

Workplace Health Connect

July 2006 Progress Report  
(DRAFT)

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# Workplace Health Connect July 2006 Progress Report (DRAFT)

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## Acknowledgements

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# Executive Summary

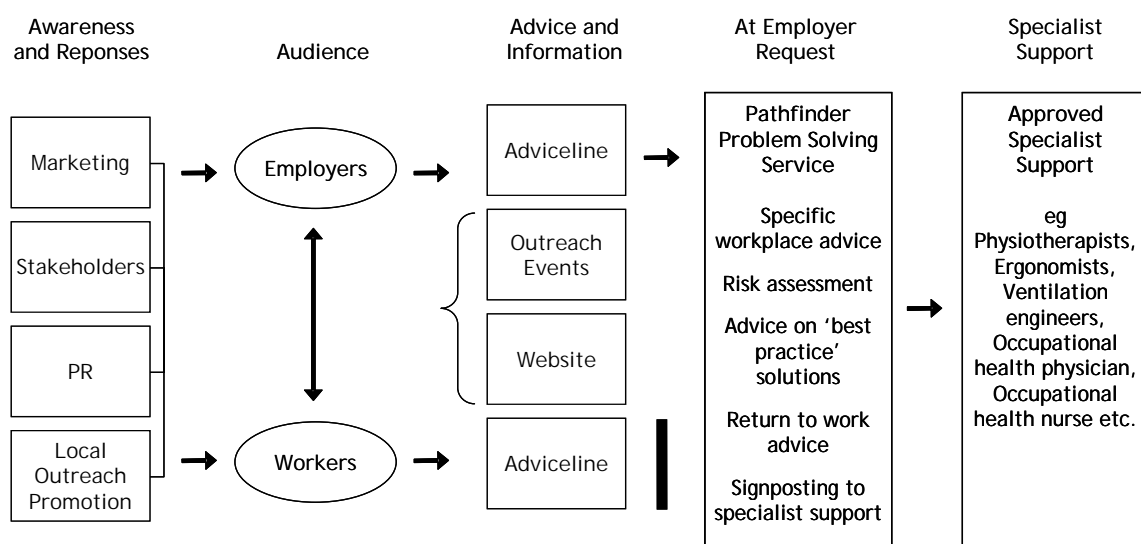
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## Workplace Health Connect

Workplace Health Connect (WHC) was launched in February 2006 and is a free, no obligation service designed to help small and medium sized enterprises. The service provides advice on workplace health and safety, and aims to transfer knowledge and skills direct to companies, allowing them to tackle future issues internally or with the help of recommended specialists. WHC is currently a pilot initiative with a national adviceline and teams of qualified advisers conducting workplace visits in five regions of England and Wales. The service is summarised in the figure below.

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Workplace Health Connect in Action



Source: WHC website ([www.workplacehealthconnect.co.uk](http://www.workplacehealthconnect.co.uk))

The WHC service therefore exists at three levels:

1. Level 1 consists of an adviceline which gives free, detailed and tailored practical advice to callers, both employers and employees, on workplace health, safety and return to work issues. This is supported by a dedicated website. The Level 1 service also acts as a referral point for Level 2.
2. Level 2 offers a problem solving service available in five regions, operated by contractors (often formed from regional partnerships) known as pathfinders, who carry out free visits (normally a first and follow up visit with a telephone follow up three months later) to advise on workplace health and safety issues.
3. Level 3 consists of signposting by the adviceline and pathfinders for employers who are directed to approved local specialists for future support.

## The Evaluation

In order to better understand these pilot activities, the Health and Safety Executive (HSE) has commissioned a team led by the Institute for Employment Studies (IES) to undertake an evaluation of their activities and impact. This is a summary of the first substantive output of this evaluation which is currently planned to continue until 2008, tracking the first two years of WHC activities.

There are two main on-going strands of the evaluation, which has already completed a development phase. These are:

1. A process evaluation to investigate and understand service delivery (including costs) and service penetration.
2. An evaluation of the impact of the initiative in terms of intermediate and final outcome measures (eg changes to attitudes about occupational health, or changes to the number of days off taken by staff within the employer), as well as an estimate of the overall costs and benefits of WHC.

The main sources of information available to the evaluation will be:

- monitoring data collected by the adviceline and pathfinder advisers
- interview data from service providers reflecting on their experiences in more depth
- baseline and follow up surveys of users (of both Level 1 and Level 2 services), with a tandem survey of non-users to act as a 'control' to help estimate service impacts
- in-depth case study work with employers, their workforces and other local stakeholders as necessary to follow up on their experiences of using the service and any impact that doing so has had upon workplace practices
- analysis of secondary data to contextualise these findings.

## Marketing the service

WHC relies on a central marketing team which includes a range of consultants and involves a combination of a branding exercise, launch events, public relations activities, radio and press advertising, the use of direct mailings and telemarketing activities. This is present to drive up demand for services, particularly to Level 1 as a referral point for Level 2 visits. Additionally, there is a range of outreach work being conducted by the pathfinders within their own regions and which is tailored to local and regional need. Outreach work will develop as and when required to supplement referrals from Level 1.

So far the most successful approach has been the telemarketing follow up of employers contacted by the direct mail (this began fairly recently at the end of April 2006), as direct mail alone did not yield the anticipated results. Another source of interest has been the internet (anecdotally the HSE website), as employers using Level 1 are most likely to have heard about the service through this source. Engaging local and national press has proved difficult and the public relations aspect of the marketing has been hard to get off the ground. So far, the numbers of employers calling the adviceline is below target levels, but the conversion rates of eligible employers on to Level 2 services are almost double original estimates. As a result Level 1 take up is low, but Level 2 take up is now at the levels required to hit national targets, despite a slow start.

The overall approach of marketing has recently switched from a sole focus on health to one which also emphasises benefits related to safety management. This is as a result of consultation with pathfinders who feel that the main draw for employers is concerns about safety, including legal compliance. Workplace health remains a priority for the service, but the decision has been taken for marketing purposes that it needs to be woven into more generic health and safety issues. The focus of future marketing will be on addressing the low take up of Level 1, and therefore be addressed nationally rather than with a region focus (which has been the case so far).

## WHC users

By 20 June 2006 (four months of official operation since the launch), a total of 1,905 calls had been made to the adviceline. The average call rate over this period was 20 per day, but this figure has been subject to variation – as it is strongly linked to the types of marketing approaches being undertaken at that time. There is an overall upward trend in call numbers over the last three months which appears to be mainly stimulated by the use of telemarketing. Despite this, call levels are below original estimates for the Level 1 service. Over the same period, 471 referrals to the adviceline had resulted in visits delivered by the Level 2 providers. The weekly referral rates are now hitting anticipated levels for the first time.

The majority (almost two-thirds) of callers to the adviceline work within small organisations (ie with between five and 49 employees) and these were spread across different industrial sectors, but with real estate/rental/business services employers the largest single group (15 per cent of callers). The overall spread of industries is not dissimilar from estimates of the population of businesses (as published by the Annual Business Enquiry), but the real estate sector (which makes up almost 30 per cent of all businesses) is under-represented. Manufacturing and the community/personal services sectors are in contrast over-represented amongst callers.

The vast majority (85 per cent) of businesses represented amongst callers did not have existing access to occupational health support. Employers taking up Level 2 visits are mostly small, rather than medium sized, and the manufacturing employers are the ones who have received the largest number of visits so far. Overall, therefore, early evidence would suggest that WHC is hitting its main target groups.

## Call and visit content

The vast majority of callers to Level 1 raise issues related to safety rather than health, and generic rather than specific queries. Most commonly individuals were calling for advice on general safety issues (63 per cent of calls), although larger employers were more likely to have a specific query. Absence management and return to work issues featured in only around 15 per cent of calls, and referrals onto further specialist sources of information (aside from Level 2) were scarce, taking place in only two per cent of calls.

The actual content of Level 2 visits varies, according to the nature of the employer. However, there are a number of standard tools (eg the HSE Performance Indicator Tool) that are available to advisers and clear quality standards for visits. There is therefore a prescribed framework for visits, but within this advisers tailor the visit to the needs of the employer in question. Despite this degree of variation, Level 2 advisers were largely in agreement that there were three types of employer motivations for contacting the service. These were:

- to help them address specific concerns
- to check existing systems
- to help them develop new systems.

A first visit is largely used to address any specific concerns that employers have and go through issues that they feel are important to them. In many cases this appears to be developing health and safety policies. The follow up visit, in contrast, often gives the advisers the space they need to introduce new issues and to focus more on workplace health.

## Satisfaction and early outcomes

Satisfaction with the Level 1 service, as recorded by advisers, is very high, with 73 per cent of users stating that they are very satisfied with the advice they receive. It will be important to collect further, more independent data, on this as the evaluation progresses. However, employers interviewed in depth by the evaluation team (although this is only eight employer representatives) were also very positive about the Level 1 service. In some cases it had been used solely as a means to access Level 2 provision, but even these employers suggested that it would be the first place they would turn to in future for assistance with health and safety issues. Therefore using Level 1 as a referral point has generated interest in the advice line service for the future, now that employers are aware of what it can offer.

The Level 2 visits also received very positive feedback and advisers feel that employers are very appreciative. There were some issues whereby employers were initially sceptical about the free and confidential nature of the service, but universally this has been overcome. Employers were particularly positive about the tailored approach of the service and the fact that advisers dealt with the issues most important to them as a priority.

It is still very early days for employers who have taken part. Despite this, the small number of employers interviewed for the evaluation were able to identify a range of outcomes that had occurred as a result of their contact with the WHC service. These included:

- the reinforcement of their existing knowledge and greater confidence about the application of this knowledge
- providing momentum to make changes that were either long overdue or which would have taken much longer to achieve without the help of the Level 2 advisers
- referrals onto other sources of support which they felt would help in making future progress.

## Quality issues

Overall, the Level 1 and Level 2 services are meeting their quality targets. There have been some issues in completing the necessary data, particularly amongst Level 1 advisers who are required to feed information to the evaluation team and provide referrals information for Level 2. However, the accuracy levels are now increasing, although this does take up more adviser time than had been anticipated. 'Mystery shopper' calls have recently started which will provide some checking of both the accuracy of data entry, but also, and more importantly, the quality and relevance of advice given at Level 1.

At Level 2, it has been difficult to assess in any depth the quality of visits as HSE warranted inspectors cannot observe actual visits due to confidentiality and trust issues. They are therefore reliant on visit reports so far to check quality, but these do not provide the depth of information required for this purpose as they are designed to provide focussed feedback to employers. However, recruitment is underway for occupational health and safety experts who could undertake this observation on HSE's behalf.

## Conclusions

This evaluation report discusses just four months of the operation of a totally new service. To date the majority of data collected for the evaluation is concerned with process issues rather than impact. It is therefore difficult to draw any definitive conclusions about the service at this very early stage, but we raise some general points in this final chapter.

### Positive response so far

The WHC model (both Levels 1 and 2) appears extremely successful in meeting employer expectations (satisfaction ratings are high), tailoring the model to meet employers needs as they see them, and engaging advisers who like working within the model, partly because they are able to build good relationships with their clients. From a client perspective (but using only limited evidence so far), the WHC offer is appreciated because it is free, credible and does not adopt a punitive approach. Monitoring employer views over the longer term and providing more supporting evidence for these claims will take place as part of the overall evaluation, starting in September 2006.

### Level 1

Level 1 has faced a number of practical issues in the first few months of operation including data completion. In addition, call volumes have been low (as driven by the central marketing). However, both the data completion protocols and the marketing have been adapted as a response to these initial problems. It has been encouraging that the referral rate to Level 2 is almost double what had been predicted, demonstrating that there is a high level of interest in the service and that Level 1 advisers are successfully 'selling' Level 2. Mystery shopper activities will also provide further validation of the quality of advice provided in future.

### Level 2

The challenge for Level 2 providers in contrast is more fundamental. Employers want advisers to focus on issues that they have identified for themselves as a first priority, which are mainly about basic health and safety issues. It is important to advisers to

respond to these as it builds credibility and trust. This means that only then can advisers move onto new, and often health issues. In some cases, therefore, the focus on health may not happen until the second visit. This does have implications for the overall success of the service, at least in terms of health targets.

Some employers are reluctant to take up second visits, perhaps more so in cases where they have been able to make little progress since the first visit. There are therefore two issues here, firstly that employers most in need of a second visit (because they are the ones with the least developed awareness or most limited resources) may be the ones reluctant to take them up affecting the degree to which WHC can have an impact. Secondly, the absence of a second visit for some employers may mean that some health issues are not discussed in detail at all in some cases.

## Messages

Despite the use of a number of specialist consultancies, getting the marketing right for the service has been difficult, but lessons have been learnt and the approach adapted accordingly. What is interesting is the concerns which employers identify with and those they do not. The main focus of the service is obviously workplace health, but employers are not calling for help with health or back to work issues in any great numbers.

This leaves WHC with three options:

1. *Introduce health issues largely 'through the back door' by dealing with them during the second visit and not making health the focus of the service in a visible way.* The issues for this approach are to understand the prompts which switch employers onto occupational health. Regional outreach, for example, could be a more effective method of putting forward health messages than is the case for central marketing. This is because it has the potential for advisers to build closer connections with employers, allowing advisers/outreach workers to discuss the benefits to employers of fixing occupational health issues on their agendas.
2. *Move away from health because employers aren't interested, focussing on the safety issues that present themselves.* This approach would hope to develop greater generic awareness amongst employers about health and safety issues, and accept (or hope) that health will eventually move up the agenda.
- 3 *Carry on pushing health, effectively 'holding your nerve'.* Work on other initiatives (eg Constructing Better Health) show that selling a 'health' service to employers is very difficult but that it can be achieved (within a specific sector) with repeated approaches which push home the importance of health. This does, however, take significant time and resources.

There is clearly a role for WHC not only in tackling the incidence of ill health in UK workplaces, but also in spotlighting occupational health more generally. The work of

the WHC pilot activities will help to develop a better understanding of this can be taken forward most effectively.

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# 1 Introduction

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## 1.1 Background

Workplace Health Connect (WHC) was launched in February 2006 and is a free, no obligation service designed to help small and medium sized enterprises (SMEs). The service provides free advice on workplace health and safety, and aims to transfer knowledge and skills direct to companies, allowing them to tackle future issues internally.

The vision of WHC is stated as:

*'Everyone working in small firms should have easy access to free consistent high quality advice on creating and maintaining a healthy workplace. Workers and employers work together to improve the quality of workplace health and return to work of colleagues when they have been ill. Businesses are more profitable and everyone enjoys the economic and health benefits of being in work.'*<sup>1</sup>

WHC is currently being run as a pilot initiative with a national adviceline and teams of qualified advisers conducting workplace visits in five regions across England and Wales. In order to understand these pilot activities, the HSE has commissioned a research team led by the Institute for Employment Studies (IES) to conduct an evaluation. This report is the first substantive output of that evaluation and it considers the progress made by the WHC pilot to date.

## 1.2 Why WHC, and why now?

The Health and Safety at Work Act was introduced in 1974, and places general duties on all employers to protect the health and safety of their workers. Since this time there has been a great deal of progress in reducing work related accidents. The rate of work-related fatalities has fallen by two-thirds since the 1970's<sup>2</sup>, though progress slowed

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<sup>1</sup> See [www.workplacehealthconnect.co.uk](http://www.workplacehealthconnect.co.uk) for further details.

<sup>2</sup> Cited in A Strategy for Workplace Health and Safety in Great Britain to 2010 and beyond, HSC, February 2004.

during the 1990's. Over the same period, the structure of the UK economy has changed dramatically. There are fewer large firms but more small firms, greater outsourcing of peripheral jobs, and part-time work and non-standard forms of employment have also increased. Women now constitute half of the workforce, the importance of the manufacturing sector to the UK economy has declined with the service sector gaining precedence. These changes bring different challenges in managing health and safety effectively.

### 1.2.1 Moving towards 2010

In June 2000, the Government and Health and Safety Commission sought to inject new impetus to better health and safety in all workplaces and launched a ten year strategy. It contains the first ever targets for Great Britain's health and safety system, namely that by 2010:

- the number of working days lost from work-related injury and ill-health to be reduced by 30 per cent
- the incident rate of fatal and major injury accidents to be reduced by ten per cent
- the incident rate of cases of work-related ill-health to be reduced by 20 per cent.

One of the ten strategy points, emphasised **the importance of occupational health support** in reaching these new targets. There was also an emphasis on the need for a more positive **engagement with small firms** and a **wider partnership on health and safety** issues. The need for a **strategic partnership approach** which involved both the public and private sectors was also recognised

### 1.2.2 Stronger focus on the 'health' in H&S

**Securing Health Together** (HSC, 2000)<sup>1</sup>, a long-term occupational health strategy for England, Scotland and Wales, aims to achieve a number of targets in relation to reducing ill-health caused by work activity and accidents by 2010. The initiatives include ensuring that appropriate support mechanisms are in place to deliver OH support. Published at the same time as the revitalising strategy, a report from HSC's Occupational Health Advisory Committee (OHAC) made 30 recommendations about occupational health<sup>2</sup>.

**A strategy for workplace health and safety in Great Britain to 2010 and beyond** (HSC, 2004), notes that the current partnership of HSC, HSE and Local Authorities (LAs) have done well in improving safety, but health now needs additional attention. Also that traditional interventions (eg enforcement) may be less effective in that

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<sup>1</sup> Health and Safety Commission (2000), *Securing Health Together*. HSE Books, Sudbury, Suffolk.

<sup>2</sup> Health and Safety Commission (2000), *Improving Access to Occupational Health Support*. Occupational Health Advisory Committee.

sphere. Of the 40 million days lost to workplace injury and ill-health in 2001/02, 33 million were attributable to ill-health.

*'The new challenges in health and safety are almost all health rather than safety but crucially, the rate of improvement in safety has now slowed <sup>1</sup>.'*

A recent HSE survey showed that only three per cent of UK companies use basic but comprehensive occupational health and safety advice<sup>2</sup>. A European survey has shown that the UK has the lowest level of Occupational Health provision in the developed EU, covering just 34 per cent of workers<sup>3</sup>.

All of this sits within the government's wider strategy for keeping people in work and helping them return to work quickly after injury or illness, as outlined in the White Paper 'Choosing Health' in Chapter 7 – Work and Health, and forming part of the wider agenda 'Health, work and well-being – Caring for our future'. Government priorities reflect the importance given to keeping people in work and helping them return to work after injury or illness in relation to the wider economy of the UK.

### 1.3 Why SMEs?

Small businesses make a vital contribution to the overall health of the UK economy and to improving the productivity of UK business. Recent figures show that small businesses, including those without employees, accounted for over 99 per cent of the UK's 3.8 million businesses at the start of 2002, 56 per cent of employment (12.6 million people) and 52 per cent of total UK turnover (£1,100 billion)<sup>4</sup>. Perhaps the dominant characteristic of small businesses in the UK is the numerical dominance of businesses which have no, or very few, employees. Looking at all UK businesses with a headcount of up to 250 people, 69.5 per cent of them have no employees at all, and 25.3 per cent have fewer than ten<sup>5</sup>. This bias is so marked, that even when the focus is solely on businesses that *do* have employees, fewer than one-fifth of them (17.1 per cent) have ten or more.

