Influencing organizational change in the NHS: lessons learned from workplace wellness initiatives in practice.

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Abstract

This article presents a discussion of the key issues in influencing organizational change in NHS settings, in the development of workplace wellness interventions to improve employee health and wellbeing. To tackle poor public health and associated rising healthcare costs, there must be a focus on the root cause of many preventable diseases – unhealthy lifestyle choices. Workplace wellness initiatives are now an important prevention strategy adopted by socially responsible organizations to target the health and well-being of working age adults. Lessons learned from initiatives in secondary care suggest that effective implementation requires change in organizational 'health culture', through a combination of education, behaviour change intervention, needs-based facilities and services and strategies for developing supportive and health-promoting work environments. Most of all, employers must demonstrate a commitment to health and wellness that is fully integrated with their mission, values and long-term vision, paving the way for sustainable lifestyle changes. Evaluation systems must be in place to measure impact and outcomes of wellness schemes.

How this fits in with quality in primary care

What do we know?

The government has called for socially responsible organizations to focus on improving health in the workplace. Workplace wellness initiatives are on the increase nationwide, though lacking in primary care settings.

What does this paper add?

Such schemes should be needs driven to effect changes in employee behaviour. Lessons from initiatives in secondary care settings suggest that changing organizational health 'culture' is possible, although there are many barriers to be addressed. Health education and top-down managerial support is essential for successful implementation.

In the context of the population decline in physical activity and health, this article outlines the government drive to improve health through workplaces as 'healthy settings' and the case for organizations to develop workplace wellness schemes. We argue that such schemes are particularly important in NHS settings, and use evidence from the literature, personal experiences and observations, with examples from initiatives in two acute hospital settings as 'models of best practice' which may be adapted for primary care. The barriers to effectively implementing schemes within organizations are presented together with suggestions for effecting positive change.

The Public Health Context

Workplace wellness initiatives are becoming ever more important since the launch of the government strategy 'Health, work and well-being - Caring for our future' in 2005. This initiated movements to improve the health and well-being of our workforce and all working age people in the UK. Our nation is unhealthy and recent data shows that a quarter of the UK population smoke, one-fifth are obese and one-fifth report suffering stress from work.[1] It is well-established that physical and mental health can be improved with regular physical activity[2] although only 37% of men and 24% of women are sufficiently active to gain any health benefit.[3] Sickness absence from preventable ill-health is a growing concern and it has been estimated that the average cost of employee absence to UK businesses is £598 per employee, per year.[1] There is an undeniable need to improve population health.

Settings approaches to workplace health

Individuals may spend up to 60% of their waking hours in their place of work and with over half of the UK population currently in employment the workplace therefore offers a significant potential setting for physical activity and health promotion. Traditional images of workplace health centre around accident and injury prevention, yet the incidence of chronic diseases such as heart disease and stroke now far exceeds the rate of accidents (Janet Voute, CEO of the World Heart Federation). Health and physical fitness are now a primary focus for workplace wellness to prevent key risk factors for disease and poor mental health. Government policy has acknowledged the importance of promoting the health and wellbeing

of the population through a 'settings' approach to health promotion[4] through prisons, schools, workplaces and community groups. The workplace has been identified as an ideal setting for health improvement for a variety of reasons. It allows access to large numbers of individuals many of whom are at risk of adverse health events. The social cohesion of workplace communities can provide positive peer support and further, workplaces have established channels of communication which can be accessed for promoting interventions, by publicising facilities, programmes and events, providing feedback and encouraging participation to assist with the process of change.

Socially responsible organizations

Improving the health of the working population requires that organizations accept responsibility for workplace wellness, whether for either altruistic, philanthropal or egotistical reasons. In practice, socially responsible organizations must provide workers with the facilities and opportunities to make healthy lifestyle choices during the working day. This can be achieved through partnership working, engaging with a diverse range of groups and communities and actively encouraging people to participate in decisions about their health and lifestyle. This approach begins with ensuring the organization has a statement, within its mission, aims or strategic plan which makes clear to employees (and others) that the goals of the organization contribute to the greater social good of the population. What's more, in a climate of increasing sickness absenteeism and poor retention of staff, employers need to ensure they do all they can to recruit and retain a workforce and it is widely accepted that embracing corporate social responsibility for workplace health is indeed profitable, through impacts on employee motivation and morale.

