged from CEO and senior management HR functions to a less senior HR position (in one organisation).

Membership of the Borders Focus Group

There were 19 attendees at the focus group. These were specifically recruited to provide representation from a wide variety of organisations: public sector, private sector, not-for-profit sector, service sector, manufacturing and professional services sectors. There was intentionally a considerable variation in the size (employee numbers) of the organisations concerned: the biggest had over 7,000 the smallest had less than 20. There was also variety in the range of management functions represented there; the majority were Human Resources/Health & Safety, but there were also a variety of line management positions including one CEO. Approximately two thirds of the group had not introduced wellbeing programmes, at least not on a comprehensive basis.

8.3 The major questions / themes covered

In essence the groups were asked to reflect on and discuss the following items:

- For those who had employee wellbeing policies –what were the reasons for their introduction and adoption?
- For those who had no such policies – what were the reasons that were holding them back, and could they envisage future circumstances when they might be interested in introducing them?
- For those who had such policies – how had they worked out in practice?
- Reflecting on the answers provided above – how would the participants see their organisation in relation to the traditional business case made for the introduction of such policies?

8.4 Organisational reasons for the introduction of wellbeing policies

In essence we had three broad schools of thought represented here at both Focus Groups. These were as follows:

a. As an instrument of larger cultural change

- Both a small professional services firm in the Borders and a large transport undertaking spoke about using such policies as an important motivator for staff, seeking to change their traditional attitudes and patterns of behaviour. In essence, they were seeking more communication, openness, honesty, professionalism *“with staff to gain an understanding of what was required of them in their jobs as this was seen as essential to the culture of the organisation”* – all of which they saw as central to their attempt to establish a no blame culture in which employees were treated with respect and responded with appropriate levels of engagement.
- As a slight variation on the above, one manufacturing establishment strongly emphasised the role of such policies in helping to promote an enhanced sense of team-working within and across the organisation. The arrival of a new CEO, visits to company operations in a number of European companies, labour market pressures involving issues of recruitment and retention, plus tight staffing levels all combined to produce this strong top down emphasis for the need for extensive team-working. The individual concern put it well; *“free doughnuts on Friday were replaced with such a strong emphasis on employee healthy eating and physical exercise that the number of photos of rock climbing and other physically demanding events lead some customers to think that the organisation had become an outward bound centre!”*
- One West of Scotland large financial services company focussed much attention on employee engagement as a key indicator of company performance, conducting quarterly satisfaction surveys, resulting in current *“employee engagement at 85%”*. This was less a commercial driver, and more about creating a positive working culture which *“takes the hassle out of employees’ lives”*. Such initiatives extended as far as offering a valet service for employees’ cars and offering a ‘shopper’ service for specific items needed by staff. Enabling work-life balance in shift patterns and the provision of a nursery on site also contributed to this aim. Benefits to the company were seen to be ultimately related to retaining valued staff and reducing sickness absence.

b. Building up from a strong workplace health and safety base

- Three quite varied (two manufacturing, all be very different product lines, and one very large public sector organisation) viewed their strong commitment to employee wellbeing programmes as a natural and logical outgrowth of their traditional commitment to good workplace Health and Safety programmes. As the representative of one of the manufacturing establishments put it: *“we wanted to gain an accredited safety system to help get work but also to take Health and Safety beyond the workplace as employee interest in the subject area shouldn’t stop when you go home at night.”* Another West of Scotland employer stated that their company’s comprehensive approach to health support and advice services developed from an initial concern to clarify its position on employee alcohol and drugs use.
- This view was also expressed in a very pragmatic way by two large private sector concerns, as building policies with the specific purpose of defending the employer against litigation by employees or union representation, associated with the way in which they were treated by their employer (from physical environment to protection of employee health).
- The representative from the public sector organisation added a specific problem-centred focus to this line of argument: he indicated that sickness absence figures were rising, with stress prominently associated with this, which provided a strong underlying performance theme to the case for having employee wellbeing policies. Some examples of initiatives introduced included subsidised gym and swimming pool access out with office hours, Reiki, reflexology, massage, Tai Chi: above all else there was a strong emphasis on the flexibility of these initiatives that the employees indicated that they wished to use the facilities before and after work rather than during their working day.

