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Acknowledgements

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WorkSafe’s state-wide workplace health promotion program, WorkHealth, taught us much about the individual and environmental drivers of health at work, and raised important questions about the relationship between personal health and occupational health and safety in the workplace.

The evaluation of WorkHealth – a collaborative program of research commissioned by WorkSafe to Monash University through the Institute of Safety, Compensation and Recovery Research (ISCRR) – highlighted a number of interrelationships between worker health, well-being and safety and how this is managed in Victorian workplaces, which warranted further investigation and research.

The WorkHealth evaluation, together with emerging trends in global practice, points to integrated approaches as a potential way to achieve measurable improvement in the health and safety of the working population.

As WorkSafe seeks to maintain Victoria’s position as the safest place to work, the ability to effectively integrate, contextualise and contemporise workplace safety practice within the changing world of work looms as a critical next step in driving significant gains in safety performance.

This report brings together the collected evidence, local case studies and theoretical frameworks to provide concrete guiding principles for implementing integrated approaches within the workplace.

The report summarises important literature on the benefits and enablers of an integrated approach, and presents best practice principles and working examples for achieving integration in the workplace.

Building on the experience of WorkHealth, this report presents an important contribution to our understanding of the various factors influencing health, safety and wellbeing at work, and the potential for new approaches to achieve improved health and safety performance for the benefit of workers, workplaces and the Victorian community.
Integrated approaches to worker health combine occupational safety and injury prevention with health promotion to advance worker health, safety and well-being.  

Such an approach refers to “the strategic and systematic integration of distinct environmental, health and safety policies and programs into a continuum of activities that enhances the overall health and well-being of the workforce, and prevents work-related injuries and illnesses”. In practice, integrated approaches combine Occupational Health and Safety (OHS) and Health Promotion (HP) programs, policies, systems and processes, and may include human resource management and other related operational functions. Integrated workplace interventions recognise the interaction between safety, environment and health, and promote organisational development, with a view to improving productivity and creating a healthy workplace climate. Rather than detracting from imperatives to provide safe workplaces, typically core business for OHS departments, integrated approaches complement injury and illness prevention with health promotion, thereby reducing the likelihood that “well” employees will become “unwell” in adverse, unsafe work environments.

Emerging research evidence and stakeholder consultation have identified further investigation into integrated approaches to worker health as a potential model for addressing a range of complex issues impacting Victorian workplaces. The overall aim of this research was to provide evidence to inform WorkSafe in the development of integrated approaches to worker health, safety and well-being. Commissioned by WorkSafe and aligned with its 2017 Strategy, this project was articulated around three components: a systematic review of empirical evidence; a framework and guideline review; and selected case studies. The research systematically reviewed the empirical evidence, and identified practice principles for the implementation of integrated approaches to worker health, safety and well-being. It also provided workplace examples specific to the current legal, regulatory and workplace context in Victoria. This Report draws together findings from all three components.

A summary of research findings is presented, followed by guidelines for the implementation of integrated approaches with illustrations from Victorian case studies.
Overall, the evidence from the thirty-two intervention studies included in the systematic review demonstrated the positive impact of integrated approaches on worker health and safety outcomes. Integrated interventions had a direct impact on smoking reduction, prevention of musculoskeletal disorders, and diminution of stress and poor mental health. Many of these outcomes were reported in studies of high quality, where the causal relationship can be considered to be robust. Mixed effectiveness was found for improving diet and physical activity, and improving organisational safety climate.

Notably, findings indicated a consensus that integrated approaches were effective in accessing ‘high-risk’ workers, those with a high risk of accident or injury, but with the least likelihood of engaging in health promotion. Integrated approaches showed promising effectiveness for addressing these compounded risks in labourers, home-care workers, and construction industry apprentices. It appears that engendering trust of employees by the comprehensive provision of safe workplaces potentially enhanced individual health participation and engagement, each mutually reinforcing the other.

Furthermore, of the eight studies reporting on the cost-effectiveness of integrated interventions, all but one reported a favourable outcome. Different assessments of reduced costs were utilised in the evaluations, including reduced worker-compensation costs, absenteeism, medical or health-care costs, and use of sick- or disability-leave.

Finally, the empirical evidence demonstrated that integrated approaches which not only combined OHS and HP, but also specifically targeted organisational or environmental change as a mechanism for improving health and safety, conveyed measurable improvements in individual health, safety and well-being. This was the case across a range of intervention targets, in diverse occupational settings, including stress reduction, reduction in occupational injuries, improvements in nutrition, subjective ratings of health, well-being and job quality, and reduced mortality rates.