Organizational change: influencing health culture in the NHS

Our knowledge of the need to invest in population health and evidence of the benefits of workplace intervention is longstanding. Action to implement workplace programmes is on the increase nationwide although is not yet universal. From the perspective of the employer, the benefits of workplace wellness programmes are significant, including improved physical and mental health of employees, reduced absenteeism and turnover, better retention of staff,

reduced rates of accidents and injuries, improved morale, motivation and job performance/productivity and reduced occupational healthcare costs.[4] Optimizing the health of the workforce in an NHS and primary care setting is particularly important since healthcare professions spend a significant amount of their time promoting health to others, although they do not always practice what they preach, with many NHS staff self-reporting low levels of physical activity, smoking, poor diet, low mood and poor sleep.[5] Yet we know that promoting health in an NHS setting is achievable since recent research has shown that moderate exercise, for example, can be successfully incorporated into working hours for NHS employees, to significantly improve capacity and cardiovascular health in this group.[6] Improving health and wellbeing in this group is also important since employees in better physical and mental health are better able to provide quality care, safely and consistently, to their patients with increased numbers of employees fit and able to work having a knock-on effect of reducing waiting lists, thus improving the NHS standard of care. A fitter, healthier and happier workforce makes economic sense.

Surveys have been conducted with NHS employees and student nurses in an acute NHS Trust in Nottingham and these showed that a large proportion were not meeting government recommendations for physical activity, with many having a poor diet, suffering from low mood and having low levels of job satisfaction (Blake et al, Baseline Q-active report; Blake and Pisano, MNursSci dissertation data). This highlights the need to provide facilities for individuals to make healthier lifestyle choices during the working day and to educate NHS employees about the importance of looking after their own health as priority. In practice, these local needs have now been addressed with wellness schemes accessible to all NHS staff, and all healthcare students onsite, as described below.

A model of best practice: lessons from secondary care

Over the past three years, comprehensive workplace health projects have been implemented in two NHS acute hospitals in London and Nottingham. Both projects adopted an 'ecological' approach to behaviour change (see Figure 1), with interventions aimed at the individual (e.g. structured indoor and outdoor exercise classes, holistic therapies, free employee health and fitness screening) supported by changes to the physical environment (e.g. enhanced cycle

storage, posters encouraging stair use) and the development or amendment of relevant policies (e.g. Green Travel plan). There are opportunities at both sites for employees to become 'health champions' for their workplace. The programmes include regular lifestyle initiatives such as loyalty schemes and health promotion campaigns, with internal educational sessions to promote physical and mental health (e.g. nutrition advice, weight management, stress management). Liaison with Trust managers has encouraged monitoring the impact of certain work situations, such as lack of work breaks, shift work and sedentary roles to facilitate flexibility in work patterns to accommodate personal health and well-being. Although these two Trusts are geographically disparate, varying greatly in size (e.g. one has ~11,000 members of staff, the other 2,200) with each experiencing organizational restructuring during programme delivery (e.g. Trust mergers and redundancies), the successes and barriers identified were surprisingly similar resulting in a unified outcome in our learning about the implementation of workplace wellness schemes in an NHS setting.

Most importantly, continued high-level managerial support from the outset is essential. As Donaldson[7] accurately reported, '… better population health is the sum of better health of individuals, but needs more than individuals' action to achieve it.' Ideally, a Director level individual would champion the cause with endorsement from the Chief Executive and Trust Board. Without this, sustaining any such work that is needed for significant changes in employee health status and therefore business indicators is difficult and at risk of being rapidly discontinued. These observations are supported by a review in 2002 which highlighted the importance of employers as 'visionary leaders' in facilitating change.[8]

We observed that stress is often viewed as a 'badge of honour' for certain groups, despite the inevitable negative health consequences of this standpoint. For instance, recent research has shown that stressed white collar workers in London are significantly more likely to develop chronic heart disease (CHD) when compared to their non-stressed counterparts.[9] In this study, increased risk of CHD was mediated through the indirect effect of stress on healthy behaviours such as physical activity and healthy eating, both of which can be positively effected through the workplace.[10-12]

The existing 'health culture' and negative attitudes within organizations can be limiting. In

practice, we observed that those members of staff who actively engaged with workplace health activities were often subject to criticism by colleagues and line managers for 'not having enough work to do'. Disapproving attitudes were prevalent on both sites yet are counter-productive given the government drive to encourage physical activity and improved health behaviours in the workplace, by incorporating them into the working day.[3]

Employees often cite a lack of time as the number one barrier to adopting and maintaining healthy behaviours[13] (e.g. Blake et al, Baseline Q-active report), and recent publications have also shown this to be one of the main reasons why both white and blue collar workers do not engage in workplace health.[14] However, the evidence points towards healthy workers having better job satisfaction, reduced absenteeism and increased productivity, so employers should view workplace health as an important and necessary investment in efficiency.