- Management of stress and reduction in absenteeism was a repeated theme for Glasgow private sector businesses, although none had to date directly monitored absentee statistics against introduction of wellbeing programmes. One hospitality concern had a 'carrot and stick' approach to this problem: engaging a voluntary sector stress centre to provide counselling services, introducing therapy sessions whilst at the same time operating a 'no pay' policy for the first three days of any employees' sickness absence and thereafter a discretionary approach to sick pay. A financial services concern subsidised a number of alternative therapies whilst all three private sector concerns represented at the Glasgow Focus Group offered free access to an employee support phone line. Whilst the smaller voluntary health sector concern had a low absentee rate (due to commitment to the issue), another larger voluntary sector organisation perceived a 'West of Scotland' employee approach to the 'right' to sick leave (in other words, an employee attitude which regards additional 'days off' as part of the expected benefits of an employee within a year, regardless of whether or not the employee is actually unwell), which wellbeing policies did little to alleviate.

c. Enhancing organisation's reputation externally

- Two SHAW award winners (one large company and one voluntary sector organisation) stated that the opportunities to promote their organisations as a 'good employer' was seen as directly contributing to their decision to become involved in the award scheme. The voluntary organisation also viewed participation as an opportunity to access free resources and networking opportunities. Their 'external' audience in this respect appeared to range from potential employee recruits (larger companies) to sector 'competitors' (housing) and industry commentators (financial services).
- Being scored as one of the 'Top 100 Employers' in a Sunday Times annual survey was regarded as a primary motivator for influencing one organisation's decision makers to dedicate further resources across the UK to wellbeing programmes, following a committed effort by one HR consultant in the West of Scotland. Two companies which had not consciously introduced wellbeing programmes also stated that external credibility would also be a primary motivating factor, with one employer acknowledging the prestige and credibility those labels as 'Fortune 500' companies offer.

8.5 Perceived barriers to the introduction of employee wellbeing programmes

Although the majority of the participants in both focus groups had not as yet introduced employee wellbeing programmes, a number of them felt that changing circumstances now and in the near future were likely to have them seriously consider the case. As an example, a representative from one of the professional services organisations commented that *“our recent change of office location was prompted to a considerable extent by the desire to improve the physical working environment of our employees. The next stage in this process is likely to be a serious think about employee wellbeing programmes, particularly given the employee recruitment and retention issues which we face in our sector and geographical labour market. Work-Life Balance initiatives will be extremely important given the particular age distribution of our workforce”*.

In general the perceived barriers to the adoption of employee wellbeing programmes to this stage fell under three broad headings:

a. More immediate and pressing problems preoccupying management

The first heading might be summarised as: the urgent often drives out the important! This was the sort of point made from the representative of one of the not for profit organisations; *“we have been too busy fire-fighting from the start of the organisation –concentrating on the high risk health and safety issues, primarily centred round the physical dimensions of safety. However, we are aware of the need to do something for all staff as a group, and to this end we have made a start with the introduction of a staff sports and social club.”*

b. Limited size / limited resources to keep up the momentum over time

This was a strong theme for a number of our small size organisations who lacked specialist in-house expertise, and hence the time to actively progress employee wellbeing programmes; it was the scarcity of time particularly to complete documentation (as with Investors in People), progress plans from the drawing board, meet and discuss with individuals who had the experience to assist them, rather than the upfront money costs that tended to come through on this issue. As a participant from one of the manufacturing facilities expressed the point: *“we have lots of ideas, but not enough time to implement them.”*

A large Glasgow based hospitality company commented that any future interface with government-backed wellbeing initiatives (such as Centre for HWL) would need to be *“quick, easy to access and low cost”* with real benefits evidenced and accrued. These observations produced some interesting discussion amongst both groups’ participants, particularly in light of our interest in future circumstances which might lead them to introduce such policies. For example, one SHAW award winner stressed that *“we are very small, but it’s surprising what you can achieve if outside sources of support can be usefully drawn upon.”* This was backed up by a large West of Scotland based SHAW award winner (900 employees), who stated that all additional resources had been met from an annual budget of only £750 (excluding opportunity costs). *“Head office has now noticed our achievements and has increased the budget to £10,000. We don’t really know how to spend it all!”*

