

## **WIN research team**

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## SUMMARY OF RESEARCH FINDINGS

The WorkHealth Improvement Network (WIN) program was designed by WorkSafe Victoria with the aim of trialling an integrated approach to employee health, safety and wellbeing. Integrated approaches involve worksites combining occupational health and safety activities with health promotion and human resource management. In the WIN program worksites were guided to set up an integrated approaches committee to lead their efforts to reduce musculoskeletal injuries, improve workplace mental wellbeing and foster a safety culture. The program was implemented in 31 work sites in 2 industry networks (public hospitals and manufacturing) in Victoria from March 2015 to July 2016. A mixed methods evaluation to determine the effectiveness of the program ran concurrently, commencing in January 2015 and concluding in February 2017.

Approximately half of the worksites in each network demonstrated improvements in employee ratings of safety culture, mental health, physical health and a reduction in musculoskeletal disorders.



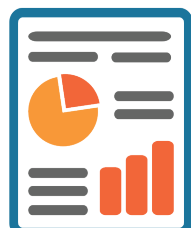
In the manufacturing network there was a substantial decrease in musculoskeletal disorders.



In the public hospitals network, reported incidents, lost-time injuries and medical treatment injuries decreased.



In the manufacturing network, reported incidents increased, although lost-time and medical treatment injuries were roughly the same.



In both networks, near misses and reported hazards increased, possibly due to greater awareness of dangers and hazards as a result of the WIN program.

A joint initiative of

## WHAT WAS DONE IN THIS STUDY?

In the WIN program, worksite representatives were guided to set up an integrated approaches committee representing occupational health and safety, health promotion, and human resource management to implement specific WIN activities intended to improve employee health, safety and wellbeing. The integrated approaches committees used a continuous improvement model in the form of Plan-Do-Study-Act (PDSA) cycles for their WIN activities, where small-scale ideas could be tested, changed, and then implemented, if deemed successful by the worksites.

Paid network chairs were contracted to lead the networks, with the Department of Health and Human Services (DHHS) leading the public hospitals network, and the Victorian Chamber of Commerce and Industry leading the manufacturing network. Network chairs received 2 full days of training on collaborative methodology together with an orientation and training package developed and delivered by the Improvement Foundation.

The network chairs led a Design Expert Group workshop prior to the commencement of the program to build understanding about the design and implementation of the WIN program. The network chairs were then responsible for recruiting and orientating worksites into the program. Throughout the program their role was to support worksite progress by facilitating learning workshops allowing representatives from each worksite to come together and learn from each other about their experiences in the program, and to provide ongoing coaching while worksites implemented their activities. Network chairs also had a key role in advocacy and sharing learnings with their relevant industry.

The WIN program was implemented across 3 waves of action from April 2015 to July 2016. Prior to the start of each wave the network chair recruited worksites into the network. The aim of each network chair was to recruit 3 worksites into the first wave and 6 worksites in each successive wave resulting in a total of 15 worksites for each network. The public hospitals network recruited an additional worksite in wave 3 so the total number of worksites was 31.

Each worksite was asked to set up an IA committee of employees with representation from occupational health and safety, health promotion, and human resource management. Each worksite nominated an IA champion to lead the committee. Some worksites included representatives from different operational areas as well, which brought diverse opinions and ideas about what the workplace problems were and how to address them.

Each worksite entered the program with their own organisational priorities and goals, and developed change ideas to address at least 1 of the 3 focal areas

of health, safety and wellbeing. The aim of the PDSA cycles were to take learnings from 1 wave into the next wave as a process of ongoing improvement. The worksites were required to conduct a minimum of 3 PDSA cycles in each wave. PDSA cycles allowed testing and implementation of ideas for change on a small scale prior to full implementation.



Examples of PDSA activities included developing or making changes to an existing policy, planning a workplace initiative or program, delivering training, and improving relationships within and between departments. Manual handling training focused on how to reduce injury, such as rotation of jobs, exercises and correct lifting. New technologies were introduced, for example a drum lifter to reduce the need for manual handling related tasks, or anti-fatigue mats preventing employees standing on concrete.

Examples of PDSA activities addressing mental wellbeing included building understanding through education and training, running wellbeing workshops designed to reduce stress and increase resilience, formation of walking groups, creating a team spirit through social activities and provision of counselling services.

An important part of the process was to understand issues from the perspective of staff, for example by surveys or focus groups. This gave insight into issues that needed addressing and helped staff to engage in the process. IA champions recorded key details about the PDSA cycles that were implemented in their worksite using reporting forms. The IA champions were supported by network chairs throughout the process.