The government has set a clear vision in recent years to make the UK an effective place to start and grow a business, and has provided a number of services specifically designed for this purpose, including the Small Business Service and Business Links.

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<sup>1</sup> In *A Strategy for Workplace Health and Safety in Great Britain to 2010 and Beyond*, HSC, February 2004, page 3.

<sup>2</sup> Institute of Occupational Medicine (2002), *Survey of Use of Occupational Health Support*, HSE CCR 445.

<sup>3</sup> Cited in, 'Support Programme Action Group: A vision for health, safety and rehabilitation support in work for Great Britain'.

<sup>4</sup> Small Business Service (2003b) *SME statistics for the UK 2002*. [www.sbs.gov.uk/statistics](http://www.sbs.gov.uk/statistics).

<sup>5</sup> Small Business Service (2004) *Annual Small Business Survey 2003*. <http://www.sbs.gov.uk/content/analytical/annualsbssummary.pdf>.

Recent research shows that the growth amongst small businesses has been marked. According to the latest Barclays survey of business start-ups, more businesses started in 2003 than at any time since its survey began in 1988<sup>1</sup>.

### 1.3.1 Health and safety in SMEs

Whilst evidence on health and safety statistics in SMEs is lacking, there is some research to suggest that the record of health and safety in SMEs is poor compared to that in larger firms, and that the profile of problems and risks differs substantially. For example, an analysis of RIDDOR and LFS data shows that the rate of fatal injury in small manufacturing workplaces is more than double that of those in medium and large enterprises. However the rate of major reported injury tends to be slightly lower in small businesses, and the rate of other non-fatal reportable injuries considerably lower. Some at least of this difference is likely to be the result of better reporting practices in larger enterprises. The same source indicates differences in the causes of injury between small and larger manufacturing workplaces – with those caused by contact with machinery most common in small workplaces<sup>2</sup>.

There is other evidence to suggest that many small businesses find it difficult to maintain compliance with the health and safety regulations that apply to them. In the latest Annual Small Business Survey, just under one in ten of all small businesses pointed to health and safety regulations as an obstacle to business, both in terms of the resources and costs associated with compliance<sup>3</sup>.

There has been increasing attention paid to Health and Safety in SMEs throughout Europe. Europe's 19 million SMEs employ over two-thirds of the European working population. At the same time, evidence suggests that SMEs are more accident prone than larger enterprises, in part because of the inherent dangers in the sectors they serve (eg construction, wholesale, retail, hotels and catering, transport)<sup>4</sup>. There are also indications that there is some tendency to subcontract high-risk tasks out of the larger companies. This coupled with lower capacity within SMEs (eg via internal experts) to protect staff from risk leaves SMEs particularly vulnerable to occupational injury and ill-health.

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<sup>1</sup> *Barclays Survey of Small Businesses: Start-ups and closures quarter 3 2003*. Barclays 2003.

<sup>2</sup> *Levels and Trends in Workplace Injury: Rates of injury within small and large manufacturing workplaces*, HSC 2001.

<sup>3</sup> Small Business Service (2004), *Annual Small Business Survey 2003*. <http://www.sbs.gov.uk/content/analytical/annualsbssummary.pdf>.

<sup>4</sup> European Agency for Safety and Health at Work (2003) *Improving occupational safety and health in SMEs: Examples of effective assistance*.

## 1.4 Existing OHS provision

Historically, the UK has had one of the worst records in Europe for the return of employees to work after long-term illness. In their review of employers' approaches to rehabilitation after long-term absence, James et al. (2000), concluded that few employers appear to provide comprehensive and integrated rehabilitative services or are able to draw on the advice and expertise of occupational health professionals when considering action to assist an employee to return to work<sup>1</sup>. However, the issue has recently risen up the policy agenda (eg the Job Retention and Rehabilitation Pilots recently run by the Department for Work and Pensions and Department of Health).

Other reports have shown how providing direct 'contact methods' of support on health and safety issues to SMEs is not feasible for either the HSE or LA inspectorate given that there are around 3.7 million SMEs but under 3,000 inspectors covering both regulatory regimes<sup>2</sup>. In addition, many organisations do not turn to the HSE and LAs for advice due to a fear of the legal and financial consequences.

The primary care sector in the NHS has been described as the 'default occupational health service', but it is argued that GPs and nurses are ill-equipped to pick up this role, due, for example, to a lack of specific training in occupational health issues or workload issues<sup>3</sup>.

## 1.5 Rehabilitation within OHS

Britain generally has a good record of preventing workplace injuries and illness compared to other EU countries but rehabilitation of those who have been injured or made ill by work is poor. Only 15 per cent of those suffering major injury return to work compared to 50 per cent in Sweden and 30 per cent in the USA<sup>4</sup>; 27,000 people leave the labour market permanently each year as a result of illness or injury<sup>5</sup>.

Occupational health support is not widespread in the UK and is often neglected in favour of short-term absence management. Attention was recently drawn to the fact that disciplinary measures are the most commonly used response to sickness absence,

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<sup>1</sup> James P, Dibben P, Cunningham I (2000), 'Employers and the management of long-term sickness absence', *The Proceedings of Seminar on Job Retention in the Context of Long-term Illness*, DfEE Publications: Nottingham.

<sup>2</sup> *Building an evidence base for Health and Safety Commission Strategy to 21010 and beyond: a literature review of interventions to improve health and safety compliance*, Wright et al. 2004.

<sup>3</sup> For example in the Select Committee on Work and Pensions Fourth Report, Chapter 15.

<sup>4</sup> Association of British Insurers, quoted in Neathey F (below).

<sup>5</sup> Neathey F, 'Rehabilitating employees following absence due to work-related stress: problems and perspectives', *European Academy of Occupational Health Psychology 5<sup>th</sup> Conference*, 2003.

despite the fact that most non-attendance is due to ill-health<sup>1</sup>. More specifically, 83 per cent of employers, according to the CIPD, respond to non-attendance with disciplinary measures, while the CBI report that employers believe that 14 per cent of absence is 'non-genuine'. The CBI also found that long-term absence accounts for just five per cent of cases but 33 per cent of working days lost.

*'Most employers are managing the smallest problem; few are addressing the biggest. The mistake many employers make is to believe that absence can be reduced simply through short term measures<sup>2</sup>.'*

One reason for a narrow interpretation and use of occupational health and safety management is that at a company level the benefits are much more difficult to assess than the costs. Common benefits mentioned as difficult to measure are<sup>3</sup>:

- improved health
- reduced fatalities and injuries
- reduced damages
- reduced production losses
- increased productivity.

These may be particularly difficult to reliably measure within small enterprises due to the small scale of operations (eg average rate of injury within a single SME is not meaningful).

## 1.6 Existing evidence base

The evidence base on the effects of occupational health and safety interventions within organisations is generally sparse. This is particularly the case when studying SMEs. As recently as 1999, Hulshof et al.<sup>4</sup> identified that there were no specific studies of occupational health interventions within small businesses and a 2004 study<sup>5</sup>

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<sup>1</sup> Ballard J, *Occupational Health a Work (editorial)*, June/July 05, in which he quotes *Who cares wins: absence and labour turnover 2005: CBI/AXA* and *Employee absence 2004:a survey of management policy and practice, CIPD*.

<sup>2</sup> Ballard J *ibid*.

<sup>3</sup> *The costs and benefits of occupational safety and health*, European Foundation for the Improvement of Living and Working Conditions, 1998.

<sup>4</sup> Hulshof CTJ, Verbeek JHAM, Van Dijk FJH, et al. (1999), Evaluation research in occupational health services: general principles and a systematic review of empirical studies. *Occupational and Environmental Medicine*, 56 (6): 361-377.

<sup>5</sup> Verbeek J, Husman K, Van Dijk F, Jauhiainen M, Pasternack I & Vainio H (2004), Building an evidence base for occupational health interventions. *Scandinavian Journal of work Environment and Health*, 30 (2): 164-168.

highlighted the need to develop an evidence base for occupational health interventions, stating that systematic reviews are lacking in any of the top priority areas in occupational health.

Several large scale or national evaluations of workplace health initiatives do exist, however, these differ from Workplace Health Connect in that they are blanket socio-behavioural and environmental interventions focusing on specific behaviours such as smoking, healthy food choices etc. (see for example the Australian National Workplace Health project<sup>1</sup> or Creating healthy workplaces in Northern Ireland<sup>2</sup>). Whilst the latter study concludes that brief lifestyle and physical activity programmes are effective at getting employees to change their lifestyles, this body of work is of limited use in understanding how Workplace Health Connect might impact.

The studies that do exist in this area tend to focus on either one aspect of occupational health intervention (eg cardiovascular<sup>3</sup>) or to be specific to an organisation/occupational setting. Thus only a small number of studies provide information of relevance to this intervention. These studies suggest that SMEs (as opposed to larger employers) generally have a low degree of interest and poor employer involvement regarding health and safety at work. They also indicate the need for health professionals to build a relationship of trust with the employer and workers when intervening<sup>4</sup>. Both these findings have implications for the Workplace Health Connect pilot, indicating that engaging SMEs will require strong pro-active strategies and that it could take several initial contacts to build a sufficiently strong basis for any intervention to take place.

Recent research from Australia<sup>5</sup>, evaluated a proactive telephone based intervention to increase workplace adoption of health promotion initiatives. A baseline survey was followed up four years later and found significant increases in seven of the eight health promotion initiatives covered by the telephone intervention. The authors conclude that a telephone based approach can be effective in increasing participation in health promotion activity across a range of health topics and in a large number of employers. These findings indicate that the telephone based element of Workplace Health Connect has the potential to have a considerable impact, although the WHC

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<sup>1</sup> Simpson JM, Oldenburg B, Owen N, et al. (2000), The Australian National Workplace Health project: Design and baseline findings. *Preventive Medicine*, 31 (3): 249-260.

<sup>2</sup> Addley K, McQuillan P & Ruddle M (2001), Creating healthy workplaces in Northern Ireland: evaluation of a lifestyle and physical activity assessment programme. *Occupational Medicine – Oxford* 51 (7): 439-449.

<sup>3</sup> McMahon A, Kelleher CC, Helly G, et al. (2002), Evaluation of a workplace cardiovascular health promotion programme in the Republic of Ireland. *Health Promotion International*, 17 (4): 297-308.

<sup>4</sup> Hulshof et al. (1999), op. cit.

<sup>5</sup> Daly J, Licata M, Gillham K et al. (2005), Increasing the health promotion practices of workplaces in Australia with a proactive telephone-based intervention. *American Journal of Health Promotion*, 19 (3): 163-166.

offer is different from the above study (which involved a number of distinct, blanket health promotion initiatives), and it will be important for this study to understand how able employers feel to take on and implement in practice, advice given over the telephone.

Further research from Canada on models of occupational health intervention in small firms, highlighted several challenges that will apply to Workplace Health Connect. Workers and managers tended to feel that external health professionals did not take sufficient time to gain an appropriate level of knowledge about the workplace before intervening and did not give sufficient support during the implementation. This view was shared amongst most of the participants in the study, regardless of whether the SMEs studied had a strong health and safety culture. The implications for this intervention are that to have credibility, it might be important to invest resource in learning about businesses prior to working with them. For the evaluation, it will be necessary to understand how employers perceive the relevance of interventions to their needs and the types of support they would find efficient and appropriate.

The study also found that SMEs with a strong health and safety culture tended to rate external interventions as less useful than those with a weaker health and safety culture, suggesting that differences in health and safety culture may well be important in determining reactions to the intervention.

Overall, the research evidence, although limited, suggests that a telephone helpline can be a very effective approach across a range of occupational health and safety topics, but consideration needs to be given to employers' ability to implement actions. With regard to the local pilots, there is some evidence that models of delivery of occupational health and safety initiatives need to be adapted to suit SMEs and that the existing health and safety culture within the organisation could be an important determinant of the extent to which SMEs rate interventions as useful. These points have been taken into account in the design of the evaluation.

## 1.7 Existing pilots programmes

The HSE has recently engaged, often in partnership, in a range of activities which have aimed to pilot different approaches to dealing with workplace health. WHC builds on the experiences of these existing pilot initiatives. These include:

- Safe and Health Working, launched in May 2003, which also targets SMEs, but runs only within Scotland. Insights from this programme informed the development of the HSE's Occupational Health, Safety and Return to work (OHSR) support model, which is currently being tested in two settings (see below).
- Constructing Better Health Pilot was launched in October 2004 and aimed its activities specifically at smaller employers within the construction industry, operating in Leicestershire. It offered a range of services including risk assessments, training on health issues and health checks offered on-site using a

mobile unit. It ceased to operate in its current form during June 2006, but industry commitment has secured funding for a future scoping phase until January 2007.

- The Better Health at Work Initiative offers free health and safety advice to businesses throughout the Kirklees District. It involves a partnership with Kirklees Metropolitan Council, three local primary care trusts and JobCentre Plus. Notably the pilot services are aimed not only at employers and employees but also individuals on incapacity benefit.

These latter two programmes are testing different aspects of the OHSR support model, and have informed the development of the model. However, neither of these two small scale pilots will provide sufficient empirical evidence to support a major investment in a nationwide support service. Workplace Health Connect is the biggest pilot to date of the OHSR support model, and the evaluation of this initiative has been designed to collect and analyse data which will provide information to support the development of further work in this area.

## 1.8 Evaluation framework

There are three main elements to the evaluation:

3. A development phase to agree the precise scope and methods to be used in the evaluation, involving consultation with a range of stakeholders.
4. A process evaluation to investigate service delivery (including costs) and penetration.
5. An evaluation of the impact of the initiative in terms of intermediate and final outcomes as well as an estimate of the overall costs and benefits of WHC.

To support these elements, there are five main data collection mechanisms:

- The management and monitoring data (the Case Management System or CMS) completed by pilot staff provide data on inputs and pilot activities which can be linked to other elements of employer-based data collection.
- Service level case studies involving interviews with key project staff at regular intervals to allow the evaluation to consider regional experiences and understand the issues involved in service delivery in more depth.
- Baseline and follow-up surveys of employers using the service (at both Level 1 and 2) and similar control surveys of non-users will help to estimate any impacts (intermediate and potentially longer term) at employer level, as well as provide a systematic understanding of employer perceptions of the service.
- Field studies involving employers, their workforces and other local stakeholders (eg occupational health practitioners), at both baseline and follow up, to investigate

why and how employers became involved in the pilot and the impacts, to them and more widely, of taking part.

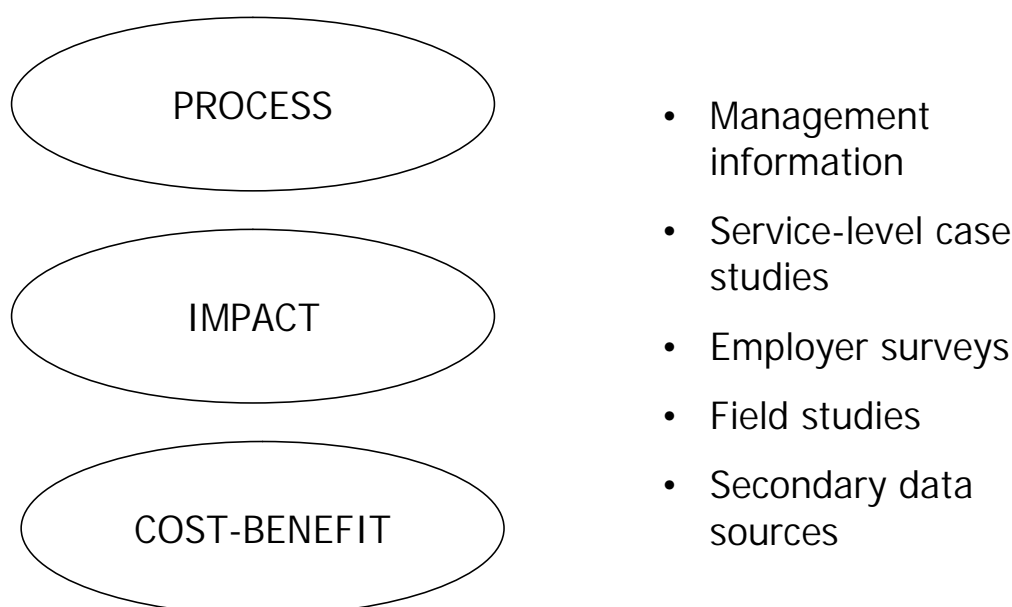
- Analysis of secondary source data will provide supplementary evaluative evidence and contextual references.

This is summarised in Figure 1.1.

The development phase is now complete and has resulted in a finalised survey instrument for use in the employer survey, as well as a provisional plan for the qualitative work to support the survey. Contacts have been established with service providers and ongoing consultation with the evaluation sub-group at HSE have meant that the overall evaluation plan is keeping pace with changes to the plans for roll-out and the evolution of the WHC service.

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Figure 1.1: Evaluation structure



*Source: IES outline of evaluation*

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## 1.9 Evaluation work undertaken to date

In constructing this report, and reflecting on the progress of the WHC initiative to date, a number of data sources have been used from within the overall evaluation framework. The report draws on the experiences of those running the service, uses the extensive data that has been collected by pathfinders and the adviceline, and provides some very early views from a limited number of service users. Further details of how this data was collected are provided below.

### 1.9.1 Interviews with service providers

WHC has a fairly complex structure, with a range of organisations taking forward the different elements of service delivery and supporting functions, and providing coverage to different areas of England and Wales. There are a number of key staff within the HSE (or working as consultants within it) who have a unique overview of how the service is functioning as a whole. As part of the preparation for this report, a number of these staff (five in total) were interviewed. The roles of those involved were:

- marketing (in providing strategic direction to the campaign)
- contract management (with the adviceline and pathfinders respectively), and
- quality (in designing and measuring performance against quality standards).

The plan for the remainder of the evaluation is to keep in touch with those responsible for these aspects of the service as it continues to develop.

In addition, each of the five pathfinder areas has been visited, or spoken to, by a member of the evaluation team twice during the first six months of operation. Initial visits were conducted in February/March to discuss their experiences of starting up the service and working under the umbrella of WHC. The second visit in June/July allowed representatives of pathfinders to reflect more on their experiences of service delivery and some of the challenges involved in marketing the service. In addition, contact has been established and maintained with the providers of the adviceline in a similar way to ensure that any issues in operating that service can be identified.

Contact with the adviceline and pathfinder providers will be maintained throughout the course of the evaluation.

### 1.9.2 Analysis of management and monitoring information

An important part of service provision for the pathfinders and the adviceline has been collecting information to help inform the evaluation and our understanding of who is using the service and for what reasons. A bespoke database (called the Case Management System or CMS) was designed to collect this information and the evaluation team have been given full access to this database. This is a major source of early information on users and the issues dealt with by advisers from the pathfinders and adviceline. The data included in this report represents four full months of service operation up to 20th June 2006.

This data will continue to be analysed throughout the course of the evaluation at six monthly intervals.