There was general agreement that not all wellbeing services in the workplace should be free, but rather subsidised. *“There needs to be a conscious buy-in by staff as well as employer”* as one company put it. *“Our policy is to encourage people to look after themselves more – take responsibility for their own health. We just give them ideas about how to do it”.*

c. Lack of evidence of added value

The lack of a clear cost saving 'business case' emerged as a key barrier in the Glasgow focus group. This was an important factor for a small not-for-profit organisation (employing 30 staff), a small but growing IT services concern and a large hospitality company, but for different reasons. For the small organisations, the lack of a problem centred rationale for the introduction of policies was an issue: the voluntary sector employer had an extremely low turnover of staff (usually only when staff retire), whilst both had a negligible sickness absence rate. Lack of clear peer evidence of an obvious bottom line pay-off (increased productivity, lower staff overheads) made further investment in wellbeing policies difficult to justify. For the IT services concern, clear evidence of the effect of wellbeing policies in retaining highly skilled staff was crucial (they already had private health care policies in place in order to encourage retention); for the large company, a clear evidence base (drawn from a competitive company in the same sector) was required in order to encourage further investment in health and wellbeing services. For both small organisations there was no active resistance to the introduction of such policies; indeed one commented that they may be introduced in the future as a result of staff requests as part of the 'team' ethos of the business.

8.6 Publicly funded voluntary services

Both Glasgow voluntary sector organisations commented on the restrictive nature of their organisations' budgets, which were solely publicly funded (or grant funding/donations) for direct service delivery. It was extremely difficult to justify to their stakeholders (even though these were likely to be public sector bodies themselves, having their own wellbeing policies in place) why undue resources were being dedicated to what might be regarded as 'staff perks' (particularly when their introduction was not associated with resolving a specific problem centred issue). For example, one organisation was currently reviewing its expenditure dedicated to offering free fruit to staff.

8.7 Additional comment: employee vs. management perspectives

Employers who do not have comprehensive programmes in place, tended to make assumptions as to the motivating factor of potential or existing employees in being attracted to or remain within their workforce. Perceptions were generally based on existing employer attitudes to staff turnover/ absence issues and anecdotal feedback from staff rather than evidence based staff surveys:

“We are a high turnover sector... people are attracted by the best pay and will go elsewhere for that extra £1.00 an hour”.

Indeed, throughout the duration of the Glasgow focus group, it became apparent that a number of assumptions were being made, through observation or anecdote, relating to:

- how employees regard wellbeing policies; and
- what constitutes a ‘good employer’ from the employee perspective.

Whilst some of these points were based on regularly undertaken staff engagement surveys, several were evidently a product of long standing management perspectives and organisational culture (some of which tended towards ‘blame culture’). As one senior HR representative from the hospitality trade, commenting on employee incentive schemes to encourage good attendance put it: *“some of our operational managers resist such schemes. Their attitude is ‘why should we reward them when they’re only doing what they’re meant to’”.*

One interesting perspective was provided by a voluntary sector employer, and confirmed by two private sector businesses, where employee feedback had indicated that there was a resistance by staff to policies which were perceived as ‘interfering’ in the personal lifestyles of staff. There was an employee attitude of *“I come here to work, not be told how to live my life”, “is it anything to do with you?”* and a perception that health promotion initiatives such as walking routes, healthy eating or occupational health monitoring could be seen as *“crossing the boundaries”* into being seen as a ‘nanny state’ and an intrusion into employee’s working lives.

8.8 Employer / sector segmentation

Given the relatively small sample size which these focus group findings offer, it would be problematic to draw robust research conclusions from this feasibility level research. However, when added to the findings of the case studies already conducted for Glasgow Healthy Working Lives, together with the experiences of current Health at Work staff, it is possible to provide the following comment on motivating factors of different segments of the employer base, presented in Figure 11.

Figure 11

Employer segmentation: focus groups

Segment	Characteristics	Motivation to adopt
Late adopters	1. High staff turnover, relatively low-skilled workforce, more 'traditional' management structures and attitudes	<ul style="list-style-type: none"> • Reputation within industry sector • Evidence that highly rated competitors are introducing programmes • Low cost, minimum hassle award programmes
	2. Small employers (less than 50 staff), often voluntary sector	<ul style="list-style-type: none"> • Clear evidence of increased productivity, reduced costs from sector relevant testimonials which will influence funders / stakeholders • Clear evidence of positive impact on staff recruitment and retention • Ease of accessing free/low cost services.
Mid term adopters	Small to medium sized organisations	<ul style="list-style-type: none"> • Low cost opportunity to demonstrate that employees are valued • Enhance reputation within sector (rather than with employees) • Building on existing H&S base • Response to a specific 'problem': sickness absence
Early adopters	1. Large companies with relatively highly skilled/ trained workforce, strong commitment to employee engagement through which they evaluate effectiveness of programmes.	<ul style="list-style-type: none"> • Staff recruitment and retention (employee engagement) • Building on existing H&S base • As an instrument of wider cultural change
	2. Medium / large public sector bodies with strong 'value' ethos and public service union involvement; employing low and highly skilled / professional workforce.	<ul style="list-style-type: none"> • Need to be seen to adopting good practice by national stakeholders. • Need to satisfy unions and avoid service disruption • Decreased sickness absence and increased job retention