### Evidence supporting integrated approaches

**Integrated approaches are effective for:**
- Smoking reduction
- Prevention of musculoskeletal disorders
- Reduction of stress and poor mental health

### Cost-effective, reducing:
- Worker-compensation costs
- Absenteeism
- Medical or health-care costs
- Use of sick- or disability-leave

### Summary of research findings
Integrated approaches in the Victorian context

Given the promising evidence base supporting integrated approaches, the findings from the case studies and the framework and guideline review provided a complementary set of criteria to inform the implementation of integrated approaches. The implementation steps were outlined using steps from the WHO Healthy Workplaces Framework (Mobilise, Assemble, Assess, Prioritise, Plan, Do, Evaluate, Improve). This framework outlines a set of general, flexible, principles for program planning and implementation, and the findings from the case studies are presented within these steps. The case studies involved a diverse range of workplaces, each with a different impetus and capacity to integrate organisational functions targeting worker health, safety and well-being. The six organisations varied in the degree to which integration had been accomplished, and each was functioning at a different stage of the implementation cycle.

Common elements of the “Mobilise” and “Assemble” stages were strong leadership and support from management for increased integration. To oversee the planning and implementation process, an “integrated health committee” was set up in several cases, comprising OHS and Human Resources managers as well as staff representatives. In all of the observed workplaces, allocating budget, staffing and resources was a decision taken by management to demonstrate commitment to health and safety to the workforce, but critically to ensure the viability of the “health committee” and of any initiatives introduced. In four of the cases studied, a specific committee was assembled to integrate existing organisational functions responsible for an overall health management system. In other cases, this integration was still in progress, but improved collaboration, planning and communication between OHS and Human Resources staff were evident.
A common leverage point for all of
the workplaces was their existing OHS
system. The established mechanisms,
processes and staffing in place to
manage regulated OHS requirements
was regarded as a practical foundation
for the extension to a broader range
of health and well-being activities.
In four cases, the review of their
internal OHS policies served as the
starting point to include a well-being
focus in their strategies. In one case,
the broadening of the Occupational
Health and Safety Act 2004 to include
psychological safety provided a strong
impetus for the organisation to focus
on extending their existing OHS
activities, integrating prevention,
and mental health and well-being
into their established activities.
Two organisations mentioned the
WorkHealth Healthy Workplace Grant
as providing a specific incentive to
pursue opportunities to integrate and
extend their current programs.
Not all of the cases had undertaken a
comprehensive ‘Assess” phase. In four
cases, the prioritisation of workplace
needs was based on the decision-
making of management, of the
integrated health committee, or in the
case of Stawell Gold Mines, following
a particular event that was perceived
by management as heightening
employees’ risk of adverse mental
health outcomes. Assessment of
employee needs was conducted in
two large organisations. ConnectEast
conducted a participatory consultation
process and provided health risk
assessments to identify needs, and
OZChild used findings from their
annual employee survey. Each
organisation had recognised the
importance of integrating
organisational or environmental
change with that of supporting health
behaviours of individual employees,
a core principle of integrated
approaches.
A range of programs and interventions
were planned and in four cases
actioned (“Plan” and “Do” steps).
Activities identified in Victorian
workplaces included social activities,
community participation and
volunteering, seminars and education
programs, provision of a subsidised
Employee Assistance Provider, and
the provision of policies aimed at
improving work-family or work-life
conflict via a suite of flexible working
arrangements. Interventions aimed
at improving diet, nutrition and
physical activity were popular
programs implemented by the case
study organisations. Expert consensus
about integrated approaches was
that early gains were a good
foundation to establish momentum
for more comprehensive organisational
change. It appeared that the Victorian
workplaces studied were targeting
some early, rapidly adopted, accessible
and low-cost initiatives (e.g. fun runs,
fitness classes, health-checks, health-
food strategies) as a feasible starting
point, to continue the momentum
introduced by WorkHealth programs
and enhance initial employee
engagement. External service
providers were a common strategy
used by the employers or management
committee, most likely due to the
competing workloads and lack of
specific expertise of those tasked
with program planning and delivery.