### 1.9.3 Employer interviews

Using data from the survey pilot (see section 1.9.4 for further details on the progress of this survey), ten employers were identified who had given their consent to be contacted by the evaluation team. Of these, eight agreed to be visited and interviewed face-to-face. The participating organisations varied in size from 11 to 100 employees, and were from a wide range of sectors (eg financial, media, education, manufacturing and horticultural sectors). A fuller description of the organisations involved in these interviews is given in Appendix A. Given the small number of employers involved at this stage, the views contained in this report cannot claim to represent those of service users as a whole in any systematic manner. However, they do provide some insights into the motivations of a small number of employers for contacting the service and some reflections on the experience and benefits for them of getting involved.

Future evaluation activities will include more in-depth case studies with a larger number of employers to investigate both their experiences of using the service in more detail, but also the impact that service use has had on their companies and employees. The next evaluation report will therefore include a more comprehensive study of user views.

### 1.9.4 Employer Survey

One of the major elements of the evaluation will be a survey of employers using WHC services. All Level 2 users, and a sample of Level 1 users, who have agreed for their details to be passed onto the evaluation team, will be contacted by BMRB<sup>1</sup> and asked to participate in a telephone survey. In addition, a matched control group of non-users will be surveyed. These same contacts will be followed up one year following their first interview to monitor any changes to their attitudes towards and management of workplace health issues over time. A survey instrument has been developed and piloted, and interviews with employers begun in the week commencing 24 July 2006.

No data from the surveys is available for inclusion in this first evaluation report, therefore, the first analysis of data from this source will be undertaken as part of the second evaluation report, due for delivery in January 2007.

## 1.10 Remainder of this report

The remainder of this report considers in more detail the progress of the pathfinders to date, and is structured as follows:

- Chapter 2 outlines details of the WHC service, including an examination of how the management structure and outreach work differ between regions, and focusing

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<sup>1</sup> The British Market Research Bureau are research partners in the evaluation alongside IES.

on the experiences of the pathfinders in setting up and running services in the early months of service provision.

- Chapter 3 provides an examination of the approaches to marketing used so far and some reflections on the relative success of these.
- Chapter 4 profiles WHC users to June 2006.
- Chapter 5 is a discussion of the issues raised by users of the adviceline and the content of pathfinder visits.
- Chapter 6 considers user satisfaction with the service so far and any early outcomes or impact.
- Chapter 7 examines quality issues around the adviceline and visits.
- Chapter 8 presents the early conclusions that can be drawn from this data.

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## 2 Details of the WHC Offer

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WHC is a combination of a national service, namely the adviceline, and enhanced regional services for eligible employers. Each region is working to clearly defined quality and service standards which bring some continuity to the service received by employers. However, each of the pathfinder areas offers something different. In this chapter, further details are provided on the national framework for service delivery, regional variations are discussed, and other organisational and resource issues considered.

### 2.1 What is WHC?

As discussed in Chapter 1, the design of WHC has been shaped by key elements of HSC's 'Strategy... to 2010 and beyond', namely the need to:

- develop innovative ways of working
- work with and through others
- provide accessible advice and support
- focus on small businesses.

It is a holistic approach aimed at providing both employers and workers the support they need. It aims to help with current ill-health in the workplace, as well as preventing incidence of illness and injury and securing an early return to work if/when they occur.

#### 2.1.1 Service framework

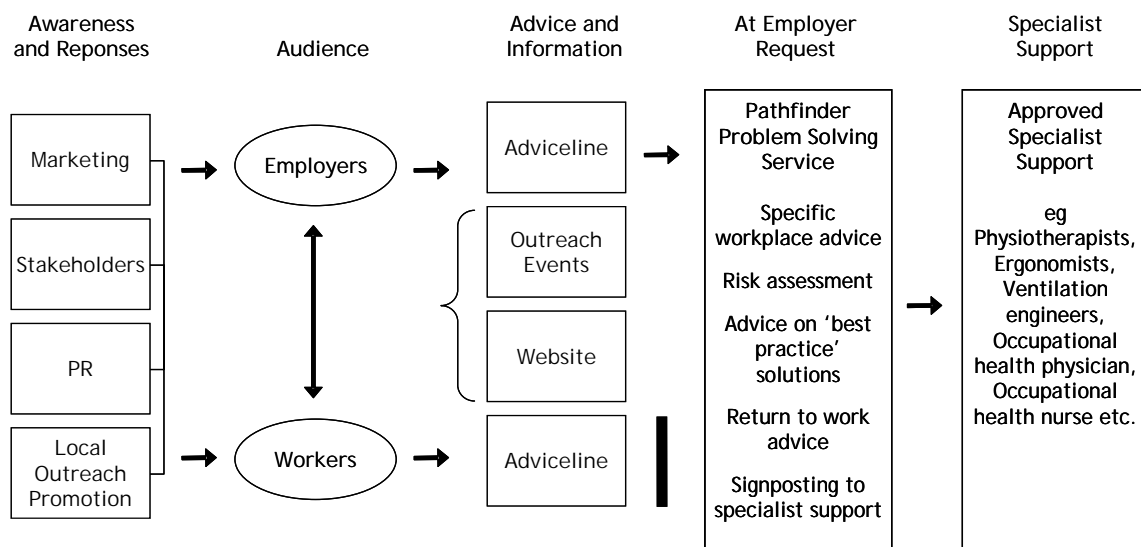
The WHC service exists at three levels:

- Level 1 consists of an adviceline which gives free, detailed and tailored practical advice to callers – both employers and workers – on workplace health, safety and return to work issues. This is supported by a dedicated website.

- Level 2 offers a problem solving service available in five regions, operated by contractors (often formed from regional partnerships) known as pathfinders, who carry out free visits to advise on workplace health issues. This service has strong links with the adviceline, which acts as a referral service for these visits.
- Level 3 consists of signposting by the adviceline and pathfinders for employers/workers directed (where appropriate) to local approved specialists who could help the organisation solve any long-term/more complicated problems. These support specialists could include physiotherapists, ergonomists, engineers, OH professionals, hygienists and occupational health nurses etc. WHC also represents a body of knowledge about existing and complementary OHSR services.

The overriding aim throughout all the stages of the process is to **transfer knowledge to small businesses and provide them with the skills to tackle and solve any existing and future workplace health problems.** Figure 2.1 presents a diagrammatic representation of the service.

Figure 2.1: Workplace Health Connect in Action



Source: WHC website ([www.workplacehealthconnect.co.uk](http://www.workplacehealthconnect.co.uk))

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### 2.1.2 Service Goals

There are a number of goals and targets which have been set for WHC. The service will seek to:

- Establish a service with the potential to significantly increase the level of healthy workplaces within small and medium sized businesses across England and Wales.

- Provide workplace health support for employers and workers who do not currently benefit from such support.
- Deliver, at a minimum, the basic principles of the problem solving service, so that employers can resolve current and future issues themselves.
- Change employer and worker behaviours so that, ultimately, preventative measures are put in place to avoid unnecessary workplace health issues.
- Provide small and medium sized businesses with the knowledge and skills to resolve workplace health, safety and return to work challenges.
- Improve small and medium sized businesses understanding of workplace health issues.
- Develop innovative partnerships that deliver a consistent service to all customers.
- Improve small and medium sized businesses understanding of the benefits of sickness absence and return to work procedures.

It will also be expected to:

- Handle approximately 60,000 calls to the dedicated adviceline.
- Make approximately 4,750 free, initial site visits (based on an average company size of 20 workers).
- Have a positive impact on 95,000 workers.

## 2.2 Level 1: the adviceline

The adviceline is managed by **National Britannia** who have experience of running the HSE infoline. The objectives of the adviceline are to:

- Be the main access point for WHC clients, providing good customer service and useful, relevant information.
- Give OHSR support to callers by probing the caller to identify potential problems and solutions wherever possible.
- Promote the benefits of level 2 support to relevant callers, encouraging them to take up the offer of a visit.
- To record initial data on callers for evaluation and management information purposes.
- Develop and maintain a website which should act as a signpost to the adviceline and provide basic OHSR information.

The service operates with a dedicated team of advisers from a range of backgrounds, for example some advisers have already worked in similar roles on the HSE infoline, whilst others have a background in occupational health. The number of advisers available can be boosted in times of peak demand from within National Britannia and will therefore vary according to call volumes.

## 2.3 Level 2: regional arrangements

Whilst each of the regional pathfinders are committed to delivering a service which meets the national quality standards and which fits into the structures associated with a service which has a national identity and framework, there is some variation in the way that each pathfinder is organised.

### 2.3.1 West Midlands

The West Midlands pathfinder is being run by **Human Focus**, which has a background in rehabilitation services and health and safety training. Human Focus is providing a full-time project manager to oversee the day to day management of the service and has recruited a full-time administrator to work with referrals and complete the monitoring and evaluation data (ie the CMS). The company also provides input from company directors, specifically in the marketing of the programme and training of advisers.

Human Focus has contracted six self-employed health and safety consultants to work as advisers and conduct the visits on an 'as and when needed' basis. The advisers all work on other projects as well as WHC. The six advisers have changed over time, as the pathfinder has consciously strived for the best skill profile amongst its advisers.

### 2.3.2 London

The London pathfinder is known as the **Working Well Together Partnership**. It comprises a partnership of four organisations, each of which has its own distinct role in the pathfinder:

- **Working Links** holds the contract with HSE and has subcontracted the other organisations. It is overseeing the pathfinder and providing three full-time staff – one project manager and two administrators. The project manager is involved in the day-to-day management of the pathfinder, and was recruited specifically for this task. The administrators were also recruited specifically and are responsible for taking referrals, arranging visits and inputting to CMS. They are also becoming more heavily involved in outreach activities alongside Tomorrow's People.
- **Systems Concepts** is a health and safety consultancy and is conducting the visits. It is providing six of its employed advisers to work full time on the project, one of

whom is also managing the Systems Concepts input. Systems Concepts gets paid a flat fee per visit, but the advisers make themselves available to the work full-time.

- **Kynixa** is a rehabilitation services organisation. Members of staff from here provide advice on rehabilitation and return to work issues to Systems Concepts advisers as and when required. They are contracted to do 20 hours of work per month.
- **Tomorrow's People** is a charitable trust which helps long-term unemployed people back into work. It has recruited two new members of staff with sales backgrounds to work full-time on the outreach and marketing for the pathfinder. These are being overseen by a part-time manager.

### 2.3.3 North West

The North West pathfinder is run by **Enworks**, the business support arm of Groundworks, an organisation involved in a number of regeneration and education projects, including a health and safety business support programme. The company has regional offices across the North West, with health and safety experts employed at each.

The WHC programme largely fits into the existing organisational framework, and is similar to other projects already being conducted by Enworks. The central holding for WHC is the Manchester office, where the pathfinder is being supported by a full-time project manager and a full-time administrator. Referrals come through the central Manchester office and are allocated to advisors in the five areas (Merseyside, Cheshire, Lancashire, Greater Manchester – all run by Groundworks – and one run by the Cumbria Regional Enterprise Agency, CREA). This provides around 20 advisers in total. All the advisors are working on other projects beside WHC and will be brought in to do visits as and when required. A number of other partners are also involved.

### 2.3.4 South Wales

The South Wales pathfinder is being run by **Holistic Services**, an organisational change, HR and health and safety consultancy. They are providing a full-time project manager, a full-time administrator and input from a project director. They have recruited six advisers to work a mixture of full- and part-time on the project. All advisers have a background in health and safety consultancy, one is an occupational health nurse, and all have experience of working with or for employers. Some of those working part-time also run their own businesses alongside their WHC duties, but they have designated specific days each week when they work for Holistic.

### 2.3.5 North East

The North East pathfinder involves a consortium of three organisations. **Accord** are providing the official project management but the core team comes from the **Health and Safety Academy** and consists of one full-time service manager and two advisers at present, both of whom are working on a contractual basis. NHS Plus is involved and will in time provide two occupational health nurses to also work as contracted advisers. Accord are also providing services in terms of recruitment and facilities management. There are now five advisers in the WHC team, three of whom have specific occupational health experience and two are from a more traditional health and safety background.

### 2.3.6 Commonalities and differences

The above pen pictures illustrate how varied the five pathfinders are in terms of the way they are organised. The core variables by which they differ include the following:

- **use of partnerships** – from complex (eg North West) to simple organisational structures (eg South Wales, West Midlands)
- **contractual arrangements for advisers** – some employing advisers full-time (eg London) , others part-time (eg North West), others contracting in as and when required (eg West Midlands)
- **recruitment/ use of existing personnel** – some using existing personnel (eg North West) others recruiting specifically for some of the tasks (all others)
- **strength of WHC identity** – tying in with other similar projects (eg North West), or separate unique area of business (all others)
- **marketing strategies** – reactive (eg North East) or proactive (eg London)
- **marketing activities** – range of approaches including cold calling, face-to-face visits, events and mailouts.

Throughout the evaluation, the extent to which these differences affect the service provided to employers, if at all, will be explored.

## 2.4 Adviser recruitment and training

In considering who to recruit and how best to equip them with the skills to be a successful WHC adviser, the adviceline and pathfinders raised a number of issues.

### 2.4.1 Recruitment

The WHC service seems to be attractive to potential recruits, and there have generally been sufficient applicants to fill posts. However, finding people with the right skill

mix has not always been easy and in some areas advisers have already been replaced as they weren't able to deliver to the standards expected by their regional service manager. A number of pathfinders highlighted the importance of 'soft skills', ie people who can successfully represent the service and communicate effectively with employers.

*'Frankly, when you get into these businesses, the health and safety stuff is not that complicated. The hardest thing is getting them to do it and think, oh, this is actually something worth doing... You can get health and safety consultants two-a-penny that know all that technical stuff. How many of them have got the soft skills?'*

(Service manager)

There also appears to be some conflict with the need for advisers to be qualified to DipOSH standard and also have relevant experience (eg in one case an experienced adviser failed their DipOSH despite 30 years of experience of working in the area, whilst another in the same area had the required qualification but was felt to have too little practical experience). This issue also applies to advisers whose background has been in occupational health, who may have qualifications at an equivalent level, but not specifically with any safety content. Within the adviceline there has been a similar conflict between those with experience of working within occupational health and individuals with prior experience of operating as a telephone adviser (eg through their work on the HSE info-line).

#### 2.4.2 Training

All advisers are offered some training specific to WHC. For those who were on board at the very start, a four-day specifically tailored course was offered. Other advisers joining later will also be offered the opportunity to undertake this training, but will have to wait until there are sufficient advisers waiting for the training to make delivery cost effective. It is also possible that a course of reduced length (two days instead of four) will be offered to new advisers who have already started making visits to reflect their on the job experience.

In addition, a distance learning pack, based on the four day training programme, has been developed for advisers. This pack has been working well within some pathfinders, with advisors setting aside time to go through it alongside their other administrative duties when they are not visiting employers. Where advisers are working freelance, however, and are paid per visit, the suitability of this pack as the main method of training has been questioned, as they have little paid 'downtime' in which to study.

In addition to these central training options, however, a number of other techniques have been employed by the pathfinders. These include:

- shadowing of more experienced colleagues in the first few weeks of joining during visits to employers
- on-the-job support and feedback
- external training events on specific topics (eg employment law).

Another issue has been training in personal safety for Level 2 advisers. One pathfinder stated that their advisers are required to go to some very deprived city centre areas to conduct their visits and this has raised concerns. They dealt with this by suggesting that none carry laptops, and advising staff to tailor their style of dress to the type of business they are visiting. This pathfinder, and one other also sent advisers on externally run personal safety courses.

## 2.5 Regional Stakeholder Forums

Each of the pathfinders have been encouraged to set up and maintain stakeholder forums within each region. The purpose of these is to help stimulate demand for WHC regionally by influencing key decision makers and stakeholders in each area and using them to generate ideas for enhancing and promoting the service. Members of these councils differ by region, but nationally include representatives of:

- Chambers of Commerce
- trade unions and the Trade Union Congress (TUC)
- the Federation of Small Businesses
- local HSE inspectorates
- insurance companies
- health authorities
- the Chartered Institute of Personnel Development (CIPD).

In most areas, the role of the stakeholder councils have been somewhat limited. Whilst members of the councils are reported as almost universally positive about the service, translating this into direct action may take longer than the elapsed four months. However, there are some examples of very useful inputs from councils. Members have attended events held by the pathfinders, and some have secured links on the websites of member organisations. In one area, the pathfinder has secured an agreement with the insurance companies that they will provide a discount to employers who are able to successfully set up adequate health and safety systems, and have set up a self-certification programme for clients of the service to use. In some regions, the council has been involved in devolving marketing to regions.

In some areas the councils have already met a number of times (eg West Midlands have had three stakeholder meetings), whereas other areas have only biannual

meetings scheduled. Initially the councils were useful to explore and generate ideas. At least one pathfinder is reviewing the role of the council to ensure that it maximise the input from active members.

## 2.6 Chapter Summary

Workplace Health Connect is a combination of a national adviceline and enhanced regional services. It is a holistic approach aimed at providing both employers and workers with the support they need to tackle current ill-health in the workplace and prevent future ill health and injury. The focus of service provision is on employers with fewer than 250 employees and without existing access to occupational health support. It consists of:

- Level 1 services consist of an adviceline providing free and confidential advice on workplace health, safety and return to work issues as well as acting as a referral point for Level 2 services.
- Level 2 provision is a problem solving services in five regions, operated by contractors (often formed from regional partnerships) known as pathfinders. The pathfinders carry out free visits.
- Level 3 signposting services to local approved specialists.

The overriding aim of the service is to **transfer knowledge to small businesses and provide them with the skills to tackle and solve any existing and future workplace health problems.**

Each regional pathfinder also operates a regional stakeholder forums which are in place to help stimulate demand for WHC regionally by influencing key decision makers and stakeholders in each area.

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## 3 Marketing and Service Take-up

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One of the major challenges for WHC has been, and will continue to be, engaging with small and medium sized businesses. There are a number of ways in which the design and evolution of the initiative has addressed this. In this chapter the approaches to marketing the service are detailed, including work by both central marketing and by the pathfinders, as well as some analysis of rates of how employers head about the service using WHC monitoring data.

### 3.1 Central marketing

Recognising the importance of reaching potential users, the HSE employed a marketing consultant to help them develop a marketing strategy for the service. This strategy involved developing a brand and the marketing of it, and the identification of appropriate agencies to work with to launch and promote the brand and take forward the different marketing elements. The Central Office for Information (COI) became involved as a way of making connections with the relevant suppliers, as the office already has existing contracts with a range of suppliers and a track record of working successfully with them. The COI also then managed these supplier contracts, using specialists who focus on public relations (PR), branding etc. Effectively the marketing has been designed and delivered by a virtual team including HSE, COI, a PR Agency, a Branding Agency and a Direct Marketing Agency.