The evaluation of the WIN program was undertaken at 4 levels, namely the safety regulator, industry networks, worksites and employees, and across four time points, at baseline, end of wave, end of program and 6 months post-program.

## WHAT WAS FOUND?

Key findings are presented across the 4 focus areas of the evaluation.

### 1. Program implementation

Worksites in both networks used multiple PDSA cycles to implement a range of WIN activities. Public hospital worksites were more likely to undertake focus group activities with employees in order to engage employees and determine priorities for IA activities. The majority of manufacturing worksites designed activities to develop new procedures, for example the use of floor-mats to prevent musculoskeletal discomfort. Employee participation in WIN activities was relatively stable across the public hospitals worksites from baseline to follow-up. In the manufacturing worksites employee participation increased slightly from baseline to follow-up.

*"I think it's been great to see the organisations realising that it's not just a health and safety person's problem, that it's the whole organisation that can make an impact and have some beneficial outputs. Not just for health and safety, but for the broader business as well."*  
– Network chair.

Common barriers to the implementation of an integrated approach in the WIN program included:

- Lack of leadership support and commitment
- Worksite culture and resistance to change
- Time constraints of the WIN program
- Complexity of the WIN program
- Lack of funding or access to resources
- Lack of capacity in smaller worksites.

Key facilitators of an integrated approach in the WIN included:

- Integrated approaches being used as a new way of working
- The support of networks
- The IA champion and committee
- PDSA cycles as 'small wins'
- Leadership support and commitment
- Using evaluation results to benchmark performance and make improvements.

### 2. Work site changes from baseline to follow-up

The worksite audits assessed the extent to which each worksite had an integrated approach to health, safety and wellbeing. Scores on this measure for worksites in the public hospitals and manufacturing networks showed some improvement, on average, from baseline to follow-up. A comparison of integration scores across the 2 networks showed that 7 of the 10 manufacturing worksites had improved integration scores at follow-up while only 8 of the 16 worksites in public hospitals had improved integration scores at follow-up.

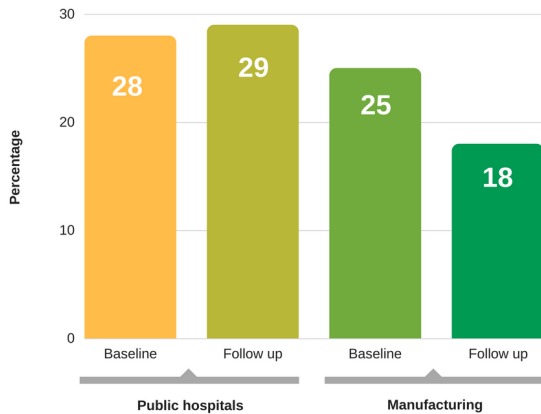
Key findings from the employee survey showed that approximately half of the worksites in each network demonstrated improvements in employee ratings of safety culture, mental health, physical health and a reduction in musculoskeletal disorders.

Other key findings included:

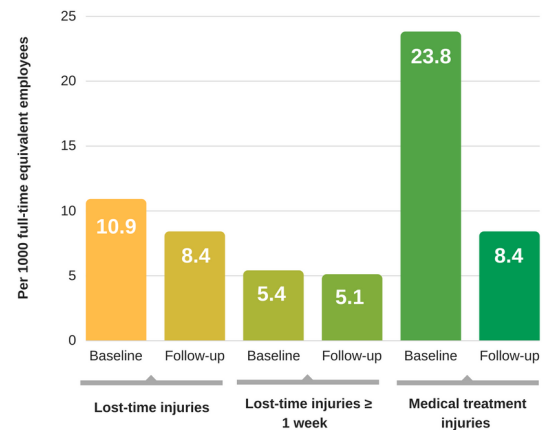
- A greater percentage of worksites in the public hospitals network than in the manufacturing network reported improvements in safety culture from baseline to follow-up
- Employees in the public hospitals network rated their worksites lower overall on leading indicators of occupational health and safety, compared to those in the manufacturing network
- Employees in the manufacturing network rated their mental health higher than those in the public hospitals network
- Physical health was rated at approximately equivalent levels in both networks
- There was a substantial decrease in musculoskeletal disorders from baseline to follow-up in the manufacturing network
- Employees in the public hospital network reported a slight increase in the experience of musculoskeletal disorders from baseline to follow-up
- Overall, the employees in the manufacturing network experienced fewer musculoskeletal disorders compared to those in the public hospitals network.