**Promote your program and celebrate successes**

*ConnectEast*
A notable challenge across the case studies was the degree of staff participation and involvement in planning, a feature recommended as vital to integrated approaches. There was some evidence of consultation and feedback from staff members at both planning and evaluation stages in the organisations studied. However, several key informants identified that strengthening employee participation was difficult, a “work-in-progress”, or a target for improvement, in particular during the “Do” stage of program action. Identified barriers to staff involvement in health activities included a geographically dispersed, or predominantly off-site workforce; and casual and shift-workers. Concerns about engaging employees in the planning process were also mentioned, mainly because of the risk of increasing expectations that could not be met. Strategies to support staff engagement included the provision of incentives and rewards; a high-saturation communications strategy; holding activities during work-time, and in the case of ConnectEast, ensuring that the health and safety activities were regarded as ‘core business’, a part of every staff member’s workload. One organisation included safety indicators as part of the managers’ key performance indicators, as a means of strengthening manager support for staff to engage in health and safety activities.

The final steps, “Evaluate” and “Improve” were also developing in the cases. There was a notable intention to carry out program evaluation by each of the organisations, but key informants were unsure about which indicators or tools to use to assess program outcomes. In five of the six workplaces, little evaluation had occurred to date. Given the early stages of implementation for most of the organisations studied, it is not surprising that the “Evaluate” and “Improve” strategies were emerging. Nonetheless, these steps are critical, particularly for organisations with fewer resources (including small-to-medium enterprises) that need to ensure efficient use of time and budget, plus opportunities to identify effective versus low-impact programs and strategies.

Programs need to be flexible, accessible and free to staff

Department of Justice
Main conclusions

- Integrated approaches are effective for both physical and mental health outcomes; evidence also demonstrates positive return on investment, and access to workers in “high-risk” occupations, who are the least likely to participate in health promotion programs.

- The evaluated case studies demonstrate an ability to build upon their existing OHS structures in order to introduce some low-cost, rapidly-adopted health-promotion strategies.

- Implementation of integrated approaches is now well underway in Victorian workplaces. Strong management and leadership and an established ‘integrated health committee’ appear to underpin successful implementation.

- Key challenges for workplaces include staff engagement and participation; inadequate internal expertise to source appropriate programs; resource (time, staff, financial) constraints; and appropriate evaluation tools.
Guidelines for implementing integrated approaches in Victoria:
Summary and examples

The following section outlines general, flexible principles for planning and implementing an integrated approach in your workplace.

In developing these guidelines, the review canvassed expert consensus and evidence-informed strategies and recommendations from thirty documents (e.g. conceptual frameworks; guidelines; ‘toolkits’) for the implementation of integrated workplace health and safety programs.

The guidelines follow the 8 step process described in the WHO Healthy Workplaces Framework and Model:\(^5\):

1. Mobilise
2. Assemble
3. Assess
4. Prioritise
5. Plan
6. Do
7. Evaluate
8. Improve
Step 1: Mobilise

Commitment from an organisation at the senior level is a critical enabler and crucial to the uptake and maintenance of all subsequent implementation activities. While the usual entry-point is engagement with senior management or the business owner, engagement at this stage may, depending on the workplace type, involve union leaders, other relevant stakeholders, any ‘informal’ leaders or persons of influence within an organisation, and boards of company directors. In larger organisations, there may be multiple audiences across the organisation, including HR departments, OHS, personnel, senior and middle management, plus any relevant external stakeholders. For less receptive organisations, that is, those without any stated interest in health promotion, OHS departments become the key entry point and contact for this stage.

In the case studies, either the general manager in small and medium enterprises (SMEs) (Hoerbiger and Prima Furniture) or the board/directors for larger companies (ConnectEast, OZChild and the Department of Justice), supported and advocated an integrated approach. Workplace ‘champions’, those who demonstrate strong commitment, sustain advocacy and promotion of the program, and have strong personal experience and beliefs in integrated approaches, were also critical at the management level.

Management engagement is necessary to oversee the integration of disparate organisational functions (OHS, HR, administration, operations), workload management, the introduction of new policies and processes, and the recruitment and engagement of managers, supervisors and staff. Senior management also have a role in promoting, communicating and supporting effective management of change across the organisation.

In the longer term, the goal of implementing a robust mobilisation phase is to embed and institutionalise the goals of an integrated approach to worker health and safety as part of the organisational vision, strategy and culture. For ConnectEast, the organisational commitment to employee health was reflected in the safety, health and well-being policy, which states that ‘ConnectEast is committed to providing a safe, healthy and supportive workplace’ and emphasises ‘team work and relationships’ as a guiding principle to achieve employee health and well-being. In this way, operational and strategic decision-making is likely to be shaped by priority consideration for the health and well-being of employees, and as part of productivity goals.