#### 3.1.1 Branding

Establishing a strong brand for the WHC service was a priority. In doing this, one option could have been to capitalise on the knowledge of HSE in the business community, although even this was felt to have greater resonance within some sectors of the potential market for WHC than others (eg greater profile in manufacturing than in financial services). However, smaller businesses are often fearful of the HSE due to concerns over the consequences of inspections. Whilst the organisation is seen as credible and worthwhile, the idea of inviting representatives of the HSE into their business could have acted as a deterrent to participation. It was, therefore, important

to balance the relative benefits of the HSE brand with the potential disadvantages in relation to working with SMEs. Therefore, the decision was taken to distance WHC from the HSE to some degree, with WHC identified as working in partnership with the HSE, but to use the HSE as leverage within the marketing. For example, rather than use the HSE logo or name in advertising, the official HSE stamp was used on the envelopes of direct mailings to encourage people to look inside. The HSE employed the service of a leading branding agency to help define and work out how to deploy the WHC brand.

*'The research is not definitive one way or the other, but we took the view that it was better to be careful than just assume that the HSE would work for us'*

(WHC central team member)

### 3.1.2 Public relations

The public relations stream was designed to ensure that messages emerging in the press and through word of mouth were managed so that the service was positioned correctly. PR was also a very important mechanism by which it was hoped calls to the advice line would be delivered. Therefore, PR was used to ensure that the WHC telephone number appeared in all articles, and that the website was referenced wherever possible. The PR was also integrated with the other marketing activities.

*'Its trying to get the noise out there, and...try to support the brand, we're trying to let people know about Workplace Health Connect which is this new brand in the marketplace'*

(WHC central team member)

Gaining coverage for the launch of WHC proved more difficult than anticipated. There was a national event involving Lord Hunt, although the focus was more on other regional events operated by the pathfinders. The difficulty was partly due to the fact that it is difficult to launch a regional service nationally, but also because the media failed to pick up the story, perhaps because it was seen as a fairly small initiative in national terms. All pathfinder regions, with the exception of the North East, ran their own launch event. The PR team are now operating to a set of clearly defined targets which focus on a range of activities, mainly placing articles in a number of key publications, including business press, trade press and other printed media.

### 3.1.3 Use of direct mail and other advertising

Given the budget set aside for marketing, the decision was taken fairly early on to use direct mail combined with some press and radio advertising, as this was felt to be the most cost effective method of direct contact with potential users. The direct marketing is the most expensive element of the overall marketing campaign. Press advertising

and radio advertising are far more expensive than direct mail, so these techniques were used for limited periods only to support the mailings.

The direct mailings used so far have yielded lower returns than anticipated, despite a strong positive response from individuals used in research for the brand and the mailings. The mailing consisted of an envelope, letter and brochure describing the service in some detail. The initial mail was phased, and after it had been sent out to around 80,000 potential users the response rate was calculated at around one per cent, (ie around one per cent of those receiving the mailing went on to call the adviceline), just half of what had been predicted. However, on a positive note, the anticipated conversion rate into people going on to take-up visits was actually double what had been predicted, at 40 per cent. However, in order to drive up the response rate, changes were made to the mailing pack and a telemarketing follow-up introduced (see section 3.1.4 for further details).

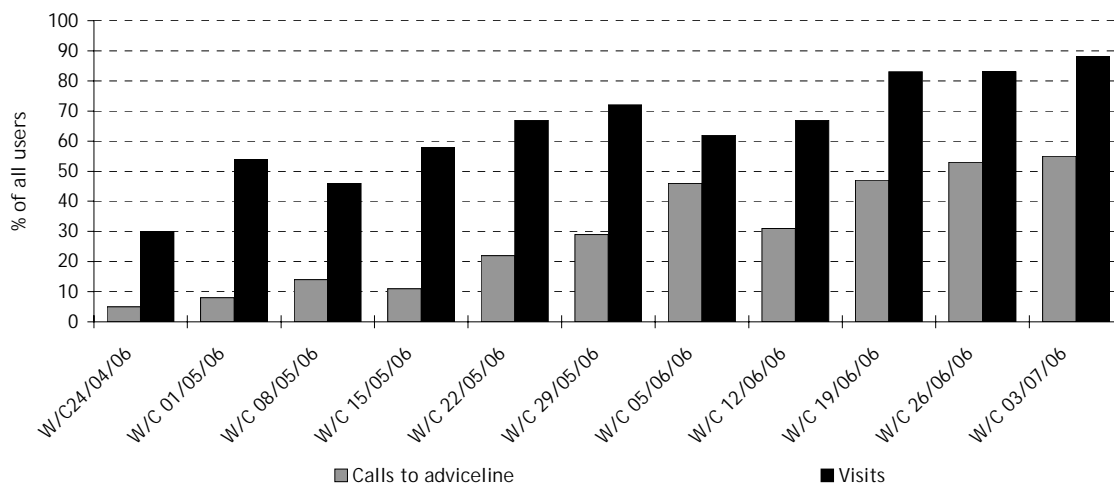
The outer envelope for the mailing was given greater impact, the letter was made much shorter and had a more aggressive sales tone. As a result the response rate has improved, however, this also coincided with the start of outreach activity by the pilots and the use of telemarketing, so it is difficult to isolate the impact that the redesigned direct mailings have had. The outcome of all these activities has been that the pathfinders are beginning to make the number of visits required to hit their targets, however, the number of calls to the adviceline still remain lower than original predictions.

### 3.1.4 Telemarketing

Given the difficulties in stimulating demand for the adviceline using direct mail and PR activities, the decision was taken to implement telemarketing approaches to companies who had already been targeted by the direct mail. It was considered important that the branding exercise and some awareness raising had already been undertaken, prior to commencing the telemarketing. *'It's very difficult for telemarketing to work in a vacuum'* (WHC central marketing contact). The telemarketing campaign began in late April 2006. It is clear that this has had a positive impact on the take up of both Level 1 and Level 2 services (Figure 3.1). By June 2006, companies who had been approached by telemarketing consistently make up over 80 per cent of all employers taking up Level 2 visits, and around half of all calls to the adviceline.

Despite the success of telemarketing in generating employer interest in WHC, once employers reach Level 2 provision through this route, there are a number of issues that need to be considered which differ from those raised when employers approach WHC directly. For example when starting visits, instead of advisers asking why employers have contacted WHC, it is useful for them to know that actually telemarketers have contacted the employer directly and encourage them to take part.

Figure 3.1: Proportion of calls to adviceline and Level 2 visits generated by telemarketing



Source: Telemarketing report to HSE

Another issue is that 'quality' of referrals from the telemarketing (ie the actual interest levels of callers in the level 2 service) has been quite variable resulting in at least one area in higher rates of cancelled appointments when employers come through telemarketers. The HSE has been working closely with the telemarketing company to ensure that the approaches they make to employers are consistent with the message of WHC, and do not unduly coerce employers into going forward to Level 2. There have also been some issues in balancing out the way in which telemarketers make approaches across areas to avoid wild fluctuations in referral numbers to each pathfinder.

### 3.2 Marketing messages

One final issue to note about the approach taken in marketing WHC has been a shift in emphasis. The original concept pushed very hard on health, because that was the identity and the factor that differentiates the service provision on offer. Feedback from advisers and service managers within the pathfinders was that small and medium sized enterprises are more concerned with fulfilling their legal obligations regarding safety than they are with their health. Safety concerns, therefore, act as a powerful trigger for individuals to contact WHC, more so than health messages. In response, and following consultation with the pathfinders, the decision was taken to change the focus of the marketing campaign to balance safety with health. It is interesting to note that in Chapter 5 the main topics raised by employers who have contacted the adviceline are generic health and safety issues. Very few report approaching WHC in order to deal with a specific health issue.

Another key message adopted in recent marketing is that there is government funding attached to the service and that there will be no charges. Additionally, future marketing will begin to promote the adviceline nationally, something that has not

been done before. It will, therefore, be interesting to consider the impact of this strategy on future call levels to the adviceline and direct approaches to pathfinders.

### 3.3 Outreach work by the pathfinders

Central marketing has always been a key aspect of the design of the WHC service, and has been tasked with generating sufficient interest amongst employers to deliver a high proportion of the visit and call numbers required for the pathfinders and adviceline to meet their targets. However, pathfinders have also developed outreach strategies which would help to generate interest within their own areas. The extent to which local outreach has actually been pursued or has been necessary within each region, however, reflects both the overall approach of pathfinders, but also the extent to which central marketing has been generating sufficient referrals in their area (for example in Wales outreach activities have been largely put on hold as their advisers are at capacity following the onset of telemarketing).

Reactions to the central marketing campaign have been mixed but some regions have expressed concerns that without some central campaign they will find it difficult to generate their own leads. Other areas, however, are confident that they could fulfil their targets solely by their own efforts.

*'I find that the contrast with the initial reluctance of people to take up the service and the absolute gratitude expressed after they've had a visit and a report is really quite remarkable'*

(Service Manager)

The approaches planned and/or used in the different pathfinder regions include:

- Approaches to specific sectors (eg the West Midlands have made approaches to childcare providers using a letter which specifically outlines some of the key issues facing the sector, followed by a telephone approach).
- Attending employer events and networking (eg attending meetings with groups such as the Chamber of Commerce such as in London).
- Developing their own press releases and marketing information specific to the region (eg regional case studies to be used in the North West).
- Working closely with intermediaries (eg Business Links in the North East and training providers in South Wales).

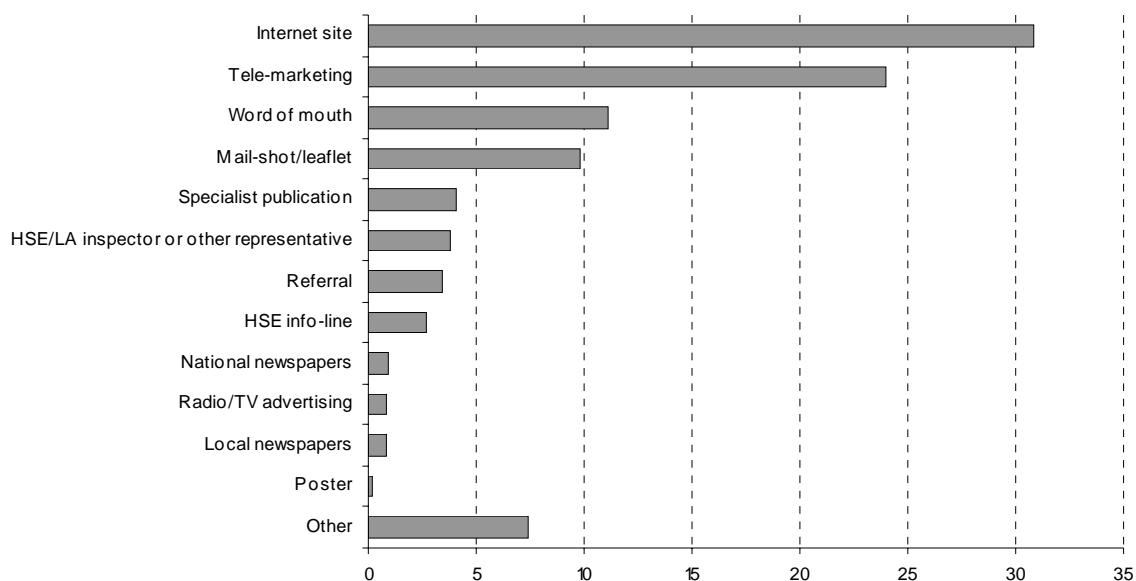
The extent to which these outreach strategies need to be developed or followed through will depend on decisions taken about, and the success of central marketing, as well as any regional differences in take up.

### 3.4 How users heard about WHC

The management and monitoring information held by the pathfinders and the adviceline provide a useful indication of how users have found out about the service. All callers to the adviceline are asked to state how they heard about the services offered by WHC (Figure 3.2).

More callers had found out about WHC through the use of an internet site (31 per cent) than via any other type of marketing, and supplementary information would suggest that this was mainly use of the general HSE website<sup>1</sup>. The second most common source of calls was through telemarketing (24 per cent), although this marketing activity only started at the end of April 2006, suggesting that this figure will rise over time, and that this may well overtake the internet as the most common route into service take-up. Word-of-mouth and direct mailings were also relatively effective marketing techniques, leading to 11 per cent and ten per cent of calls respectively.

Figure 3.2: How customers heard of the service



N = 1,750, Missing = 155

Source: WHC Case Management System (to June 2006)

The data also allows further analysis of the impact of marketing by both workplace size and industry type (using the Standard Industrial Classification (or SIC) code).

<sup>1</sup> When references to WHC were removed from the HSE website, calls to the adviceline fell.

### 3.4.1 Size differences

There were a number of differences according to the size of the employer, most notably the degree to which they had been prompted to call through their contact with central marketing (Table 3.1). The main differences were that:

- Small employers (ie 5 to 49 employees) were most likely to have heard about the service through telemarketing (31 per cent, compared to 16 per cent of medium sized employers).
- Small employers were also most likely to have heard about the service through WHC direct mailings (12 per cent compared to eight per cent of medium sized employers).
- Small businesses were also most likely to have heard about WHC through word of mouth (14 per cent compared to nine per cent of callers from medium sized workplaces).
- Fifty one per cent of large employers, compared to just 22 per cent of small and 40 per cent of medium sized employers had heard about WHC via the internet.
- Micro businesses (ie those with fewer than five employees) tended to have heard about WHC through the internet (33 per cent) or word of mouth (13 per cent), although a number claimed to have been directly targeted by telemarketers (14 per cent) or by direct mail (eight per cent).

### 3.4.2 Sectoral differences

At this early stage in service delivery, however, only ten out of the 17 industry classifications have sufficient callers for analysis, although more robust data should become available over time. Industries from which there have been 50 or more callers to the adviceline are presented in Table 3.2.

There do appear to be some difference in how employers have heard about WHC, although these may be due to differences in the way that marketing approaches were made to different employer sectors, and further investigation could be conducted to investigate this.

Given this consideration, the most notable differences were as follows:

- Telemarketing appears to have been particularly successful in reaching employers from the hotel and restaurant trades, 62 per cent of callers from this sector had heard about WHC from this source.
- Direct mail was most successful in reaching callers from community, social and personal service activities, and 22 per cent had heard about the service through this means.

Table 3.1: How individuals had heard about WHC, by the size of their workplace (per cent)

	Local newspapers	National newspapers	Specialist publication	Internet site	Referral	HSE info-line	HSE/LA Inspector or	Word of mouth	Tele-marketing	Radio/TV advertising	Mail-shot/leaflet	Poster	Other	Total (N)
Micro (less than 5)	-	0.6	3.8	33.3	4.4	2.5	6.9	13.2	13.8	1.9	8.2	-	11.3	159
Small (5 to 49)	0.2	0.5	3.4	21.8	4.0	1.6	3.3	13.5	31.0	0.6	12.4	0.3	7.4	959
Medium (50 to 250)	1.9	-	5.9	39.8	2.6	6.7	3.3	9.3	16.0	0.4	7.8	-	6.3	269
Large (more than 250)	2.0	2.0	8.9	50.5	3.0	5.0	6.9	6.9	5.0	1.0	1.0	-	7.9	101
All employers	0.6	0.5	4.3	28.2	3.7	2.8	4.0	12.2	24.7	0.7	10.3	0.2	7.7	1488

Note: Data is missing for 417 callers

Source: WHC Case Management System (to June 2006)

Table 3.2: How individuals had heard about WHC, by the industrial sector of their employer (per cent)

	Local newspapers	National newspapers	Specialist publication	Internet site	Referral	HSE info-line	HSE/LA Inspector or other rep	Word of mouth	Tele-marketing	Radio/TV advertising	Mail-shot/leaflet	Poster	Other	Total (N)
Manufacturing	0.7	-	4.4	28.8	3.3	4.4	6.3	10.7	27.7	-	6.6	0.7	6.3	271
Construction	-	-	5.4	31.8	3.4	1.4	5.4	15.5	21.6	-	8.8	-	6.8	148
Wholesale/retail trade/motor vehicles repair/personal/household goods	1.2	0.4	3.7	23.1	2.1	0.8	4.5	9.1	37.6	0.8	9.9	-	6.6	242
Hotels and restaurants	-	0.8	0.8	9.0	0.8	-	3.3	8.2	62.3	-	9.0	-	5.7	122
Transport, storage and communications	1.1	5.3	1.1	32.6	5.3	4.2	3.2	17.9	16.8	2.1	4.2	1.1	5.3	95
Real estate, renting and business activities	0.7	-	5.2	40.2	4.4	5.5	1.1	10.3	17.7	0.7	10.0	-	4.1	271
Public administration and defence; compulsory social security	-	-	5.6	43.1	2.8	1.4	5.6	16.7	12.5	-	8.3	-	4.2	72
Education	-	1.2	3.6	37.3	2.4	3.6	2.4	8.4	3.6	1.2	2.4	-	33.7	83
Health and social work	3.6	0.9	4.5	40.5	3.6	4.5	-	9.0	9.9	3.6	6.3	-	13.5	111
Other community, social and personal service activities	0.4	2.9	3.3	25.4	5.7	0.4	3.7	12.7	17.6	1.2	22.1	-	4.5	244
Other	1.1	1.1	7.7	42.9	1.1	2.2	5.5	6.6	17.6	1.1	6.6	0	6.6	91
Total	0.8	1.0	4.1	30.9	3.4	2.7	3.8	11.1	24.0	0.9	9.8	0.2	7.4	1750

Note: Data is missing for 155 callers

Source: WHC Case Management System (to June 2006)

- The sectors most likely to have heard about WHC through their use of an internet site (either WHC or other sites) were those in real estate/renting, those in public administration/defence/social security and those in health and social work. Around 40 per cent of callers from these industries identified the internet as the source of their information about WHC.
- Thirty-four per cent of educational establishments said that they had heard about WHC by 'other' means (ie outside of central marketing or generic PR). This could reflect the activities of local outreach work (eg the North East pathfinder has been using a local further education provider to help promote their services).

### 3.5 Motivations for using the service

The CMS data provides a useful overview of why employers got involved with WHC. In order to find out more about their motivations, however, it is necessary to engage in more detailed discussions. The small number of interviews (eight in total) conducted with early service users provide some further insights on this topic, but should not be taken as representative of users as a whole. Further interviews and in-depth case study with employers are planned for the remainder of the evaluation and will be used in future evaluation reports.

As might be expected from the CMS data, individual's reasons for getting in contact with WHC ranged from very specific issues to more general reviews of health and safety systems. Where specific issues were raised, these were:

- dealing with employees off work due to long-term sickness absence
- introducing health surveillance
- general absenteeism
- occupational stress.

Those wanting a general review felt that this was needed for reassurance that they were doing all that they were required to do by law and to reduce the risk of employees making compensation claims against them. Some referred to changes in legislation being difficult to keep up-to-date with, and more than one respondent mentioned the prohibitive cost of hiring in health and safety expertise, others to the need for systems reviews due to staff changes (including individuals taking over responsibility for health and safety management and needing some help getting started in this role) or company expansion.