8.9 Rethinking the business case for employee wellbeing programmes

We used the notion of ‘the business case’ (i.e. a compelling bottom-line rationale for introducing a new practice or approach) as a summary device to draw together some of the main themes of the discussion. In summary the following main points were made:

- Employee wellbeing programmes were particularly attractive options to some employers because of their relatively limited upfront costs, together with the existence of some Government-based financial and resource assistance.
- HWL programmes needed to be quick, easy to implement and enhance employer’s reputation within their sector at national (or wider level) to be attractive to mid or late adopters. Through the literature review, we have already seen that ‘no-blame’, collaborative management cultures are seen as an important environmental factor in employee wellbeing: this poses some problems for effective wellbeing programmes if they are seen as purely a ‘cheap fix’ to be seen to do the right thing, rather than engaging in a comprehensive change process. (Note the issue of time for smaller organisations mentioned earlier in Section D).
- Virtually none of the representatives from our organisations had produced or been asked to produce ‘hard data’ concerning the bottom line payoff from these wellbeing policies: one of our participants from a large transportation company made the following comment: *“it’s a matter of getting the balance right between employee wellbeing programmes and running a business as the finance department can’t see a direct return on investment in social activities etc for staff.”*
- Sickness absence figures (with their stress element) seem to be the set of objective figures that organisations were most likely to have if asked to justify the case for such policies.
- Most of those which didn’t have policies (or at least a comprehensive or conscious approach towards them), needed to be convinced through hard evidence and ‘proof by testimonials’ from equivalent organisations / sectors of the benefit of such programmes on the key issues of reducing sickness absence and staff turnover. Staff turnover was more important for those operating in environments requiring ‘knowledge intensity’ (one financial services business stated that over six weeks training were required before new recruits were even allowed to deliver services) rather than low-skilled workforces where there appeared to be an acceptance that turnover would be high and therefore investments in wellbeing restricted accordingly.

- Most of our organisations who had such policies believed that there was a positive business case for the introduction and operation of their wellbeing policies. However they produced a much more subtle and nuanced version of the business case for these policies. In essence they did not subscribe to the view that (with the possible exception of sickness absence figures) short-run and direct costs or benefits flowed from these policies. Rather they believed that the relationship was more of a longer run and indirect nature. The view that sums up this line of argument so well is the one set out below by the representative from one of the manufacturing organisations:

“When you pay the same wage rate as bigger employers in the area you have to add a little bit more. We can’t always add money so we have to rely on the people hearing that we are a good company to work for: it’s all about reputation in the area and keeping the staff once we get them in.”

9. Conclusions: developing the research agenda

9.1 Introduction

Our original research brief for this feasibility study stated two main objectives:

- To establish the parameters of a potential healthy working practices demonstration and research project; and
- To ensure that the right questions to be answered are at the heart of the research.

9.2 Summary of findings

This report has attempted to meet both these objectives through reviewing relevant theory and practice in the fields of healthy working and health promotion more generally, whilst reflecting on the employer's perspective through a small sample of case studies and focus groups. What does our research suggest?

- a) That adoption theory when linked to social marketing processes could provide a robust framework for approaching further employer related research.
- b) That the characteristics of late mover employers are very different from innovators and that the exchange needs to be determined based on segment characteristics;
- c) That the traditional 'business case' for HWL is not as important to early movers as might have been first thought BUT
- d) That robust evidence is required to convince late adopters, which can only be provided through further research and evaluation of the impact of HWL programmes by organisations which are adopting;
- e) That reducing sickness absence and job retention are key drivers for organisations and
- f) That a number of assumptions are made by employers about the motivation and values of their staff, for which there is not necessarily robust evidence (difference between perception and reality).