This is when you start to think about your staff as people and not only as employees, that the two areas of OHS and well-being are merging.
Assembling the staff, resources and budget for the implementation of an integrated approach is the second step of integration. There is universal consensus that a multi-disciplinary, representative committee, employee advisory board or specific team needs to be established\(^6,8,9,13,14\). All Victorian organisations had already taken this step. In many instances, staff had been made available for committees, or organising well-being activities had been added to managers’ roles. Additionally, a specific budget was allocated in four of the cases (Hoerbiger, OZChild, Stawell Gold Mines and Prima Furniture).

OHS has been an important entry point to integrated approaches in the Victorian workplaces observed. For large organisations (OZChild and the Department of Justice), a review and consolidation of the OHS policy had clearly marked the beginning of the adoption of integrated programs. OHS committees and units were rebranded to include health and well-being dimensions (e.g. “People and Culture”, “Workforce and Culture”). ConnectEast’s health and wellbeing program was initially developed within the OHS unit and then evolved to a more integrated mechanism with the establishment of a HR, Risk & Safety Team. Prima Furniture considered the health and well-being initiative as an extension of the OHS management system that had already established mechanisms of identification, consultation, communication and engagement across the organisation.

The literature recommends additional resourcing (time, staff and budget) to support the integration of organisational health promotion and individual well-being activities into existing OHS infrastructure, and this was evident in Victoria. OZChild had recently recruited a new person to assist in the process. At ConnectEast, the HR, Risk & Safety Team was supported by external service providers to ensure professionalism in the delivery of specific activities such as the Employee Assistance Program. At an early stage of development of the approach, Stawell Gold Mines commissioned consultants to assist in policy planning and formulation. All key informants interviewed recognised the value of involving external resources; many also referred to financial constraints as limitations here (OZChild, Prima Furniture and the Department of Justice).

**Step 2: Assemble**

**Case study examples of assembling a team for an integrated approach to worker health and safety**

- **HR, Risk & Safety team** responsible for planning and developing the corporate strategy dealing with health, safety and well-being issues. Managers, HR, OHS and employees engaged in planning and evaluation process through a regular staff survey-feedback (ConnectEast).

- **Safety and Well-being Governance Committee** (comprising the Safety and Well-being manager, nominee of the Secretary and nominees of all business divisions) as a decision-making body to approve all programming and budgeting (Department of Justice).

- **Specific Health, Safety and Well-being Committee** involving employee and management representatives to identify and implement activities (Hoerbiger, OZChild and Prima Furniture).
Step 2: Assemble (continued)

There is also universal consensus that the committee in charge must have representatives of a broad range of stakeholders in any organisation. They may include employers, employees, union representatives, health and safety professionals, human resource personnel, relevant government agencies, health coaches or educators, and any external providers of safety and health services or programs (safety training, employee assistance providers, health check providers)\(^6,7,15\).

Among the Victorian workplaces studied, all relevant committees included both management and employee representatives, with the exception of Stawell Gold Mines. In small-to-medium enterprises, this may involve external persons with relevant expertise as consultants to the committee, such as a local health-promotion practitioner, or a local industry peak-body\(^7\). This was not necessarily reflected in the workplaces studied. However, consultation with pro bono professionals (via the services of the local city council or personal network) was considered as an option (OZChild and Prima Furniture).

The representation and involvement of staff in every phase of decision-making and implementation is central to integrated approaches\(^6,10,16,17\). Employees have experiential knowledge that is critical to the identification of workers’ health and safety risks. Furthermore, employees are able to ascertain congruence between health risks and any workplace policies, processes and programs implemented to address these needs\(^18\). This participatory approach was well developed in ConnectEast, where regular mechanisms of staff consultation and feedback are established (e.g. via an interactive Intranet platform, OHS Committee meetings, informal discussion and a staff engagement survey), and supported by a strong culture of care. The planning process had evolved from a management leadership structure to a participatory process, where employee input is taken into account. In contrast, employee engagement in the planning of health and well-being activities remained a challenge for Hoerbiger. The manager here perceived employee involvement as risking the creation of high expectations that may not be met. For this reason, mechanisms of consultation with the rest of the staff were mainly informal in this small enterprise.