*' .. you get a little bit of legislation through and you know...at times you just feel as if it's just overpowering. And you get to the stage where you know, and you try to dot all the I's and cross all the T's, you get to the stage where you think this is physically impossible'*

(Managing Partner, Manufacturing Company)

*'Basically up until last year we used to be much smaller. We ran the limit of five employees but in the past year we've gone over that limit so we've had rapid expansion and so we...need a formal policy, our insurers had been asking us if we had a formal policy. So starting this year, I took it upon myself to make sure that we actually did what we were required to do as employers'*

(Office Manager, Manufacturing Company)

The majority had little existing contact with occupational health support. However, there were some examples where employers had sought out and received help before. One respondent had used the local occupational health service on a routine basis to carry out annual health checks on shiftworkers, and to run first aid training for the company. A few respondents had researched using private consultants but had decided that these were too costly and also that they did not feel confident in dealing with them or in specifying what they actually needed from such a service. In one case, a respondent had used WHC to provide information which then gave him confidence to deal with a consultant.

*'..rather than sort of go looking through, or trying to source occupational health providers and going along that route...I would have liked a bit of a grounding in what was required, how we should go about it. You know, from an independent source rather than the supplier or the provider themselves'*

(Managing Partner, Manufacturing Company)

One respondent had contacted her local University for advice from an employment specialist but found the information and advice to be too general for her needs and wanted help with more specific issues. WHC was able to deliver this.

*'We found they were able to give very specific advice....and the person on the phone knew exactly the kind of problem that we would be facing, explained how the best way to go about things, how to try and integrate the person back into the workplace if they ever came back. Things like that. It was very very good advice'*

(Manager, Horticultural company)

The fact that WHC was a free service was attractive to most of the employers spoken to as they could not afford a private consultant. Additionally, the fact that the service was independent and confidential was appreciated, as was the fact that it was associated with the HSE. There were some concerns that the WHC visit may have a punitive approach but in fact advisers were complimented on their helpfulness and cooperative manner.

*'So because it was supported by the Government it gave us a lot more reassurance to go for it, so that's why we did that'*

(Manager, Horticultural company)

*'I see this thing that workplace health connect is probably a little bit more approachable, you can speak to these guys. Whereas a lot of people fight shy of talking to the HSE, getting their input'*

(Health & Safety Manager, Manufacturing Company)

One respondent stated that they had been attracted to WHC as it would involve a visit and be tailored to the business rather than involving something generic like a training course.

*'Basically I didn't want to just go off on a course with a commercial company because I'd done this before, paid several hundred pounds for a course, a one day course or two day course, gone there and been given leaflets and whatever, but you know walked away thinking OK, how do I use all this in the workplace? So I didn't want to do that, I wanted something more specific, ... and the fact that these guys exist and it was completely free was of great benefit. The fact that they could come in and talk to us and sort of ... see the whole environment and help us out was what we needed'*

(Office Manager, Manufacturing Company)

One employer felt that the service could have been advertised better.

*'The only thing I would say is that, I don't think it's well advertised, I don't think it's well known because there are so many businesses that could really do with help like this'*

(Office Manager, Manufacturing Company)

## 3.6 Chapter Summary

Successfully marketing WHC to the target employers is recognised as one of the major challenges for the initiative. The service has two main methods of marketing:

1. Central marketing driven through a range of consultants and involving a combination of a branding exercise, launch events, public relations activities, radio and press advertising, the use of direct mailings and telemarketing activities.
2. Outreach work by the pathfinders targeted regionally and tailored to local and regional need and expertise.

Central marketing is the main driver of take-up and is expected to provide the majority of referrals to both Level 1 and Level 2. Outreach work will develop as and when required to supplement referrals from Level 1.

So far the most successful approach has been the telemarketing follow up of employers contacted by the direct mail. Direct mail alone did not yield the anticipated results. Engaging local and national press has proved difficult and the public relations aspect of the marketing has been difficult to get off the ground. So far, the numbers of employers calling the adviceline is below targets, but the conversion rates of eligible employers on to Level 2 services are almost double original estimates. As a result

Level 1 take up is low, but Level 2 take up is now running at the levels required to hit national targets despite a slow start.

Employers are most likely to have heard about the service through use of the internet, and it would appear largely through links with the HSE main website, as the WHC website is currently fairly static. Work is being undertaken to develop the WHC site, including search engine optimisation activities and the development of more material to post on the site which will interest employers.

The overall approach of marketing has now switched from a sole focus on health to one which also emphasises benefits related to safety management. This is as a result of consultation with pathfinders who feel that the main draw for employers is concerns about safety, including legal compliance. Workplace health remains a priority for the service, but the decision has been taken for marketing purposes that it needs to be woven into more generic health and safety issues. The focus of future marketing will be on addressing the low take up of Level 1, and therefore be addressed nationally rather than with a region focus (which has been the case so far).

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## 4 User Details

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The Level 1 service is provided for all callers, whether they are calling about an issue that affects them directly, or about something related to their employer, and regardless of size or any other employer characteristics. The Level 2 service in contrast is targeted only at SMEs. For both services, it is therefore interesting to examine the types of employers getting involved in WHC, particularly at this fairly early stage in delivery, to determine whether there are identifiable trends in service use. In this chapter, the CMS data on users is therefore examined in further detail.

### 4.1 Use of Level 1: adviceline

A total of 1,905 calls were made to the adviceline between 2 January 2006 (when pre-operational calls began to filter through to the service) and 20 June 2006 (when analysis on this data began for production of this report). In this section further data is provided on how call volumes have changed over time, and more detail on the types of individuals using the service, and the types of employers they work for.

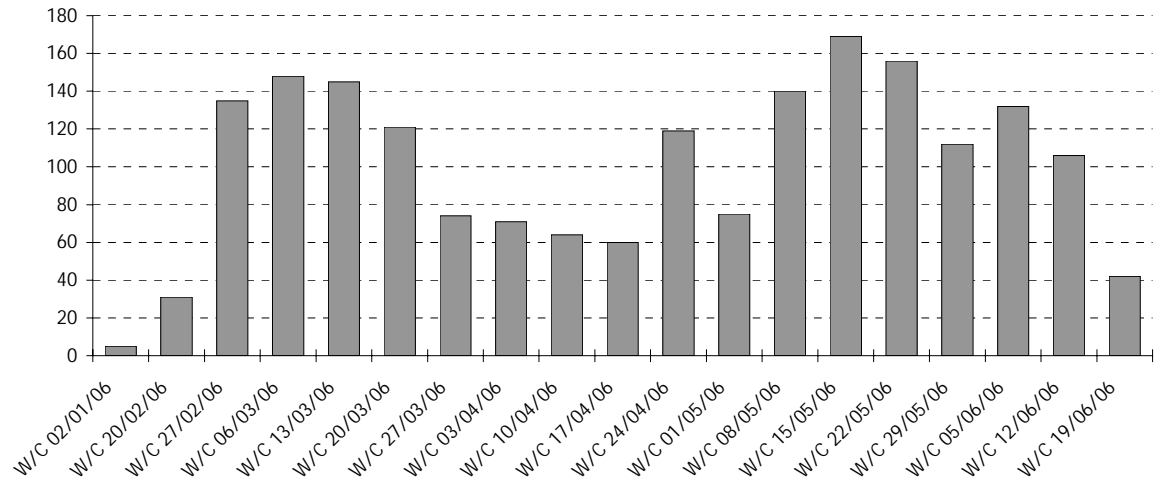
#### 4.1.1 Call rates over time

The weekly breakdown of call volume (Figure 4.1) shows that after a steady increase in the number of calls following the service launch, clear fluctuations occurred from week to week. Peak call rates can be seen at Weeks 14 and 15, while the lowest number of calls (following the initial launch phase) was during week ten.<sup>1</sup> The daily average of incoming calls across this period has been 20.

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<sup>1</sup> Week 25 would appear to be a low volume week, but the data for that week is incomplete, as the cut off for the supply of data for analysis occurred in the middle of that week.

Figure 4.1: Number of Level 1 enquiries by week

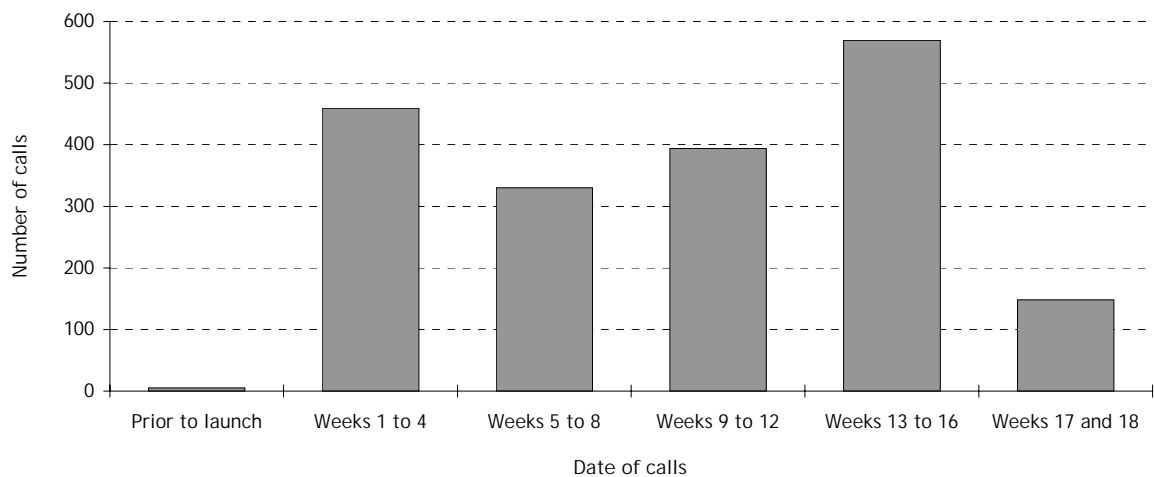


N = 1,905

Source: WHC Case Management System (to June 2006)

Given the weekly variations, it is perhaps more useful to consider the month-by-month breakdown of call volumes (as shown in Figure 4.2). The first month of operation (which started on 20 February 2006), resulted in 459 calls, but there was a reduction in call volumes in the 2nd and 3rd months (to 330 and 394 respectively), with a peak call rate of 569 calls taken in month. The upwards trend in caller numbers starting in the third month of operation is likely to reflect the on-set and impact of telemarketing which began in week ten.

Figure 4.2: Number of Level 1 enquiries by month (ie four week periods)



N = 1,905

Source: WHC Case Management System (to June 2006)

It is difficult to estimate with any certainty the level of calls expected from a new national service of this nature in advance, and projected caller numbers have been

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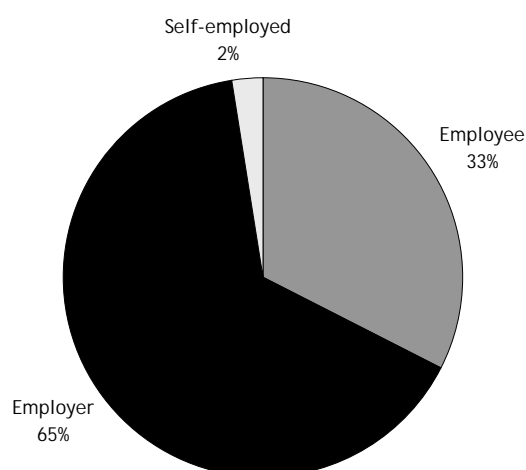
kept deliberately vague. However, the number of calls received during the first few months of operation have fallen behind the lowest estimates. The adviceline has never been tasked with generating its own callers, but has been expected to rely on central marketing to do this. The fact that the first four months of service delivery have resulted in lower than anticipated call volumes, therefore, would seem to remain an issue for marketing (and Chapter 3 provides further details on how marketing approaches are being modified to take account of this). Some discussion is currently underway, however, about the role of the website in this, and it is likely that this will move from a fairly static to a more dynamic site in the future. This is partly a response to the high proportion of callers who have found out about WHC through using the web. Despite relatively low caller numbers, however, the referral rates to Level 2 are actually higher than anticipated, meaning that in the most recent months of service delivery the number of referrals to Level 2 channelled through the adviceline are at, or more recently (in some areas) above, target levels.

#### 4.1.2 Caller profile

All callers were asked to state whether they were an employee of a company calling on their own behalf, or whether they were calling as a representative of their employer (eg as a manager or health and safety representative). In a number of cases (around 20 per cent) callers did not wish to disclose this information, but the majority of callers who did were classified as employers as opposed to employees (65 per cent compared to 33 per cent) and a further two per cent of calls came from the self-employed (Figure 4.3). Ninety-two per cent of callers were working 'full-time' (ie more than 16 hours) at the time of their call.

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Figure 4.3: Level 1 caller profile



N = 1,719, Missing = 186

Source: WHC Case Management System (to June 2006)

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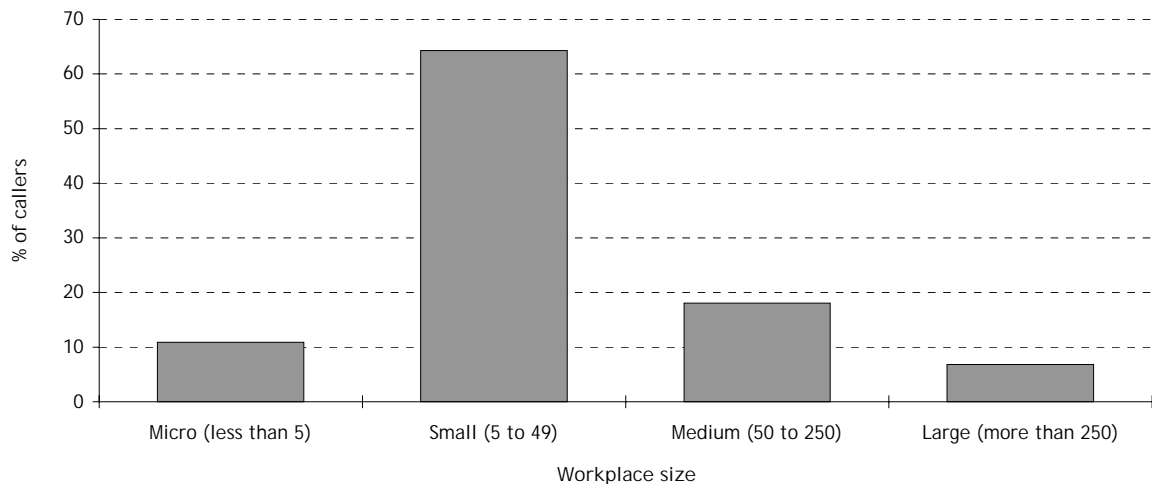
### 4.1.3 Employer profile

Callers were also asked to provide information (where relevant) on the type of employer they worked for, in terms of workforce size and industry type, and whether their employer already had access to occupational health support.

#### Size

Callers were asked to state the number of staff employed at their workplace, and were also asked, in the case of employers operating from multiple sites, to provide the overall size of the employer across all these sites. The mean workforce size and employer size were fairly similar at 111 and 170 respectively, with the largest participating employer having 20,000 employees nationwide. Overall, the greatest proportion of calls were taken from employers with fewer than 50 employees at the workplace they were calling from (three-quarters of calls made by employers where their size is known as highlighted by Figure 4.4).

Figure 4.4: Level 1 users, workplace size



N = 1,509

Source: WHC Case Management System (to June 2006)

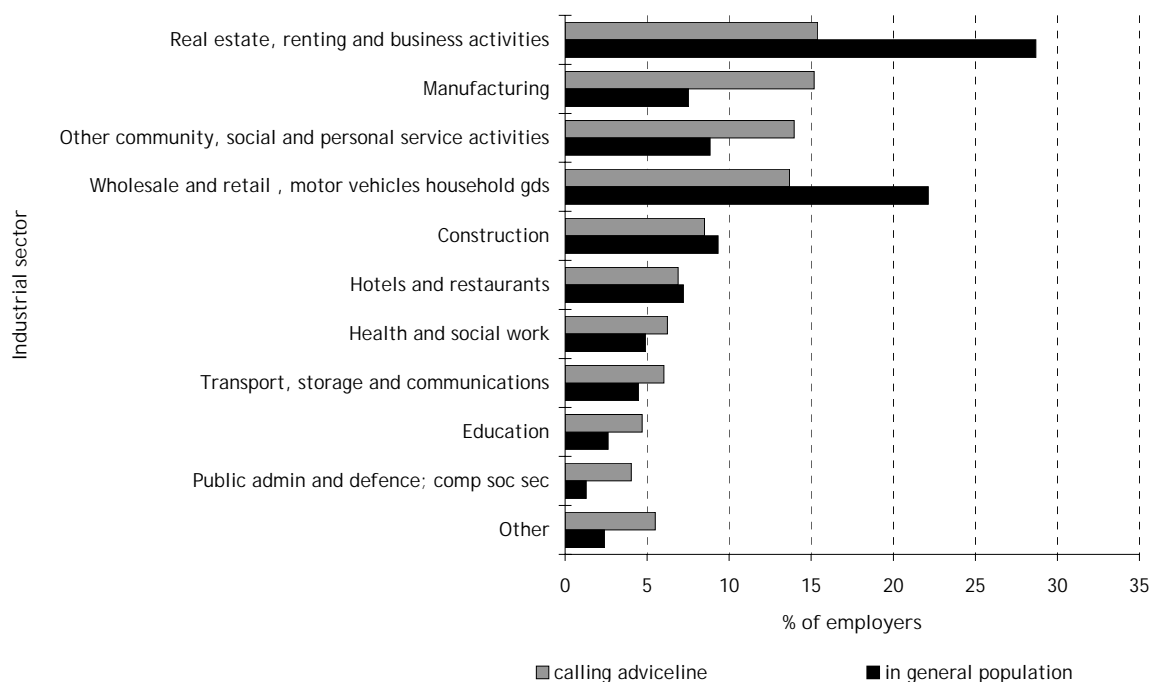
#### Industry

Callers were asked to identify the main activity of the company where they worked. The largest number of calls were from employers in real estate, rental and business activities (making up 15 per cent of all calls), followed by calls from the manufacturing sector (14 per cent of calls), and the community/personal services sector and wholesale trade (each making up 13 per cent of calls). Comparing these proportions with the overall proportions of the type of business in the UK economy (Figure 4.5), it is clear that WHC is receiving more calls from the manufacturing and community/personal services sectors than would have been anticipated if calls from the different sectors were equally likely. It is possible, therefore, that there is

something different about these sectors which makes the WHC service more attractive or relevant to them.

In contrast, most of the other sectors, most notably the wholesale trade and real estate, renting and business activities sectors, are less likely to have called than the composition of the UK economy would have suggested. This analysis does not, however, take account of any regional biases (ie different industrial distributions within sectors targeted, for example, by telemarketing), although future evaluation reports will consider the regional dimension in more detail.