It was also observed that the health and welfare of employees may not be a priority for external profit-making companies associated with the NHS, such as those providing food in hospital canteens and filling vending machines. Whilst some may question the relevance for Primary Care Trust (PCT) employees, in fact many PCT staff spend significant periods in an acute setting during their working week and hence access the on-site catering. Lessons learned by both workplace wellness teams is that working with private caterers for whom health is not a priority can be exceedingly difficult in terms of making healthy changes to menus and 'lip servicing' being paid to health promotion.

Both workplace wellness schemes identified difficulties in influencing health behaviours amongst certain employee groups within the NHS. Engaging nursing staff was challenging and further investigation into barriers to workplace wellness in this group appears necessary, particularly since nurses are often subject to high levels of stress.[15] Our own observations show that although the nursing role by nature involves promoting health to patients,[16] this is not always transferred into their own lives (Blake et al, Baseline Q-active report; Blake and Pisano, MNursSci dissertation data). However, there is a strong case for improving employee health within the nursing profession.[17] Employees from non-professional job roles (e.g. portering services, domestic services, catering assistants) were also less likely to engage in health activities at either site which demonstrates current difficulties in accessing these groups in the workplace. The government is committed to reducing health inequalities, and

this agenda could be aided by specific targeting of such groups through workplace schemes. A promising NHS approach currently underway is to educate and train individuals in these professions to be 'Health Trainers' purpoted to promote health amongst their colleagues, although no published results of these pilot projects are presently available. The Royal Institute for Public Health 'Level 2 Award in Health Improvement' is currently being delivered at an increasing number of sites nationally, including our Nottingham site, to employees wishing to promote health within their organization as dedicated 'Health Champions'.

Influencing Positive Change

Whilst the evidence base for workplace health promotion is still relatively weak, we feel this is primarily due to a lack of investment in formal evaluation of such schemes, and a lack of relevant data collection and outcome measures, since a rising number of schemes are being implemented successfully although findings do not always reach the academic literature. However, the published evidence is growing and there are positive findings appearing internationally.[12,18-20] Innovative methods for workplace health promotion are also emerging and have included the use of technology (e.g. Internet, email) to encourage positive health behaviours such as healthy eating, physical activity and smoking cessation amongst employees[21]. Historically, one key setback has been in *delivering* the evidence to the most appropriate and influential individual or group who can provide the support needed to ensure that positive changes are self-sustaining. Nevertheless, the recent NICE guidance targets those at 'top level' by recommending that organizations develop policies and activities to encourage their employees to give up smoking and increase their physical activity levels.[10,22]

Such policy development and implementation of activities can be simplistic and low cost, although for significant changes to 'health culture' and health behaviours and sustainability of the scheme, a more 'ecological' approach is required. Changes to the physical environment are especially important as these may be permanent; examples might include the provision of showers, secure storage for cyclists and improvements to signage and the appearance of stairwells to encourage people to use the stairs.

Trusts should also take advantage of the skills that they have in-house; occupational health staff, cardiac and diabetes nurses, physiotherapists, Health Promotion specialists, Human

Resources employees and employee representatives or 'health champions' can all provide valuable input. It is also important that implemented activities engage employees and involve doing things *with* them, not *to* them.

Active Travel

Any workplace can take steps to encourage their staff to be healthy by promoting active transport to and from both home and any community commitments/meetings, since this is known to confer real health benefits. For example, employees who walk or cycle to work have decrease their risk cardiovascular risk by 11% [23] and are also exposed to less pollution than car drivers.[24] Promoting active travel is a significant step in workplace health for employers, not least for encouraging positive health behaviours amongst individuals, but also for supporting and implementing national health policies and strategies related to physical activity and obesity, and reducing their carbon footprint.

One of our initiatives showed a statistically significant increase in the percentage of employees walking or cycling to and from work[25] with the second region still at intervention stage yet anticipating a similar increase. Increases in cycling to work were achieved by changes to Trust policy regarding car permit applications, providing staff access to cheaper bicycles through a salary sacrifice scheme open to all UK NHS Trusts, investing in showers, secure cycle storage, on-site maintenance workshops and cycling proficiency training.