*"There's a lot more acceptance and I think there's a lot of behaviours that are being generated though the whole process. Everyone across the business to be more accepting of people that may have mental [health] issues."*  
– IA committee member (manufacturing)

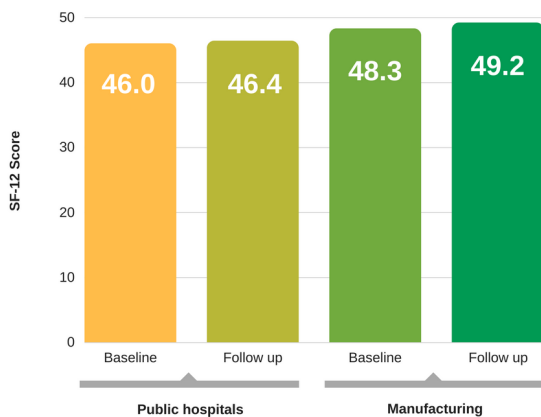
### Employees experiencing musculoskeletal disorders



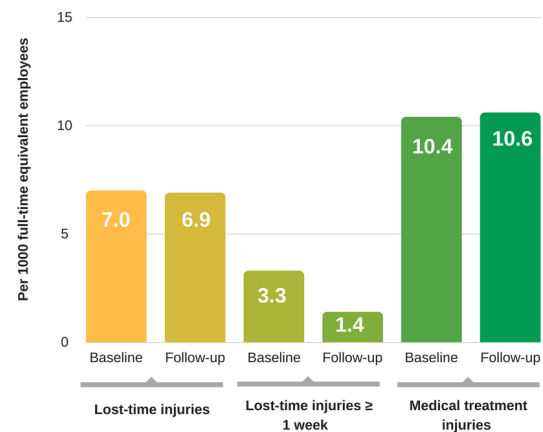
### Public hospitals network



### Employee mental wellbeing



### Manufacturing network



## 3. Economic analysis

In the public hospitals network, reported incidents, lost time injuries and medical treatment injuries decreased from baseline to follow-up. In the manufacturing network, reported incidents increased from baseline to follow-up, although lost-time and medical treatment injuries were roughly the same.

For worksites in both networks, reported near misses and reported hazards increased from baseline to follow-up. It is possible that this could reflect a greater awareness of potential dangers and hazards as a consequence of the WIN program. The reductions in workplace injuries observed following the implementation of the WIN program did not translate into an improvement in productivity or reduction in compensation claims. This may be because of a lag in the timing of compensation claims.

## 4. Sustainability of an integrated approach at worksites

Key factors contributing to the likelihood that a worksite would sustain an integrated approach beyond their participation in the WIN program included:

- The support and commitment of leaders in their organisations
- The ongoing role of an IA champion and committees with suitable knowledge
- Frequent employee consultation
- The use of evaluation research to guide decisions
- Leaders within the organisation having the skills and resources to support health, safety and wellbeing activities, such as appropriate training, evidence-based guidelines etc.
- Monetary investment and support for health, safety and wellbeing activities.

## WHAT ARE THE IMPLICATIONS OF THE FINDINGS?

- Network chairs play a key role in the success of integrated approaches by providing stability and leadership and require comprehensive training prior to the commencement of the program.
- In larger organisations, integrated approaches committees should comprise representatives from occupational health and safety, health promotion and human resource management.
- Learning workshops and supporting materials need to be tailored to the level of organisational readiness and capabilities.
- Worksites greatly valued the opportunity to collaborate and share learnings within their networks and between the different industries.
- Worksites require flexibility on their adoption of integrated approaches and may require time to embed the activities in their annual planning and budget cycles.
- Evaluations should be co-developed alongside the program to provide clear objectives and maximise the opportunity for the delivery of timely feedback throughout the program.

## CONCLUSION

The WIN program was designed to trial an integrated approach to worker health, safety and wellbeing in two selected industries. The evaluation findings provide some good evidence for the feasibility and acceptability of implementing an integrated approach to improve the health, safety and wellbeing of workforces as well as some preliminary evidence of the short-term benefits. However, further research using a stronger evaluation study design would help to determine the longer term benefits of the WIN approach.

Building on previous research, the WIN program has shown that while using an integrated approach can have positive outcomes, strong support and leadership is required by employers and their employees to plan, implement and sustain the program. Other factors for worksites' successful implementation of the WIN program were: the coaching support from network chairs; education and resourcing of IA committees; and the use of evaluation data by organisations to understand better the workforce health, safety and wellbeing issues in their worksites.

**More information** De Cieri, H., Shea, T., Oldenburg, B., Quirk, S., Knott, R., Zemanek, J., & Joss, N. (2017). *WorkHealth Improvement Network (WIN) Evaluation Research Project: Final Report*. ISCRR report number 112-0517-R17. Monash University: Caulfield East, Australia.  
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