Figure 4.5: Distribution of Level 1 calls by industrial sector with population comparison

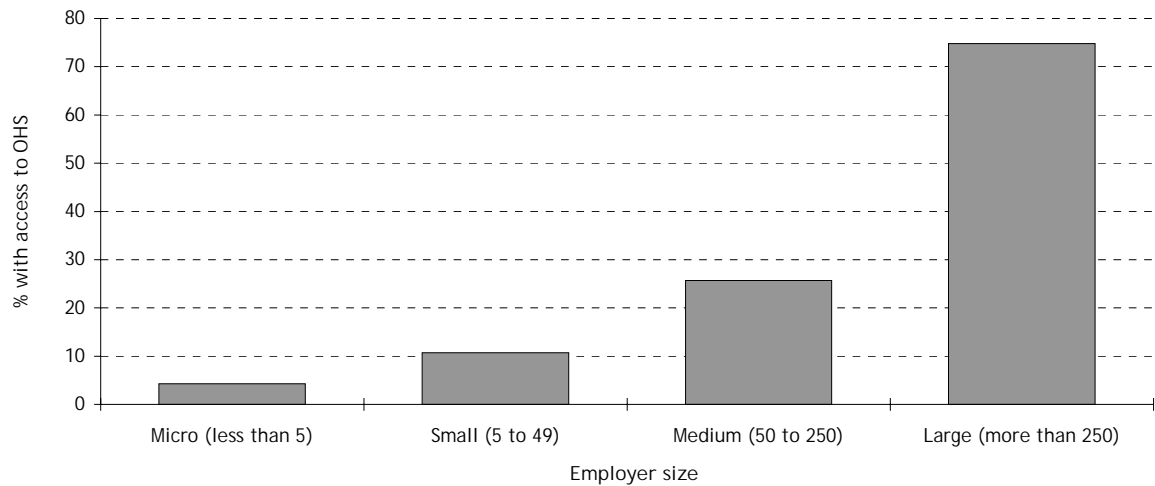


Source: WHC Case Management System (to June 2006) and Annual Business Inquiry from NOMIS (June 2006)

### Access to occupational health support

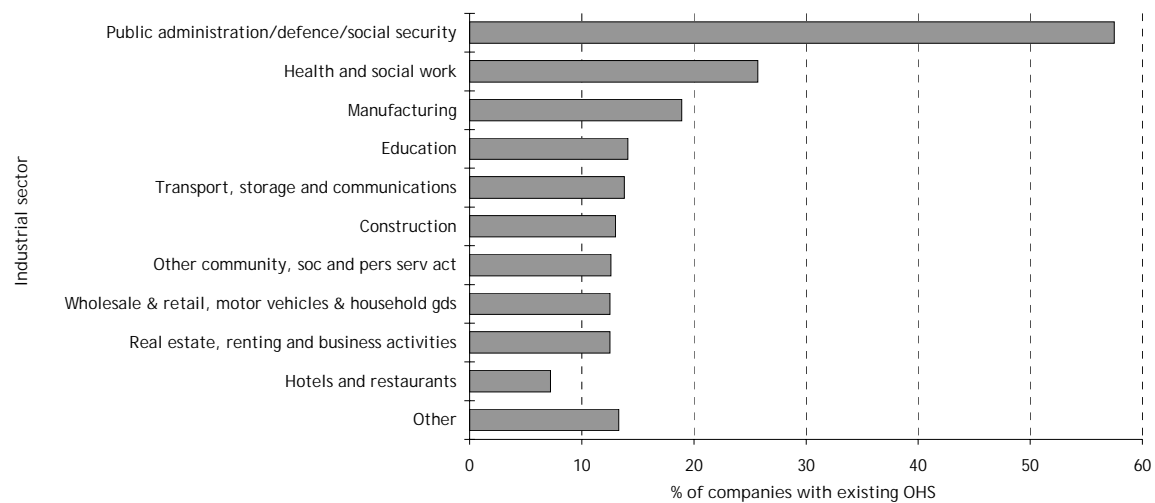
The vast majority of advice line callers (85 per cent) did not have access to occupational health support at their workplace. There was significant variation in the availability of support, however, by size and sector (Figures 4.6 and 4.7). As would be expected, micro, small and medium sized employers were less likely to have existing OHS when compared to large employers, three quarters of whom **did** already have access to support. The sectors most likely to have support were organisations in public administration/defence and health/social work and manufacturing (58 per cent, 26 per cent and 19 per cent of which had access to OHS respectively). The sector with the lowest proportion (only seven per cent) of employers offering such support was employers in the hotel and restaurant business.

Figure 4.6: Access to OHS by workplace size (Level 1 callers)



Source: WHC Case Management System (to June 2006)

Figure 4.7: Access to OHS by industrial sector (Level 1 callers)



Source: WHC Case Management System (to June 2006)

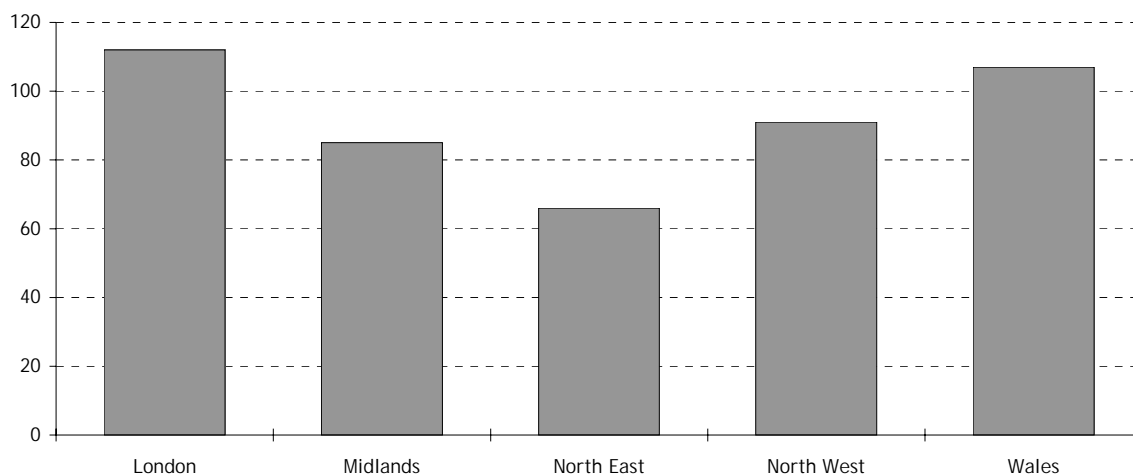
A further question is whether having access to OHSR services, used here as a proxy for having better overall health and safety systems, has affected how employers hear about the WHC service. There is insufficient data so far to conduct a detailed analysis which takes account of the contribution of size and sector to this issue, although future re-analysis will take these factors into account. Nevertheless it does appear that proactive approaches (eg through the use of the internet) are more likely from employers with existing OHSR access (45 per cent of these employers heard about the service through the internet compared to 29 per cent of employers without existing OHSR). In contrast, although this is likely to be size related, employers without existing access to OHSR are more likely to have come through telemarketing (24 per cent compared to 20 per cent), word of mouth referrals (12 per cent compared to eight per cent), or through direct mail (11 per cent compared to five per cent).

## 4.2 Referrals to Level 2: pathfinder visits

Whilst the adviceline is an important service operating in its own right, one of the key aims of the service is to act as a source of referral for interested and eligible callers onto Level 2 service provision offered by their local pathfinder. Central marketing for WHC has focused on this route into Level 2, so it is important to gauge the extent to which this has been successful so far. Overall, 471 adviceline callers had been referred onto a Level 2 provider by mid-June 2006, a conversion rate of around 25 per cent. This figure does not, however, take account of the number of eligible callers referred to the adviceline (as regional data on eligibility was not available in time for this report), and the proportion of referrals from this group which will be larger.

So far these referrals have not been equally spread between regions, however (Figure 4.8 shows the number of referrals and Figure 4.9 the proportion of referrals to each of the regional pathfinders). London and Wales have, so far, received the largest number of referrals so far.

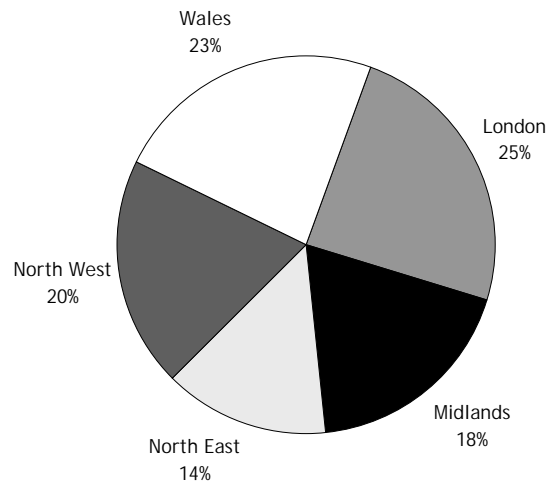
Figure 4.8: Number of enquiries referred Level 2 regions



N = 461, Missing = 10

Source: WHC Case Management System (to June 2006)

Figure 4.9: Proportion of referrals made to Level 2 regions

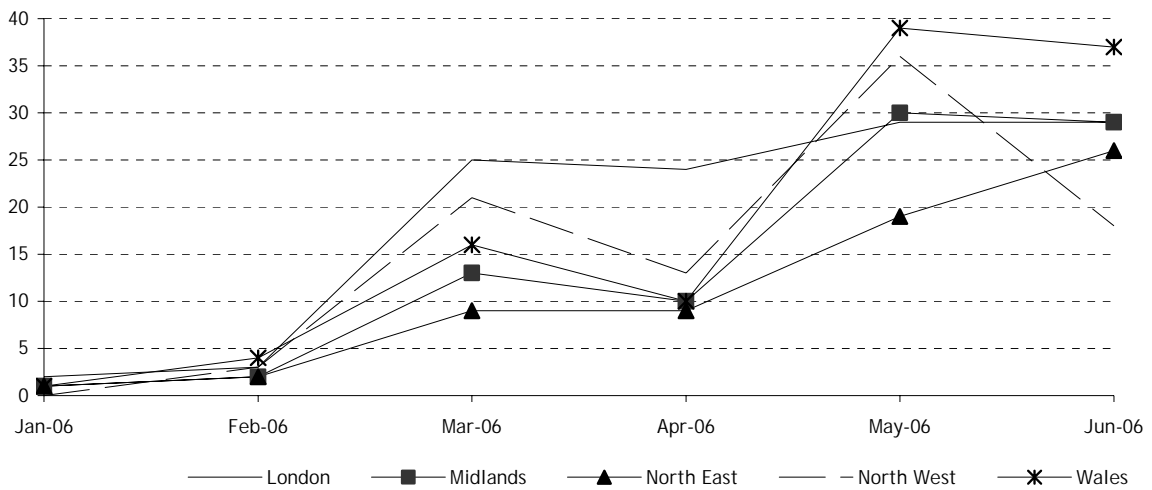


Source: WHC Case Management System (to June 2006)

#### 4.2.1 Referrals over time

The scale of referrals to each pathfinder region, however, has been subject to some variation over time (Figure 4.10 shows a month-by-month breakdown of Level 2 referrals). Despite this, most areas show a gradual build in the numbers of referrals following the project launch, followed by a slump in April, followed by a 'recovery' in May and June. The recent growth in referral numbers is likely to reflect the start of telemarketing activities toward the end of April. A week-by-week breakdown of referrals (as shown in Figure 4.11) shows a similar trend. It is interesting to note that Weeks 17-18 are the busiest during this period, three weeks later than the busiest weeks for Level 1 enquiries. This is likely to reflect the time taken to set up visits, particularly given the fact that pathfinders report most SMEs prefer not to have the visit within one week of the call (this is a quality standard for pathfinders that they must offer a visit in this timeframe), opting instead for visits two or three weeks after their adviceline call in some cases.

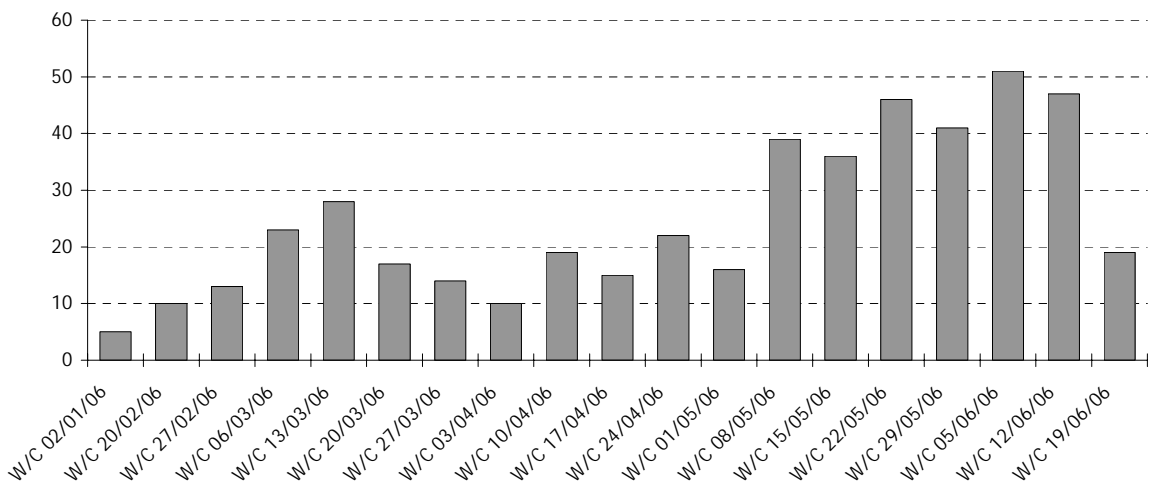
Figure 4.10: Monthly Level 2 referrals by region



N=461, Missing = 10

Source: WHC Case Management System (to June 2006)

Figure 4.11: Weekly level Level 2 referrals



N = 461, Missing = 10

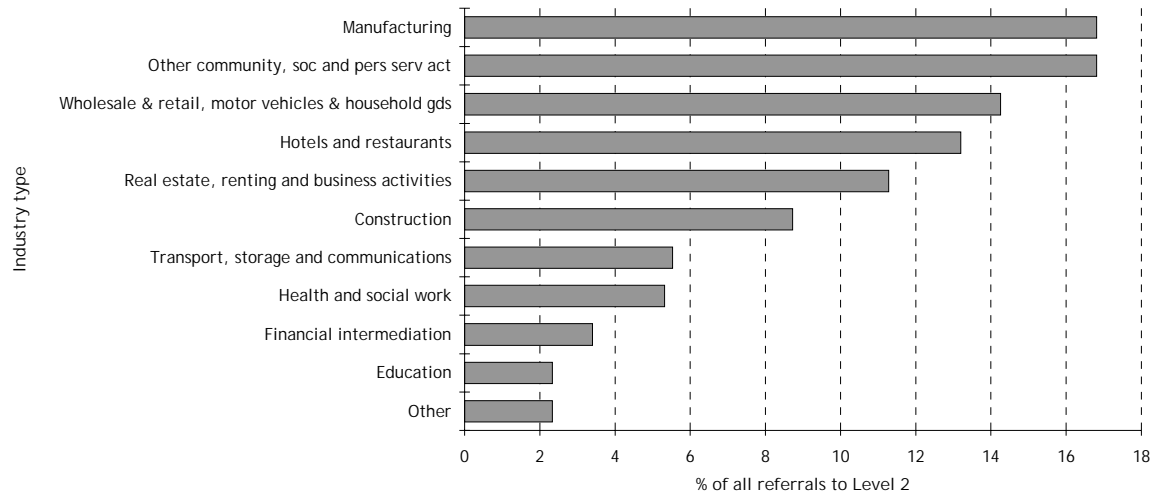
Source: WHC Case Management System (to June 2006)

### 4.2.2 Employer profile

It is also possible to examine the types of employers who have been referred to Level 2 provision using the available employer size and sector data (Figure 4.12). Employers from the manufacturing and community/personal services sectors are most likely to have been referred onto Level 2 provision (around 17 per cent of all referrals in both cases), as might be expected given that these are the two of the most likely sectors to have called the adviceline (see Section 4.1.3 for more details). What might be surprising is that the sector most likely to have called the adviceline, namely real

estate, renting and business activities, were only the fifth most likely sector to have been referred to Level 2. The next evaluation report will need to deal with eligibility data to determine why this is the case (ie are callers from this sector less likely to be eligible for Level 2 provision or more likely to refuse a visit?).<sup>1</sup>

Figure 4.12: Referrals to Level 2 provision by industrial sector



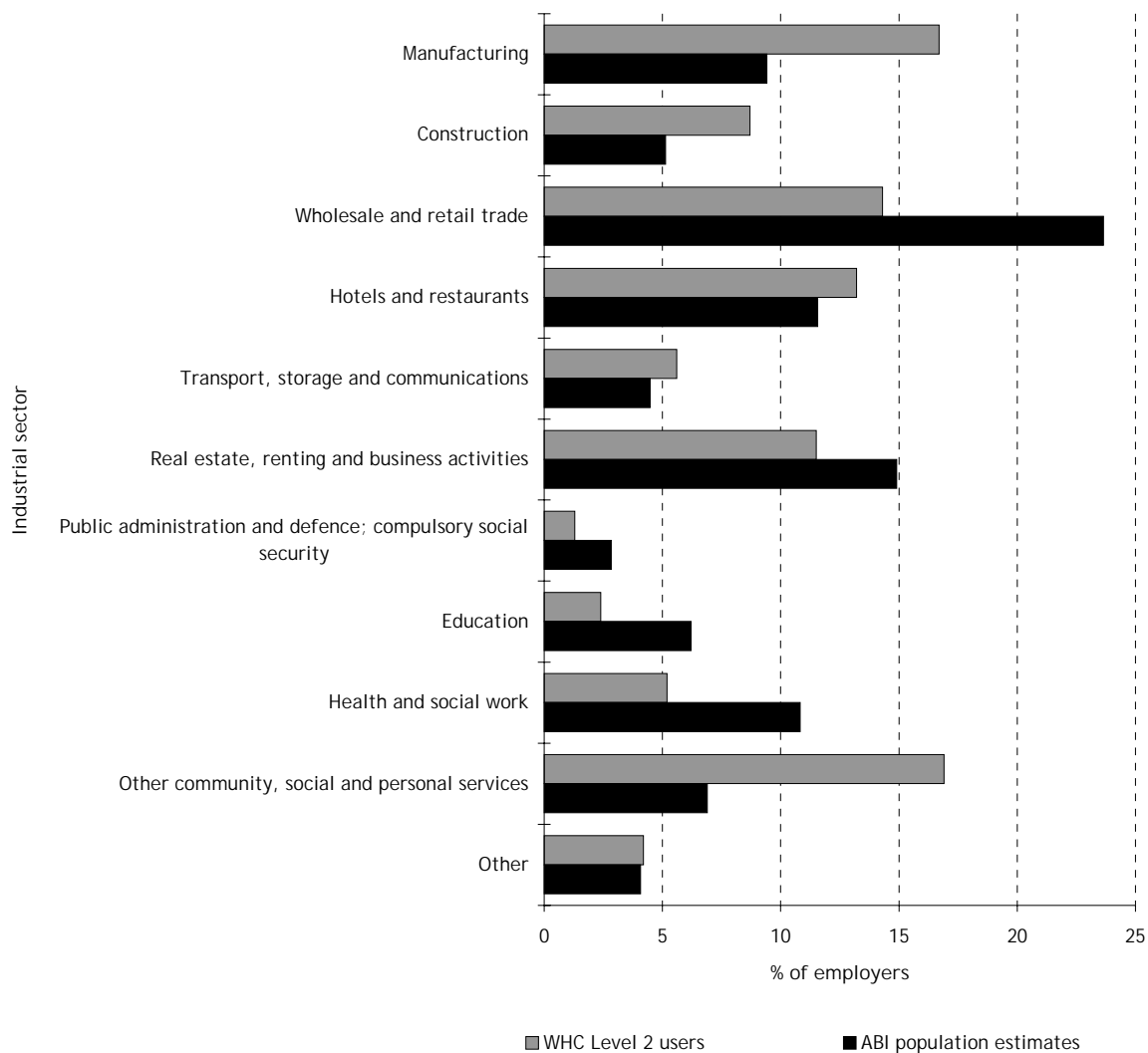
Source: WHC Case Management System (to June 2006)

When this profile is considered against population estimates for employers with a similar size profile (Figure 4.13), there are a number of sectors which are over represented within the WHC Level 2 user profiles. These are:

- Manufacturing
- Construction
- Community and personal services.