Middle managers and supervisors should also be represented on the committee or the integrated health team\(^6,10,18\). Middle management, as the link between senior management and staff, has a key role in supporting employees, demonstrating leadership skills and managing change in the workplace. Punnett et al.\(^18\) noted that managers’ concerns, about workload and operational constraints, for example, should be heard, as they pre-empt barriers to employee participation in health and safety programs. Stawell Gold Mines made the training sessions compulsory for managers and Hoerbiger introduced specific related Key Performance Indicators for supervisors, giving them clear responsibility to promote and implement well-being activities. The managers from ConnectEast actively encouraged employees to take part in programs and activities as well as to provide input and feedback. Along with Hoerbiger and the Department of Justice, ConnectEast included well-being and safety indicators in employee performance management plans to reinforce their approaches.
Step 3: Assess

Prior to the planning of any health program, policy or organisational change, a needs assessment is recommended5,13,14. Assessing needs to inform the priorities and desired future of the organisation ensures tailored, efficient strategies are implemented, specific to the workplace or organisation. In many instances, data can be compiled and integrated from existing data sources within an organisation. The SafeWell approach also recommends the integration of data management systems at this stage to ensure co-ordination across multiple arms of the organisation (HR, OHS, operations, etc.), and to establish consistent mechanisms for the evaluation and tracking of change over time10. Some new data collection techniques are also suggested to assess employee health, and perceptions of needs, risks, stressors, satisfaction and preferences, for example10. These may include staff surveys, inspections, policy audits or small focus group discussions, the latter being particularly relevant for small businesses10.

ConnectEast conducted a participatory consultation process and provided health risk assessments to identify staff needs, and OZChild took guidance from a survey of their employees in deciding program content. In other cases, priorities were identified and set by management or the integrated health committee. This was driven by events at Case 2 that were perceived by management to heighten employees’ risk of adverse mental health outcomes.
Step 4: Prioritise

It is recommended that a fundamental priority is the amelioration of immediate workplace hazards. This is placed within a broader set of priorities, about which the following decision tools are suggested:

- **Consider some early gains** by implementing programs shown to be effective, with ready implementation to promote participation. Physical activities and healthy food programs offered an easy and accessible starting point for all organisations to initiate their integrated approaches, as evidenced by the case studies;

- **Consider risk to workers** – severity, probability, and the cost of not addressing a risk. All Victorian organisations studied were convinced about the cost-effectiveness of having an integrated approach. Mental health was one of the main risks identified as potentially costly and needing to be addressed (OZChild, Stawell Gold Mines, Prima Furniture and the Department of Justice). In ConnectEast, the existence of high standards and financial penalties in the industry was seen as driving the need to invest in a motivated and healthy workforce;

- **Identify priorities that are valued by staff** goals, needs and preferences as discovered in Step 3;

- **Consider available resources, and cost-benefit information.** Such practice was mainly used by organisations from the public sector, where financial constraints were more prioritised in decision-making (OZChild and the Department of Justice).
Step 4: 
Prioritise 
(continued)

<table>
<thead>
<tr>
<th>Case Studies’ Policy Objectives and Priorities – Summary Table</th>
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<tr>
<td><strong>ConnectEast</strong></td>
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<td><strong>Stawell Gold Mines</strong></td>
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<td><strong>Prima Furniture</strong></td>
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<td><strong>Hoerbiger</strong></td>
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The goal of integrated approaches is to maximise the organisational capacity, not only to support healthy behaviours, but also to reduce environmental, occupational and psychosocial risk. This integration of individual and organisational change was well developed across all case studies, with programs targeting both individual and organisational outcomes. Strategic goals and priorities were set up and formulated in a Safety, Health and Well-being policy or a mission statement.
Guidelines for implementing integrated approaches in Victoria: Summary and examples

Step 5: Plan

There are two common principles in the guideline literature underpinning the planning of integrated approaches: integrated domains of intervention and integrated systems of delivery. The first principle refers to the content of the planned activities. The planning of activities within an integrated approach is informed by the recognition that any health or safety goal is likely achieved by action at multiple levels, targeting a range of interacting individual, organisational and environmental influences on the desired outcome. In the case studies, the planning process was still in its infancy for several organisations, as a dedicated budget had just been allocated for 2014. The identification of activities was still in progress at the time of data collection. Conducted internally or with the assistance of external stakeholders, the planning process was shaped by organisational goals and the priorities defined in the Safety, Health and Well-being strategy. Larger and more mature organisations like ConnectEast and the Department of Justice demonstrated well-developed planning mechanisms involving evaluation, consultation, identification and formulation of activities that target both employees’ individual behaviour and organisational changes.

The second principle refers to the integration of the systems, or organisational functions, engaged in the delivery and evaluation of activities. This requires integration of the OHS and Human Resources representatives, shared data and shared evaluation and reporting mechanisms, in a move to one overall health and safety management system. Most of the case studies organisations had established a specific committee to oversee OHS and HP issues, integrated into a program management cycle. High worker engagement at this stage is suggested to improve the likelihood of high participation during the implementation phase. To date, ConnectEast was the only example of a workplace implementing a regular mechanism of staff consultation for planning purposes. Others were initiating this process formally or planning via informal consultation with staff.