Before suggesting future development of the research agenda, it is useful to reflect upon the strategic context of any healthy working lives initiative in Glasgow and specifically the delivery of the Scottish Centre for Healthy Working Lives' (SCHWL) strategy and action plan, together with the recent publication of Glasgow's economic strategy. There are a number of key points arising from these strategies which should inform any further research developments.

9.3 Scotland's Healthy Working Lives Strategy

The Scottish Centre's Business Plan contains five key component actions, one of which encompasses two strategic themes of relevance to this study:

- To populate the evidence base for HWL
- To build the long term business case for HWL agenda.

In discussion with the Centre's Director, it is clear that further collaborative work is possible around these two areas. Reflecting upon the lack of evidence of impact found in the last large scale evaluation of the SHAW scheme, referred to earlier in this report (NHS Health Scotland, 2002), there is a pressing need for robust evidence of the penetration levels of healthy working lives programmes within the target population, together with more credible, definable evidence of impact (strengthening the evidence base).

The Centre also has a longer term interest in ensuring that employers are assisted to create workplace settings which are capable of supporting and retaining people who have returned to work, making national and local employability strategies sustainable (Equal Access, Pathways to Work, Healthy Returns, etc.). In addition, the Partnership for Health and Safety in Scotland is keen to add to its evidence base, ensuring that an integrated approach is taken to viewing healthy working lives programmes (involving both health promotion and occupational health and safety) whilst at UK level the Department of Work and Pensions' Health, Work and Wellbeing group continues to gather evidence for its 'evidence and research workstream' at the same time as allocating specific funding to employability initiatives within cities, such as Glasgow.

9.4 Glasgow's economy

“What might success look like? More people contributing to the Glasgow economy with average UK levels of unemployment and welfare dependency. An improved health and social profile, with labour market policies more focused on raising skill levels and encouraging in-work development and progress to meet the needs of expanding, high productivity companies”.

(Glasgow Economic Forum 2006, 28)

A recent Glasgow economic analysis and benchmark report carried out for Scottish Enterprise Glasgow by BAK Basel Economics (SEG 2005) recognises that since the 1980s employment in Glasgow has reached or surpassed other regions. The recently published Ten-Year Economic Strategy for the city celebrates the 60,000 plus additional jobs created in recent years (Glasgow Economic Forum 2006). Whilst GRO projections still show a decline in the working-age population in Glasgow to 2024, this is at a lower rate than the overall fall in population (growth in 0-15 and 65+ age bands will be small), so that its relative size will increase, particularly when seen alongside the effects of Eastern European in-migration. Alongside such positive economic indicators, there are several significant challenges for the city's future economic strategy, two of which are of particular relevance to the area of employer adoption of HWL policies and are seen in the strategy's two priorities of 'Shared prosperity' and 'Move (ing) up the value chain'.

a. **Sharing prosperity: sustainable employment for those previously workless**

‘While parts of Glasgow have prospered with greater employment and better paid middle-class jobs, in other parts ‘worklessness’ and low income are commonplace.’

(Hanlon et al 2006; 309)

The city's approach to employability, seen through programmes such as the Full Employment Initiative and the recently developed Department of Work and Pensions (DWP) Cities pilot, highlights the challenge in maximising employment for those of working age, with 30% of the working age population not economically active (Hanlon et al 2006). Whilst labour supply shortage may not be a major issue in the short term (see above), it is likely to become increasingly important within the next decade as the population continues to decline. Given this fact, it is equally important, that *people are sustained in their employment once they access work opportunities*, particularly those coming off long-term benefit into the workplace, who will tend to come from specific – relatively disadvantaged – communities across Glasgow: this issue of 'employment retention' is one of the key areas which Glasgow is seeking to address through its DWP City Strategy, which particular recognition of the challenges facing small and micro businesses in this regard.