A notable lesson learned in implementing workplace wellness schemes is that health promoting behaviours can be made *convenient* for employees, which in turn increases the likelihood that health behaviours will be easily adopted. For example, by accessing a 10 minute health check in the workplace, individuals may save time in visits to their general practitioner (GP) or practice nurse. Workplace health screens may also help to identify previously undiagnosed clinical issues such as high blood pressure, in which case the individual can be referred to their own GP for early follow up. In our experience, whilst some of these individuals are then found to be normotensive at follow-up, a greater percentage require medical intervention to control their blood pressure and treatment can be initiated early following workplace screening.

The future of employee wellness initiatives for primary care

Although many employers currently have programmes linked to wellness they are often limited in scope and do not accurately measure improvements in health and productivity[26]. By adapting established health programmes that improve employee wellness, models of effective workplace wellness initiatives may be applied in the primary care setting. The importance of 'settings based' health promotion in primary care has been acknowledged and 'creating a healthy working environment' has been proposed as an important element of a 'health promoting general practice'.[27] Nevertheless, whilst attempts are being made to introduce legislation and workplace health policy to improve employee health in this setting, to our knowledge, at present there are no published findings of PCT employee wellness interventions although anecdotal evidence suggests that interventions in this setting are emerging. The Health Development Agency 'Framework for Action in Primary Care' provides a useful tool for planning, implementing and evaluating workplace health within GP practices.[28] This model reflects the particular needs of primary care and the processes outlined in this model include: setting up support structures, gathering information, developing a strategic action plan, implementing and monitoring the plan, and finally reviewing the plan and support structures. Whilst the importance of workplace wellness is increasingly recognised, there is clearly scope for the development and formal evaluation of employee wellness schemes in primary care.

Conclusion

There should be an increased focus on creating a healthy working environment for primary care employees. The real cost of poor public health will be felt by those organizations who do nothing about employee health and wellbeing. Workplace health is not a short-term fix, but rather a long-term commitment or fundamental organizational strategy. However, to successfully initiate organizational change in 'health culture', a fresh perspective on transformational leadership is required. Healthy workplaces form part of our long term vision for public health, and organizations which effect change are those which embrace the concept of corporate social responsibility for the health and wellbeing of the workforce. These organizations provide models of best practice which are transferable to the primary care setting.

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Conflicts of Interest

None to declare.

References

1. Chartered Institute of Personnel and Development. Absence Management Report, July 2006.

2. Department of Health. At Least Five a Week – Evidence on the Impact of Physical Activity and its Relationship to Health. London; 2004a.

3. Department of Health. 'Choosing Activity'. London; 2005.

4. Department of Health. 'Choosing Health' White Paper. The Stationary Office: London; 2002b.

5. Blake H, Lee, S. Practising what we preach: worksite wellness intervention for healthcare staff. In: Turley AB, Hoffman GC, eds. Lifestyle and Health Research Progress. NovaScience Publishers Inc, USA; 2008.

6. Hewitt JA, Whyte GP, Moreton M, van Someren KA, Levine TS. The effects of a graduated aerobic exercise programme on cardiovascular disease risk factors in the NHS workplace: a randomised controlled trial. J Occup Med Toxicol 2008; 28 (3): 7.

7. Donaldson L. The Report of the Chief Medical Officer's Project to Strengthen the Public Health Function. Department of Health, London; 2001.

8. Chu C, Dwyer S. Employer role in integrative workplace health management: a new model in progress. Disease Management and Health Outcomes 2002; 10 (3): 175-186.

9. Chandola T, Britton A, Brunner E et al. Work stress and coronary heart disease: what are the mechanisms? European Heart Journal 2008; 29 (5):640-648.

10. National Institute for Health and Clinical Excellence. Workplace health promotion: how to encourage employees to be physically active. London; 2008.

11. Arao T, Oida Y, Maruyama C et al. Impact of a lifestyle intervention on physical activity and diet of Japanese workers. Preventive Medicine 2007; 45: 146 – 152.

12. Engbers LH, van Poppel MN, Chin A Paw MJ, van Mechelen W. Worksite health promotion programs with environmental changes: a systematic review. Am J Prev Med 2005; 29 (1): 61-70.

13. Laffee L, Rex L. Incentives and barriers to physical activity: women's responses to a workplace fitness center. Melpomene Journal 1999; 18 (3): 23.