We are willing to establish a good program this year because when you have the foot in the door, it makes it easier to include it in the future.

OZChild
Step 6: Do

This stage is the implementation and conduct of the plan(s) devised in step 5. To supplement the actions and initiatives outlined in the plan, several further suggestions for optimal implementation have been identified, and were evident in the case studies:

- **Promote employer or senior-management involvement, advocacy and participation.**
- **Develop an effective communication strategy.** Communication tools employed included policy documents, emails and Intranet, verbal communication, meetings and on-site visits.
- **Retain an employee-centric focus and keep all activities on-site, during work hours where possible.** There was universal agreement among the case study organisations to hold activities that were relevant to the workforce (age, gender) and adapted to operational constraints (work type, working hours).
- **Tailor and customise any pre-existing or vendor-supplied programs to the specific workplace, based on staff input.** Due to limited in-house expertise and financial constraints, most organisations adapted existing programs to their own needs. Time was allocated to source external providers.
- **Embed accountability, responsibility and reporting into the plan.** This was clearly included in the policy documents of larger organisations, where roles and responsibilities were stated for senior executives/management, mid-level managers and employees.

“Do” examples from case studies:

- Monthly health and well-being activities
- Employee Assistance Program
- Workplace Safety Program
- External presentations/seminars
- Community volunteering/fundraising including time-off scheduled
- Fresh fruit baskets daily, weekly or monthly
- Health assessment
- Flexible working arrangements
- Sponsored recreational activities (fitness clubs or dance classes)
- On-site sponsored café offering healthy food
Guidelines for implementing integrated approaches in Victoria: Summary and examples

Steps 7 and 8: Evaluate and improve

Evaluation and continual improvement are integral parts of the planning and implementation cycle, and are inter-related; therefore, these two steps are presented together\(^5\). There are several goals and purposes of evaluating an integrated health program, policy or organisational intervention – for accountability, for decision-making by the integrated health management team, for the purpose of continual improvement and for longer-term monitoring and organisational information including benchmarking against similar industries or organisations\(^5, 6, 8-10, 20\). There was consensus among the case study interviewees about the need for strengthened evaluation. However, there were concerns about the best method to be employed and the indicators to be used.

_Evaluation for accountability_ links the outcomes to the program objectives, and addresses the issue of program effectiveness. All case study key informants viewed evaluation as essential to demonstrate tangible benefits and return-on-investment of integrated approaches. However, validated or standardised tools to assess changes or improvements in the planned program, as recommended by NIOSH, were in use only for ConnectEast and the Department of Justice\(^8, 21\), who considered cost outcomes such as absenteeism, sick leave, employee turnover, health claims, medical costs, and workers’ compensation costs.

Benchmarking is also unanimously considered relevant. For some health outcomes, a stabilisation (rather than a reduction) in incidence might indicate improvement when other organisations in the industry have reported an increased incidence in the desired outcome\(^5\). Several well-established frameworks for the evaluation of occupational health interventions are available, including the PIPE Metric (Penetration, Implementation, Participation, Effectiveness)\(^12, 22\); and the NIOSH framework\(^21\). In addition, the assessment of the following additional elements may highlight changes at the organisational and environmental level that might otherwise not be captured in evaluations of health or safety outcomes: psycho-social safety in the workplace; organisational health and safety climate; inter-personal interactions; intra-personal resources (e.g. resilience, coping)\(^23, 24\). Increased communication within the organisation and better staff morale were also mentioned as immediate outcomes in four cases.

In more advanced cases (ConnectEast and the Department of Justice), the evaluation was mainly used to inform the decision-making and planning process, as part of the on-going response to the needs of the organisation. Evaluating an intervention provides further information about workers’ needs, priorities, opportunities, participation and relevance. This in turn informs subsequent planning by the integrated health team. In this way evaluation informs continual improvement. As they are in the early phases of adoption, most of the case studies did not yet have in place structured evaluations.
Steps 7 and 8: evaluate and improve (continued)

**ConnectEast evaluation process**

Assessment of the health and well-being activity schedule

- Indicators used: absenteeism rate, attrition rate, employee engagement survey, sick rate, participation level in the activities and safety indicators. Results are then benchmarked against similar statistics in the call centre industry.
- Review undertaken in conjunction with the inputs given by the OHS Committee and the external service providers.
- Revised activity schedule prepared by the HR, Risk & Safety team and presented to the OHS Committee members who will then consult with employees across departments.
- Document finalised based on feedback.