The challenges for changing the culture and attitude of classically later adopter employers (such as hospitality or retail sector) will be that as long as there are enough people to take entry level jobs and replace high turnover positions, there is less incentive for employers to change their workplace culture (including wellbeing policies).

b. Moving up the value chain: supporting high productivity employers

Despite impressive employment levels, Glasgow's Economic Strategy recognises that the city's productivity per capita as well as productivity growth is significantly below other comparable metro regions. Part of the reason for this lies in the relatively high number of entry level jobs ('low value') populating the workforce, the sort of jobs into which those leaving behind benefits are likely to be employed. However, Glasgow's labour market entrants are increasingly graduates, sometimes not starting employment until their early to mid 20's and then entering 'professional' or social class I and II jobs. Since low entry level jobs mean lower productivity, a shift in balance towards encouraging growth in sectors which assume prior knowledge (the knowledge intensity that the case studies mentioned earlier) and move jobs up the value chain is recognised as a key priority. Sectors relevant here are 'added value services' such as life sciences, digital media, design and consumer oriented services, the encouragement of which the strategy terms as 'economic specialisation'. As a recent Economic and Social Research Council publication puts it:

'Jobs will grow in the aesthetic economy as income is earned not in making things, but in designed and marketing them.The knowledge economy will expand to include jobs in personalised customer support to advise on individual needs'.

(Moynah and Worsley 2005, 2, 116-117)

As our feasibility study has shown, the motivational factors of reputation and job retention are far more important for these 'growth' high productivity sectors, where attracting and retaining the right employees is crucial to business competence. Here the challenge for HWL is to provide robust evidence as to what does attract the right employees to workplaces and to support them to develop collaborative cultures and wellbeing policies which deliver this in practice.

c. Partnerships for employee health

A final challenge worth mention here relates to the need to engage with the right industry participants (networks, sector councils, etc) to help produce a more focused and homogeneous programme of healthy working lives initiatives within individual industries. This is because the less complex, the more transparent and the more the opportunity for pilot testing of industry based programmes, the greater the potential for widespread adoption within individual industries. Working to improve communications and information within relevant sectors will be important in order to harness peer influence (good practice promoted by trusted sources) as a primary motivator.

9.5 Future research questions

What could these challenges and priorities mean for developing further research? Four options may be worthy of further consideration by the Glasgow Centre and its potential collaborator partners, presented here in the form of the following research questions:

1. **How does an employer defined as a late adopter (low value employer) differ from an early adopter (higher value employer) in its approach towards the same set of HWL services?** This question requires further qualitative and quantitative research, using a comparative study approach, to support the propositions of this paper, through investigation of and development of a mixed strategy framework to support the work of HWL teams. It would also attempt to provide clearer definitions of how we define 'effective healthy working and wellbeing' policies (in other words, what level of adoption or diffusion penetration is necessary to really effect change?).
2. **What would make late adopters move earlier?** This question would suggest focusing on up to three late adopting organisations (which would classically have lower skilled workforces) from comparable sectors (e.g. retail and hospitality) and developing an 'exchange' with meaningful benefits for those employers (using a social marketing approach to defining the message and monitoring its impact). Such an intervention would provide a clear focus for developing the kinds of products and messages which may be attractive to organisations which are likely to be future employers of those who have greater support needs.
3. **Given the organisational characteristics of early movers, which employers should be adopting earlier and aren't?** This research question recognises that not all companies exhibiting some early adopter characteristics may have embedded health and wellbeing policies within their culture. Such an approach would provide an opportunity to develop a social marketing approach, providing a clear 'exchange' between HWL services and the employer and monitoring impact. The area for research offers potentially 'quicker wins' where organisational characteristics suggest that there would be an element of receptiveness from this type of employers. It also supports the economic strategy's themes in attempting to contribute to the development and support of a higher productivity sector.

4. **To what extent do wellbeing policies impact on employee motivation to work for and remain with their employer?** Of key concern to higher productivity companies is their ability to recruit, retain and develop the right people with the right skills specialisation for the job, yet this study has shown that a number of assumptions – not necessarily backed by evidence – are made by employers relating to their staff. This research question directly addresses the issues of reputation, investment and job retention which have been identified as key drivers for higher-skilled workplaces. The research would test the assertion that wellbeing policies do encourage employee retention, through further investigation of employee motivation (interviews and focus group within a key growth sector) and exploration through employer case studies to ascertain the extent to which wellbeing policies can impact on business competency. Through demonstrating the efficacy of HWL policies, the research would aim to build a meaningful ‘exchange’ for high productivity employers within a defined sector, which will contribute to the efforts of the economic strategy to support the development of such business sectors.

Further consideration of strategic priorities by potential key partners, such as the Scottish Centre for Healthy Working Lives, the Partnership for Health and Safety in Scotland, City Council / enterprise company and Department of Work and Pensions initiatives will be necessary to produce a detailed proposal which is capable of strengthening the evidence base in this field and providing practical examples of how change can be made to happen voluntarily.

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