14. Fletcher GM, Behrens TK, Domina L. Barriers and enabling factors for work-site physical activity programme: A qualitative examination. Journal of Physical Activity and Health 2008; 5 (3):418-429.

15. McGowan B. Self-reported stress and its effect on nurses. Nursing Standard 2001; 15: 33-38.

16. RCN. The community approach to improving public health: Community nurses and community development. Royal College of Nursing, London; 2002.

17. Blake H, Lee S. Health of community nurses: a case for workplace wellness schemes. B J Community Nurs, 2007; 12 (6): 263-267.

18. Renaud L, Kishchuk N, Juneau M, Nigam A, Tereault K, Leblanc MC. Implementation and outcomes of a comprehensive worksite health promotion program. Can J Public Health 2008; 99 (1): 73-77.

19. Beresford SA, Locke E, Bishop S et al. Worksite study promoting activity and changes in eating (PACE): design and baseline results. Obesity (Silver Spring) 2007; 15 (Supp 1): 4S-15S.

20. Dalziel K, Segal L. Time to give nutrition interventions a higher profile: cost-effectiveness of 10 nutrition interventions. Health Promot Int 2007; 22 (4): 271-283. Epub Oct 4.

21. Blake H. Using technology in health promotion intervention. In: Blakely MR, Timmons SR, eds. Lifestyle and Health Research. NovaScience Publishers Inc, USA; 2008.

22. National Institute for Health and Clinical Excellence. Workplace health promotion: how to help employees to stop smoking. London; 2007.

23. Hamer M, Chida T. Active commuting and cardiovascular risk: A meta-analytic review. Prev Med 2008; 46: 9-13.

24. Kaur S, Nieuwenhuijsen MJ, Colvile RN. Fine particulate matter and carbon monoxide exposure concentrations in urban street transport microenvironments. Atmospheric Environment 2007; 41 (23): 4781-4810.

25. Bull, F.C., Adams, E.J. & Hooper, P.L. Well@Work: Promoting Active and Healthy Workplaces – Final Evaluation Report. Loughborough: Loughborough University, 2008.

26. Young JM. Promoting health at the workplace: Challenges of prevention, productivity, and program implementation. NC Med J 2006; 67 (6): 418-424.

27. Watson M. Going for gold: the health-promoting general practice. Quality in Primary Care 2008; 16: 177-185.

28. Health Development Agency. Workplace Health is good practice. Framework for action in primary care. 2001.

Figure 1.

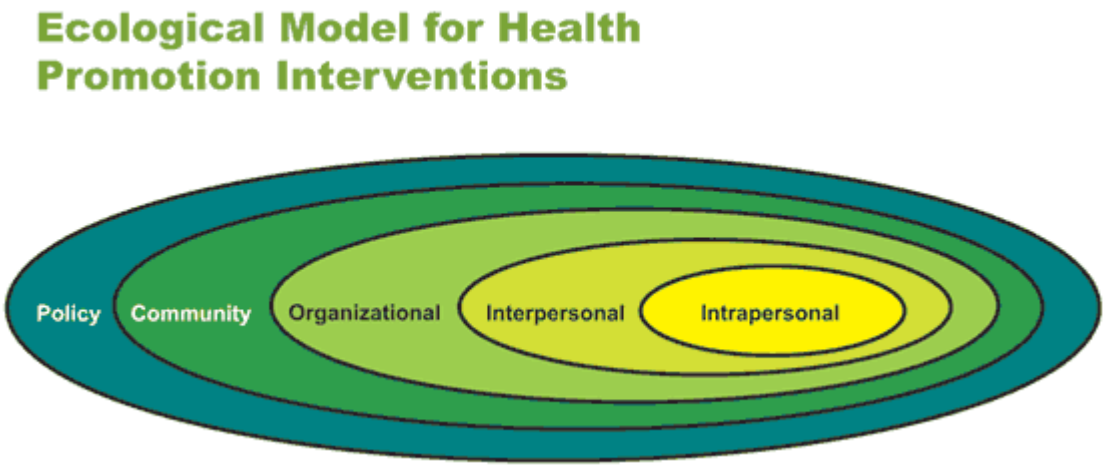
Ecological Model for Health Promotion Interventions
Policy
Community
Organizational
Interpersonal
Intrapersonal

Figure 2.

Source: Health Development agency (2001) *Workplace health is good practice: Framework for action in primary care.* London: HDA. Available from www.nice.org.uk. Reproduced with permission.