**December:** Approval of the activity program

**January:** Program disseminated on the intranet

**February-November:** Activities implementation

**Department of Justice evaluation strategy**

The OHS strategy is evaluated at the end of every year against a set of tangible and measurable expected outcomes listed for each priority area. Based on progress reports (including achievement of OHS targets and key performance indicators), new or emerging priorities are eventually incorporated into the strategy. To measure the impact of several programs, evaluation surveys are conducted using SurveyMonkey but there is no systematic measurement of the activities’ participation rates. Direct feedback from staff during on-site visits or meetings is also taken into account in addition to internal reporting. Their national Employee Attitude Survey is considered a valuable benchmarking tool enabling the organisation to compare its results against the Victorian Public Services as a whole.
Summary of Victorian case studies

The organisations sampled reflected a diversity of workplaces in Victoria based on size, industry and sector. Characteristics are summarised in the table below.

<table>
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<th>Workplace profiles – Summary table</th>
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<tr>
<td>Size</td>
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<tr>
<td>------</td>
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<tr>
<td><strong>ConnectEast</strong></td>
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</table>
| Large | Private sector | • White collar  
• 210 employees  
(28.5% at headquarters and 71.5% at call centres)  
• 59% full-time, 25% part-time, 19% casual | • 24/7 activities  
• Multiple sites in Victoria (headquarters and call centres) | 2008 |
| **Stawell Gold Mines** | | | | |
| Large | Private sector | • Blue collar  
• 350 workers (full-time)  
• Mainly men aged from 35 and 54 years | • Part of a wider group  
• 24/7 activities  
• 1 site divided in surface and underground work | 2013 |
| **Prima Furniture** | | | | |
| Medium | Private sector | • Mix of white (25%) and blue (75%) collar  
• 102 employees  
• Mainly men | • Part of a wider group  
• 1 site (office and shopfloor) | 2012 |
| **Hoerbiger** | | | | |
| Small | Private sector | • Mix of white and blue collar  
• 30 employees  
• Mainly men  
• Age diversity | • Part of a wider group  
• Multiple sites (Melbourne and across Australia) | 2013 |
| **OZChild** | Not-for-profit | • White collar  
• 180 employees  
• 90% women  
• 70% social workers  
• Mix of permanent, part-time and casual staff | • Head office in Melbourne  
• Branches across Southern Metropolitan Region  
• Client services | 2008 |
| **Department of Justice** | Public sector | • White collar  
• 7000 employees  
• 90,000 volunteers | • Three-level operation: state-wide, regional and local | 2010 |
Enablers to integrated approaches

Considered as early adopters, some of these organisations initiated integrated approaches at least 3 years previously, demonstrating well-developed mechanisms of implementation (ConnectEast, OZChild and the Department of Justice). The others have embarked on integrating their OHS and health promotion programs more recently (1–2 years), and they were still at an exploratory stage (Hoerliger, Stawell Gold Mines and Prima Furniture). Despite their differences, several common enablers and barriers have been noticed in their attempt to develop further programs in worker health, safety and well-being.

From the case studies, several critical enablers have been identified for the implementation of integrated approaches in Victorian workplaces.

**Main enablers**
- Strong management commitment
- Allocated budget and resources
- Clear policy and strong program visibility (communication strategy)
- Culture of care or culture of safety
- Participatory approach engaging employees in the planning and implementation process
- Building on existing OHS mechanisms and supportive regulatory framework
- Flexible and accessible activities
- External expertise sourced where affordable

**Strong leadership and management commitment**, including specific resourcing of initiatives, were foundational in each setting. An explicit **culture of health and safety** was also notable, with organisations striving to invest in their human resources across a range of initiatives. **Participation across all levels of the organisation** was highly valued and sought-after. **Flexible and accessible activities** were a common strategy for maximising employee engagement. For most workplaces, **building on established OHS infrastructure** was a practical entry-point to deriving a comprehensive health management system, extending initiatives to support a broader range of health and well-being targets. The **use of external expertise to support** program planning and delivery was also favoured.
Barriers to integration and implementation

Several common barriers were identified. The difficulty of transferring activities across multiple, diverse, unique workforces within one organisation was noted. Further, even when leadership demonstrated financial commitment to the program, resource constraints were evident. Key informants reported a lack of time or staff to take on the additional roles and workload required to implement health and well-being programs. Financial constraints were reported, particularly outside the private sector; employee participation was also challenging in many cases. Finally, there was evidence of a knowledge gap in workplaces about the most appropriate tools and indicators by which to evaluate program effectiveness.