<sup>1</sup> It remains necessary to allocate employers to regions based on their postcodes (this will be done before the next evaluation report), and without this data it is not possible to determine whether or not employers were eligible for a Level 2 visit.

Figure 4.13: Profile of Level 2 users with population estimates (controlling for size)

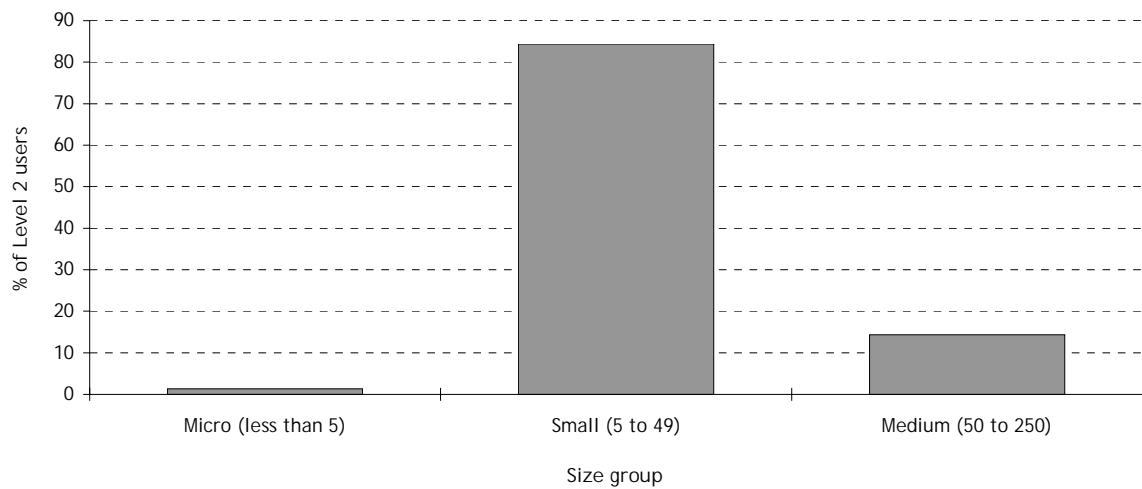


Note: Data for ABI based on users with up to 299 staff whereas WHC users relate to those with up to 249 staff, thus there will be a slight discrepancy and this Figure should be considered indicative only

Source: WHC Case Management System (to June 2006) and Annual Business Inquiry from NOMIS (June 2006)

As size is one of the main ways in which eligibility is established, it is not surprising to find that no referrals have been made to large employers, but there are a very small number of micro-employers who have been provided with visits (Figure 4.13). A higher proportion of smaller employers, however (41 per cent) have been referred onto Level 2 than medium sized employers (25 per cent). This may be because they are more likely to be ineligible for provision, or that they are less likely to take up an offer if they are eligible. Alternatively, this could just reflect the fact that there are far more smaller employers in the population. Further analysis using regional data (which was not available at the time of this report, but which will be available for the next evaluation report) will help to determine which of these has the strongest influence.

Figure 4.14: Referrals to Level 2 provision by employer size



N = 461

Source: WHC Case Management System (to June 2006)

### 4.3 Chapter Summary

By 20 June 2006 (four months of official operation since the launch), a total of 1,905 calls had been made to the adviceline. The average daily number of calls made over this period was 20, but this figure has been subject to variation. There is an overall upward trend in call numbers which appears mainly to be stimulated by the use of a telemarketing service to generate interest. These levels are below original estimates for the Level 1 service. Over the same period, 471 referrals to the adviceline has resulted in visits delivered by the Level 2 providers. The weekly referral rates are now hitting anticipated levels for most pathfinders and these largely follow (but with a three week lag) the levels of calls to the adviceline.

The majority (almost two-thirds) of callers to the adviceline work within organisations with between five and 49 employees and these were spread across different industrial sectors, but with real estate/rental/business services employers the largest single group (15 per cent of callers). The overall spread of industries is not dissimilar from estimates of the population of businesses (as published by the Annual Business Enquiry), but the real estate sector (which makes up almost 30 per cent of all businesses) is under-represented. Manufacturing and the community/personal services sectors are in contrast over-represented amongst callers. The vast majority (85 per cent) of businesses represented amongst callers did not have existing access to occupational health support. Employers taking up Level 2 visits are mostly small, rather than medium sized, and the manufacturing employers are the ones who have received the largest number of visits so far.

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## 5 Issues Dealt With/Raised by Visits and Calls

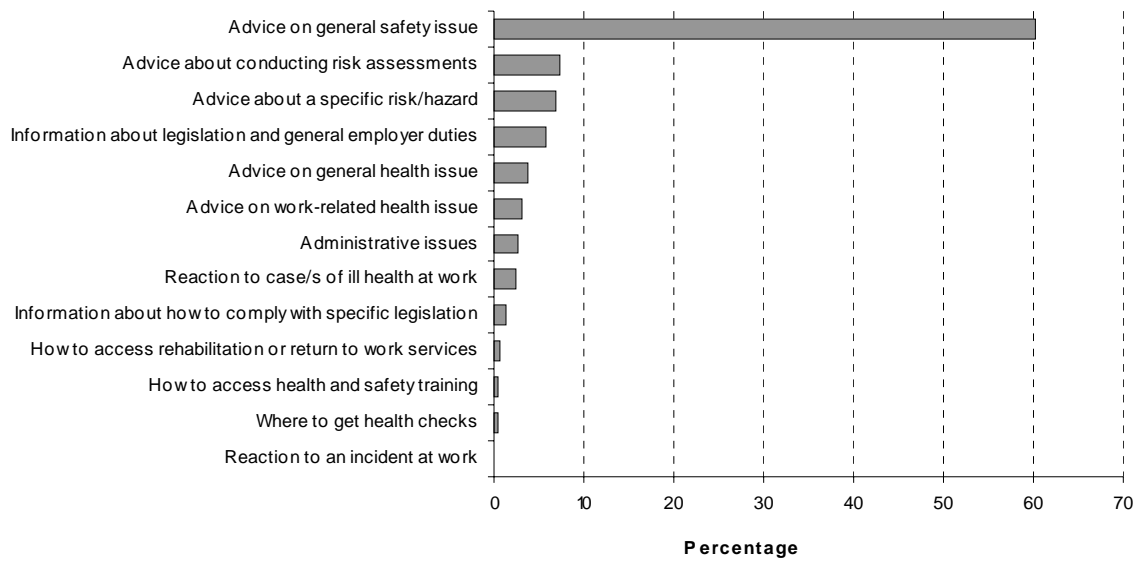
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The Workplace Health Connect service obviously needs to reach a certain number employers nationally, and within the Level 2 region to hit its numerical targets and to be judged as a success in these terms. Another area on which it will be judged, however, is the type of advice given to employers and the extent to which they become engaged in workplace health issues. To this end, in this chapter, data is examined which on the content of calls and visits so far to help understand the WHC experience in more detail.

### 5.1 Level 1 enquiries

Logging the types of enquiries individuals raise during calls to the adviceline, it is clear that the vast majority of queries are relatively non-specific and concerned with safety rather than health (Figure 5.1). Most commonly, individuals were calling for advice on general safety issues (63 per cent of calls), while another eight per cent requested advice on conducting risk assessments, and seven per cent required advice about a specific risk/hazard. Only a relatively small proportion of enquiries were health related: four per cent categorised as advice on a general health issue and three per cent were advice on a work-related health issue. Other categories of enquiry were represented in relatively small numbers.

Figure 5.1: Most common Level 1 enquiry type



N = 1,875, Missing = 30

Source: WHC Case Management System (to June 2006)

### 5.1.1 Enquiries and employer size/industrial sector

There was a clear trend in the employer data whereby the larger the employer, the less likely they were to be calling about a general safety issue (Table 5.1). Whilst 69 per cent of micro-employers were calling with this type of enquiry, only 53 per cent of large employers did so. However, this was still by far the most common enquiry type for all sizes of employers.

Table 5.1: Queries raised in Level 1 calls (per cent)

	Advice on general safety issue	Advice on work-related health issue	Advice on general health issue	Advice about a specific risk/hazard	Advice about conducting risk assessments	Information about legislation and general employer duties	Administrative issues	Reaction to case/s of ill health at work	Other enquiry	Total (N)
Micro (less than 5)	68.9	1.9	1.9	8.1	5.0	8.7	1.2	-	4.3	161
Small (5 to 49)	62.9	1.7	2.7	6.6	11.1	6.5	3.7	2.0	2.7	951
Medium (50 to 250)	55.3	6.4	5.7	8.0	7.6	4.9	2.7	4.9	4.6	264
Large (more than 250)	52.9	7.8	4.9	14.7	2.0	4.9	2.0	6.9	4.0	102
All employers	61.5	3.0	3.3	7.6	9.2	6.4	3.1	2.6	3.3	1,478

Source: WHC Case Management System (to June 2006)

There was also some variation in the way that different enquiry types were distributed within different sectors (Table 5.2). Construction employers were the least

likely sector to be calling with a general safety issue (54 per cent), and hotels and restaurants the most likely (75 per cent). Aside from general safety, callers from different sectors had a range of different further enquiries, most notably:

- Over 10 per cent of callers from three sectors (compared to an average of seven per cent across sectors): education (13 per cent), public administration/defence (14 per cent) and construction (12 per cent) were concerned about a specific risk/hazard.
- Risk assessments were the focus of their call for more than 10 per cent of callers (compared to an all sector average of eight per cent) from manufacturing (11 per cent), wholesale/retail (12 per cent) and health and social work (11 per cent).
- Twelve per cent of construction employers, compared to an average of just six per cent across all sectors, were calling the adviceline for information about their general employer duties/legislation.

Advisers are also asked to state the types of advice they have provided for employers in response to the issues raised by employers themselves. Currently, the majority of calls have been coded as involving 'other' advice, and lay outside the main categories available in the CMS (Figure 5.2). The most common advice provided aside from this was hazard identification and risk assessment (14 per cent), stress (six per cent), sickness absence' (five per cent) and return to work (three per cent)

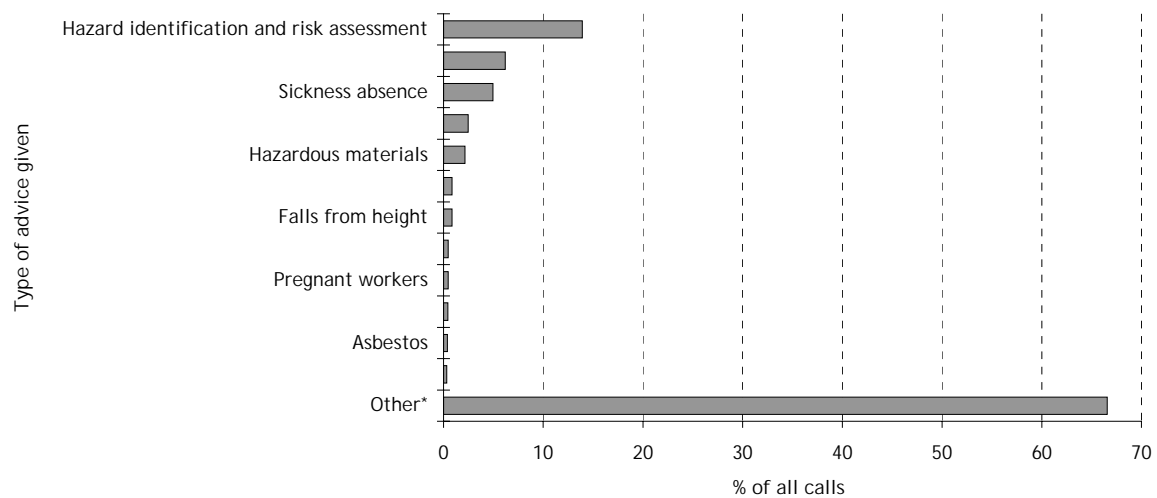
Table 5.2: Nature of Level 1 enquiry by industrial sector

	Advice on general safety issue	Advice on work-related health issue	Advice on general health issue	Advice about a specific risk/hazard	Advice about conducting risk assessments	Information about legislation and general employer duties	Administrative issues	Reaction to cases/ of ill health at work	Other	Total
Manufacturing	55.9	2.9	3.7	8.8	10.7	4.4	2.9	4.4	6.2	272
Construction	53.4	4.1	2.7	11.5	8.1	11.5	4.1	0.7	4.1	148
Wholesale and retail trade, repair of motor vehicles, motorcycles and personal/household goods	62.2	1.2	4.1	7.9	12.0	5.0	2.9	2.5	2.1	241
Hotels and restaurants	75.2	1.7	3.3	-	8.3	5.0	4.1	0.8	1.6	121
Transport, storage and communications	70.8	7.5	2.8	4.7	2.8	6.6	1.9	1.9	0.9	106
Real estate, renting and business activities	66.8	4.6	4.6	4.2	6.5	5.7	0.8	1.9	4.9	262
Public administration and defence; compulsory social security	62.9	2.9	4.3	14.3	2.9	1.4	2.9	4.3	4.2	70
Education	63.9	2.4	1.2	13.3	4.8	8.4	2.4	2.4	1.2	83
Health and social work	57.5	2.8	6.6	6.6	11.3	6.6	2.8	1.9	3.7	106
Other	70.0	5.6	2.2	4.4	4.4	5.6	2.2	2.2	3.3	90
Total	63.7	3.3	3.6	7.0	8.0	6.0	2.8	2.3	3.3	1,747

N= 1,747, Missing = 158

Source: WHC Case Management System (to June 2006)

Figure 5.2: Types of advice given (Level 1)



N = 1,875, Missing = 30

Source: WHC Case Management System (to June 2006)

### Absence management and return to work

As discussed in Chapter 3, the original marketing messages for the WHC service focused on return to work and absence issues, and the long term impact of WHC will also be judged at least partly on these issues. It is therefore interesting to note that of a total of 1,509 calls where this information was available, only 128 (eight per cent) involved an absence management issue and 104 (seven per cent) a return to work issue. These numbers are too small for further analysis by sector, but the propensity for calls to involve absence management or return to work issues increases with employer size, from around four cent of calls from micro employers to 13 per cent of large employers.

### Referral to another service

Only 34 (two per cent) of callers were referred to another service, and the majority of these were referred to other HSE information sources. The pathfinders also report that further signposting has been unnecessary in the majority of cases where a visit has been made. This could simply reflect the fact that most employers are calling the adviceline with very general queries, and therefore the generic advice and tailored support that WHC provides is sufficient to meet their immediate needs.

## 5.2 Level 2 visits

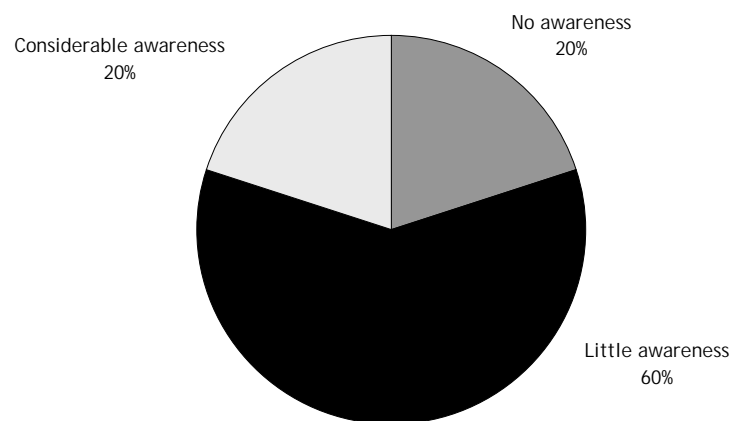
There are national protocols which shape the way in which pathfinders approach visits. The Health and Safety Performance Indicator Tool is suggested in quality documentation as one that should be used on visits, for example. Within this framework, however, there are bound to be regional variations, and as each visit is

tailored to the needs of the specific employer, even further variation in reality. All pathfinders, however, are required to conduct a first and follow up visit, with guidance that this take place roughly one month following first contact, and that employers are provided with a visit report which sets out actions required by them to address the specific issues identified during the visits. Given this framework, Level 2 advisers were asked to discuss in further detail the content of visits they have undertaken so far.

### 5.2.1 Level of engagement with health and safety issues

After all visits, Level 2 advisers are asked to rate employers' awareness of health and safety issues (Figure 5.3). In only 20 per cent of case was this judged to be non-existent. Only seven (less than one per cent) cases were referred to Level 3 by a Level 2 advisor.

Figure 5.3: Adviser rating of customer awareness of health and safety issues (Level 2 users)



N=461, Missing = 10

Source: WHC Case Management System (to June 2006)

Given this variety of employer expertise, it is not surprising that there is no such thing as a typical visit, they vary quite widely. Employers are presenting a range of issues. One service manager described employers as motivated, largely, by one of three concerns:

1. The need for specific problem solving where employers have a clearly identified issue that they need help with, over and above more generic concerns.
2. Help in the validation and checking of existing systems/policies/documents to ensure that they meet legal obligations or good practice standards.
3. Help in initiating health and safety systems 'from scratch' where nothing exists or procedures have been neglected.

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*“The most common issue is that they don’t have anything. They’ve got no policy, no risk assessment, nothing and they want to make a start.”*

(Pathfinder service manager)

As such pathfinders feel that the initiative is reaching a wide range of employers, with differing standards of existing health and safety management. However, there is a strong feeling that the service does reach out to those most in need. In some cases companies have become involved because of pressure from a third party, such as an insurance party or a client who requires some health and safety information as part of a tendering process.

Organisations spoken to had varying complexities of health and safety management systems. All mentioned a health and safety policy. In some cases, the health and safety system had not been reviewed for a period of time. Some received/had sought out relevant publications or searched on the Internet. Many mentioned fear of litigation and claims being made against them. Some had fairly simple health and safety arrangements from a small office environment with a health and safety policy and accident book, to a manufacturing environment with protective gear supplied.

Only one out of the eight employer representatives interviewed had the role of Health and Safety Officer. Most were responsible for health and safety as part of a wider role. Health and safety responsibility was shared in a few cases, but the individual interviewed was most often the only person responsible. Where responsibility was shared, this was because a Director had overall responsibility for health and safety but had delegated its management to another person in the organisation. The time these individuals spent on health and safety ranged between one and three days per week. A few respondents said that they expected to spend less time on it in future having been in the process of reviewing their health and safety system recently. Individuals had various levels of experience in health and safety, ranging from someone having just taken on a role which involved some health and safety responsibility for the first time to a health and safety manager with four years experience, and a Director in post for 11 years in a small manufacturing concern.