Main barriers
- Delivery to diverse workforces and work-sites within single organisation
- Financial and time constraints
- Continuous employee motivation and engagement
- Set up of indicators of performance
There was consensus from the case study organisations that the introduction of an integrated approach was a strong contributing factor to improved employee health, safety and well-being. Immediate positive changes were reported within the workplaces, including improved health behaviours (lunchtime walking groups, healthy lunch boxes) and improved staff morale (positive mindset, openness to new ideas and initiatives). Overall communication across the organisations had also significantly improved.

ConnectEast reported the following outcomes for the calendar year 2013, attributable to their integrated health management system: $176k cost benefit due to a significantly reduced number of sick days; a low attrition rate (1.4% for the corporate office, 17.8% for the contact centre, 1.3% for the sub-contractor) and strong safety outcomes (0 lost time injuries since December 2009 and 0 medically treated injuries since May 2011).

Perceived outcomes
Immediate benefits
- Healthier lifestyles and increased physical activity among employees
- Improved staff morale, self-esteem and overall worker satisfaction
- Improved communication across the organisation

Medium-long term benefits
- Strengthened safety outcomes
- Improved cost-efficiency and return-on-investment
- Increased productivity
The definition of integrated approaches (IAs) used in the research was based on five criteria provided by the US National Institute for Occupational Safety and Health (NIOSH) and the Safewell Practice Guidelines:8,10:

<table>
<thead>
<tr>
<th>Criterion</th>
<th>Description</th>
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<tbody>
<tr>
<td>1</td>
<td><strong>Integrated domains of intervention and targeted outcomes</strong>: combining individual worker and workplace organisational actions, and occupational and personal health;</td>
</tr>
<tr>
<td>2</td>
<td><strong>System integration</strong>: collaboration and integration between health-related organisational functions;</td>
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<tr>
<td>3</td>
<td><strong>People engagement</strong>: active participation from workers and management in the planning and implementation of integrated activities;</td>
</tr>
<tr>
<td>4</td>
<td><strong>Clear planning and resources allocated</strong>: program feasibility in terms of human and financial resources, and clarity (e.g. available related strategic documents);</td>
</tr>
<tr>
<td>5</td>
<td><strong>Program evaluation and continual improvement</strong>: evaluation/assessment mechanisms, flexibility and responsiveness in the implementation, barriers and problem management.</td>
</tr>
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**Summary of Victorian case studies**
Summary of research methods

Evidence review

A systematic review of the empirical evidence on the effectiveness of integrated approaches for worker health, safety and well-being was conducted.

Eligible studies were those which reported on an evaluation of a workplace intervention (or program); targeting improvements in worker health, safety or well-being; demonstrating integration of program delivery, program management and individual and organisational outcomes; and published in the peer-reviewed scientific literature since 1990.

Two-rater consensus was applied to ascertain the final sample of thirty-two studies.

Data were extracted and categorised according to the level of integration (full or medium); the outcomes assessed, and the causal inference derived from the study design.

Framework and guideline review

The framework and guideline review was a purposive, targeted search collating relevant, authoritative strategies and guidelines to establish consensus informing the practice and implementation of integrated approaches.

Purposive searching of established and authoritative websites and agencies of organisations (both Australian and international) was conducted.

Identified documents were included in this review if they presented a conceptual model for, or the program logic of, an integrated approach to worker health, well-being and safety; or guidelines or plans (e.g. for organisations or employers) for the planning, implementation or evaluation of an integrated approach to worker health, safety and well-being.

Summarised findings are presented in the WHO Healthy Workplaces Framework, within eight process steps: Mobilise, Assemble, Assess, Prioritise, Plan, Do, Evaluate, Improve.

Case studies

Cases were exploratory in nature and focused on the implementation of integrated initiatives combining health promotion and OHS practices. A two-phase purposive sampling framework was utilised.

First, WorkSafe identified a shortlist of 22 potential organisations which were involved in the WorkHealth program and considered as exemplar businesses for the purpose of the project. A telephone-screening tool was administered by the WorkHealth team, categorising the workplaces according to their level of integration of OHS and HP activities. A scoring matrix was applied to identify workplaces with the strongest evidence of integration.

Finally, 15 organisations were invited to participate in the research, of which six agreed.

Semi-structured interviews were conducted at each workplace using a detailed interview question guide. Representatives from senior management, occupational health & safety, and/or the human resources departments were interviewed.

Organisational documents were collected and audited to support the data collected from interviews.
References


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