### 5.2.2 First and follow up visits

Follow up visits also tend to vary depending on how much was achieved during the initial visit. If there are a number of actions from the first visit and the employer has been quite open and happy to talk about things then it’s more about measuring progress and discussing any problems. If during the first visit the employer wanted to talk about one particular topic then it might be that the second visit is starting to talk about other issues and how they could tackle them. Safety concerns tend to be the dominant interest of most employers prior to their first visit, and a number of advisers noted that the first visit tends to deal with these, in part to develop trust and be seen to be responsive to employer interests. Users also reflected on the follow-up visit, and that it generally involved checking on progress made against the action points

contained in the feedback report. Any additional concerns or queries were also addressed at this time.

Often it is not until the second, follow-up visit when health issues can be adequately discussed. One adviser identified some possible reasons for this:

*'Very occasionally we've had problems with absence and a return to work, and it's not that common, because it's not a big problem for small businesses, because with a lot of them if they don't work they don't get paid.'*

(Level 2 adviser)

Health and safety policies do seem to be a focus for employers. Whilst they may not understand what they need to do to construct or improve one, there is a high level of awareness that a policy is a legal requirement, so this can often be the first thing employers want to start with. The remainder of the visit can then be a case of trying to work away from this document per se and trying to help them see what they actually need to do in a broader sense.

### 5.2.3 New versus existing concerns

The first visit lasted between one and a half hours and half a day. It generally involved a walk around the workplace, a review of existing health and safety systems, and a discussion of issues of concern. The employers interviewed for this report indicated they were allowed by advisers to focus on the issues relevant to them rather than being forced into a set approach. However, they also indicated that the visits sometimes picked up on areas they had thought were not a concern.

*'I told her our concerns and the things we needed to look at. And then, she generally had a look at our system, what we were doing at the minute, and what we had in place, risk assessments, COSHH, looked at our manual, you know just general health check really. We showed her around the shop floor, to see the sort of environment we're working within and obviously the risks associated, assess the risks within that environment and what we needed'*

(Managing Partner, Manufacturing Company)

*'And she's addressed other issues that we didn't think we had an issue with, I mean with the absenteeism thing. The noise assessments and such like that, so really she's really went through and picked bits and pieces out which we need to address which possibly we didn't really think we needed to address. So we got more from it than just what our original concerns with the health surveillance and such. There was a lot more come out of it unexpectedly which has all been good feedback'*

(Managing Partner, Manufacturing Company)

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### 5.2.4 Supporting information

The visits involve the use of a number of materials, all of which are HSE based, including guidance on policies and risk assessments and the HSE's top ten leaflets, and this seems to apply across most of the pathfinders. The approach generally appears to be deliberately 'low tech', rather than referring employers to the HSE website as a general source of information (although this does occur), pathfinders tend to prefer to leave the relevant information with employers or send it with the visit note. Vague signposting is not felt to offer much to the employer who is unlikely to have time to respond.

Whilst the quality standards for visits and general guidelines are followed, advisers feel strongly that the service needs to be very flexible, particularly in the way that visits are approached. The Health and Safety indicator tends to be used on most visits – it opens up a level of discussion that allows for a quick understanding of what the health and safety issues might be. The stress management tool suggested for use on visits by the HSE was initially found difficult to work with, but once its application was better understood, it was becoming easier to apply. One pathfinder identified the HSE's document on return to work interviews as a useful source of information, and provides this for employers, which has been well received.

*'Sometimes we'll start by having a wander around, and a chat, and other times it (ie the Health and Safety Indicator Tool) will come later in the visit after we've discussed some things with them, and that to me is just normal flexibility.'*

(Level 2 adviser)

However, the Performance Indicator was not universally well regarded. Within one pathfinder, the way in which employers are scored was not felt to be a useful aspect of the tool.

*'They go in, they bang in a load of questions and answers to a lot of things and they get a score. What do I do with that? They're busy, they haven't got a lot of time for health and safety and you would say you scored four and a half out of five, or three. So what? What do I do with this information? How do I use it?'*

(Level 2 adviser)

## 5.3 Chapter Summary

The vast majority of callers to the adviceline raise issues related to safety rather than health, and generic rather than specific queries. Most commonly individuals were calling for advice on general safety issues (63 per cent of calls), although larger employers were more likely to have a specific query. Absence management and return to work issues featured in only around 15 per cent of calls, and referrals onto further specialist sources of information (aside from Level 2) were scarce, only two per cent of calls.

Level 2 advisers were largely in agreement that there were three types of employer motivations for contacting the service. These were:

- to help them address specific concerns
- to check existing systems
- to help them develop new systems.

The first visit is largely used to address the specific concerns that employers have and the issues that they feel are important to them. In many cases this appears to be developing health and safety policies. The follow up visit, in contrast, often gives the advisers the space they need to introduce new issues and to focus more on workplace health.

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## 6 Satisfaction and Outcomes

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As WHC represents an entirely new service, it is important to monitor the extent to which its clients are satisfied with what they receive. In addition, the service must demonstrate that employers make some changes to their practices as a result of calling the adviceline and/or meeting with advisers. The evaluation will examine any evidence of short and medium term impact as a priority in future reports, using the employer survey as the primary source of information, supplemented by qualitative case study data. At this point, given the relatively short period of service operation, it is difficult to provide any conclusive evidence on impact, so this chapter considers early pathfinder and employer reflections on what has been achieved so far.

### 6.1 User satisfaction

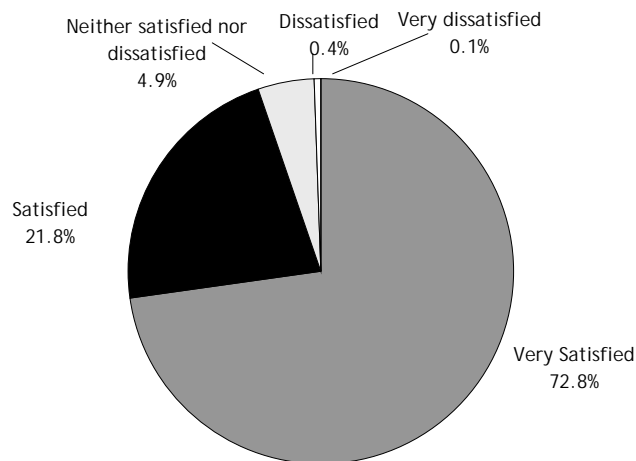
The satisfaction ratings of users are one way of gauging how well the service is being received. Each pathfinder will be conducting their own exercise to collect user satisfaction scores over time, but this information is not yet available. Additionally, the employer survey and case studies will touch on this issue. For now, the main sources of information about user satisfaction are the ratings given to the adviceline and user/adviser views on visits.

#### 6.1.1 Level 1 calls

At the end of their call, all adviceline callers are asked to state the extent to which they were satisfied with the call and advice received (Figure 6.1). It is clear that the vast majority of callers were satisfied with the service they had received. Less than one per cent of callers expressed dissatisfaction. It is important to note, however, that these very positive results, whilst encouraging, could be a reflection of the fact that the individual taking caller enquiries is also the person asking callers to rate the service that has been offered. This is likely to encourage positive ratings. The employer survey data, when it becomes available, will provide a more independent assessment of user satisfaction.

In the majority of cases (88 per cent), Level 1 queries were reported as 'resolved', and only nine per cent of callers were signposted to another services. ACAS and the HSE infoline were the most common destination of referrals. Further adviceline contact (eg where advisers need to research topics and call back employers) was necessary in only two per cent of cases

Figure 6.1: Satisfaction ratings of Level 1 callers



N=1,078, Missing = 197

Source: WHC Case Management System (to June 2006)

Of the employers that were spoken to in depth as part of the evaluation, some of these had used the adviceline only to arrange an appointment for Level 2 visits, but indicated that the adviceline would be their first point of call should they need further help.

*'I would but I've never really used the help line, as in for help. It was just an initial contact and then you know, arranged the first appointment. But I mean, .....that facility's there and if you ever need it, to ring up and say. If I had a problem or if I had a concern, that's probably the first place I would ring'.*

(Managing Partner, Manufacturing Company)

All respondents who used the adviceline for advice found the advisors to be knowledgeable, the advice specific and helpful. One respondent thought the service was excellent: practical, specific, comprehensive advice from an approachable and empathic advisor. The problem they raised related to an employee off work on long-term sick leave and this was clearly a difficult issue to broach.

*'I thought that the advice line was very very useful. I thought the person on the end of the phone was very approachable and everything was treated confidentially so you felt that you could say exactly what the problem was and they were able to empathise and deal with it. I actually thought the help line was excellent, I really did, and it was really useful but practical advice that you can actually implement'.*

(Manager, Horticultural company)

### 6.1.2 Level 2 visits

The overall reaction of employers to visits at this early stage appears to be extremely positive. However, a number of employers expressed their scepticism and/or low expectations of the service. Areas of concern appear to be that the service was related to enforcement in some way, and/or that the level of service that could be reasonably be expected for no charge would be minimal. Reassuringly, where these concerns existed, employers felt that these had been overcome.

*'.. mean when I first seen it I just couldn't believe it. I thought it was some consultant writing us a letter disguised as a Government body'*

(Managing Partner, Manufacturing Company)

*'Do you come in and find that hang on, we're not doing it and we've got cables trailing and are you gonna slap us and fine us or something. It was hang on, this is too good to be true but the fact that it was free meant that yes, it was worth me even contacting them and getting them in..... and they reassured me it was completely free, it's impartial, it's not legislative in the sense that if we were doing something wrong it's not hey, you get slapped'*

(Office Manager, Manufacturing Company)

Mostly, the service met or exceeded expectations.

*'My expectations were low.... I thought somebody would just come in and just say here are the leaflets, here's the booklets, this is it, and walk away literally'*

(Office Manager, Manufacturing Company)

*'I expected something that would answer my questions, point me in the right direction, tell me where I was going wrong..... And I didn't know how that would pop out, how it would actually present itself but all the things were touched upon. And my fears and concerns were assuaged and alleviated'*

(Director, Financial Services)

There is felt to be a distinct difference in the WHC model and an inspection. This difference was expressed as:

*"Look, we're here just to help you get it right. We can't do it for you, but we can get you started and help you get there....It was more than just business, it was being able to talk about the problems and how to compartmentalise it. It was almost like business counselling."*

(WHC central HSE team member)

The things that most appeal to employers are that the service is free, it's confidential, it's to the point, and they like the reports because they are not too long. Employers

realise that what has been discussed is only a small part of what a whole and effective health and safety system would look like, but generally they feel that they have made a start and that the tasks that WHC suggests for them to take on next are manageable. All the employers that we spoke to indicated they would use the service again, some said they would recommend it to others, and others that would like an annual visit/check. The majority thought that the service could not be improved.

## 6.2 Outcomes

Employers were not only positive about the service itself, but also about the changes they had made or were planning to make within their organisations. All of the eight employers interviewed, spoke about making some changes as a result of the Level 2 visit they had received. Changes varied from revising health and safety policy and rewording existing policy, conducting risk assessments, to seeking advice on introducing health surveillance and stress management. One respondent had partly used the visit to help manage her own stressful working environment.

### 6.2.1 Reinforcement

One aspect where WHC was felt to be useful was in reinforcing existing knowledge. One employer felt that WHC did not actually change their approach to health and safety, but help to identify what they were already doing right, or their existing approaches. Another felt that it had helped them to become more professional in their approach to health and safety.

*'So maybe I think she's probably getting us looking at it a little bit more professionally ..... doing training, using consultants. Yeah, I think that way she's probably getting us looking at it a little bit more professionally than we possibly were doing'*

(Managing Partner, Manufacturing Company)

The follow-up visit provided a further opportunity to ask any further questions or address any other concerns. It also provided reassurance that they were making progress in the right direction.

*'..but it did reassure me to know that what he'd suggested and the way I was going about it was the right way so - it was more of a reassurance thing than anything else'*

(Manager, Horticultural Company)

### 6.2.2 Providing momentum

Another issue for employers was that WHC provided the impetus to tackle health and safety issues. Additionally, some employers felt that it had helped their tasks seem more manageable and to therefore achieve progress in a shorter time, or that they now had a more proactive approach to workplace health.

*'It's really given us the kick start that we needed, otherwise it could have been you know, this could have dragged on for another 3-6 months so it's just really prompted us to get on with things and actually do it'*

(Office Manager, Manufacturing Company)

*'I guess, I needed to do health and safety risk assessments. I was doing quite a bit of reading but really needed help. I guess I could have done it by myself but this process sort of helped me to do it a little bit more quickly and in a bit more of an organised way'*

(HR Officer, Financial Services)

*'So we've set up an absenteeism database so that we can see if somebody's off on a particular day so they might have a particular problem at home on that day or things like that. So that we can address it as opposed to, oh well you're off every Monday, here's a verbal warning. It's instead you know well why are you off, is there anything that we can help you with? So it's certainly a more, we've got a more proactive approach now as opposed to a disciplinary approach'*

(Manager, Horticultural Company)

One respondent indicated that the changes that had been made had been on the drawing board for some time, but contact with WHC had focused people's minds.

*'OK right we've got to do that, got to do that. Not simply because there was any big stick wielded over us but you know, sort of focus people's minds. We've been looking at that, let's get it done'*

(Health and Safety Manager, Industrial Engineering Company)

### 6.2.3 Referrals

Apart from encouraging employers to take action, the fact that advisers then provided information on professionals who could continue to help employers in the future if necessary was also appreciated. In some cases, the WHC advisor had provided names of consultants where specialist support could be obtained. One respondent stated that the WHC advisor had given him the confidence to deal with a consultant.

*'And they gave us three competent providers to source what we needed from. So they told us roughly what we needed and then we had to get it, which was good. So because of that, I've now got the confidence to deal with the provider, knowing that we're not getting charged for something that we don't really need. So I'm quite happy to deal with them now, knowing that we're paying for what we need'*

(Managing Partner, Manufacturing Company)

## 6.2.4 Sustainability

All the employers we spoke to felt that they would be able to sustain the changes that they had implemented so far. Some stated that this was because they had been given the information and tools to work from, others intended to introduce additional training and felt this would help sustain the changes.

*'So once it's been in the system yeah, it won't be a problem maintaining it, we'll be able to do that. Especially when we've got like the health and safety rep training as well'*

(Managing Partner, Manufacturing Company)

Some stated that they felt small companies may need more than two visits to get their health and safety up to scratch.

*'I think it would be really, it would be a good thing I think, if it would be possible to get .... to revisit on an annual basis just to review the system, that would be excellent, that. I know it would be a costly thing to do but I mean that would be really good. I think companies of our size which aren't as aware on health and safety as what we are, I think they probably need a lot more than three to get them up to speed'*

(Managing Partner, Manufacturing Company)

## 6.2.5 A tailored approach

One of the things that employers appreciated the most about the service was that the service was tailored to their needs. Some stated that the advisor had work experience in their type of industry and this helped.

*'...especially with the way she come in and from an industrial environment where she used to work in. Possibly similar to what we've got here, she was ideal'*

(Managing Partner, Manufacturing Company)

*'But getting somebody coming in and you know, specific to helping us, understanding our business and what our issues are, and helping us deal with health and safety issues at work was really really great'*

(Office Manager, Manufacturing Company)

A few respondents mentioned that advisors had experience specific to their area of concern and that this was particularly useful.

*'She told us when she was here that she'd been heavily involved in health surveillance because she'd actually worked for a large company doing that. So she was really on the ball and tuned into what we needed. Really good, really good'*

(Managing Partner, Manufacturing Company)

Respondents found the first visit practical, tailored to their business, addressed their areas of concern, and many mentioned that it was good that it was helpful rather than related to enforcement.

*'We've read the material handling guides, and a lot of it we thought was more tuned into sort of an operation, a repetitive sort of operation environment where you were picking the box up and putting it in a certain place so many times an hour. But what our guys do, they'll not do the same thing twice so we were concerned how we've got like a general policy in place for material handling. She's helped us with that... She's helped us with advising us how to write a new risk assessment dedicated to material handling, which we're doing'*

(Managing Partner, Manufacturing Company)

In one case, the respondent was pleased that the advisor had focused on the issues that she wanted addressed rather than pointing out any/all health and safety issues in their work environment.

*'I felt they were mainly concerned about why I'd asked them to come in, about the health issues, about work life balance and about in general how I was going to improve my health and safety so that I could manage in a more productive way. Because I remember, I took them around, because I've got another classroom over there where we have the nursery, and I said to them something like I know you can probably pick out 100 things for health and safety reasons but please just focus on what I've shown you'*

(Manager, Education and Social Care Services)

## 6.3 Chapter Summary

Satisfaction with Level 1, as recorded by advisers, is very high, with 73 per cent of users stating that they are very satisfied with the advice they receive. Employers interviewed in depth by the evaluation team were also very positive about the service. In some cases it had been used solely as a means to access Level 2 provision, but even these employers suggested would use Level 1 services in the future to deal with health and safety issues now that they are aware of what the service can offer. The Level 2 visits also received very positive feedback and advisers also feel that employers appreciate the service. There were some issues whereby employers were initially sceptical about the free and confidential nature of the service, but universally this has been overcome. Employers particularly appreciated the tailored approach of the service and the fact that advisers dealt with the issues most important to them as a priority.

The limited number of employers interviewed for the research identified a number of outcomes that had occurred as a result of their contact with the WHC service. These included:

- The reinforcement of their existing knowledge and greater confidence about the application of this knowledge.
- Providing momentum to make changes that were either long overdue or which would have taken much longer to achieve without the help of the Level 2 advisers.
- Referrals onto other sources of support which they felt would help in making future progress.

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## 7 Quality Issues

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A final aspect of the work of WHC so far is ensuring that the quality standards of the service are met and monitored. Considerable efforts have been undertaken to determine how best to ensure the quality of the WHC experience for users, including the development of a detailed quality manual setting out protocols for all service providers. This chapter presents some limited data relating to quality issues.

### 7.1 Measurable quality targets

The CMS provides data on various quality targets and this is supplemented by monthly quality reports compiled by central HSE staff. These measurable targets are generally being met (Table 7.1). All pathfinders have been able to meet or come close to meeting their targets with respect to the time taken to call referrals back, offering initial visits within five working days and issuing initial visit reports within five working days. Since WHC has been live for only four months not all quality indicators are informative. Only a small number of second visits have taken place to date, and a number of customers are not interested in taking the second visit, finding that the first visit meets their requirements in full. A total of 141 visits were cancelled over this four month period between individuals agreeing for a pathfinder to contact them at the adviceline stage, and the pathfinder making contact (adviceline data: Weekly report 07/07/06).

In almost all cases (99 per cent) Level 2 advisors felt that they were aware of the topic area in question without needing to research supporting information. In the four cases where supporting information was required, all advisors reported that it was readily available. Additionally, in 99 per cent of cases Level 2 advisors felt that the visit had been useful for that employer.

Table 7.1: Quality indicators for visits and adviceline calls

Indicator	Region					
	London	West Midlands	North East	North West	Wales	All
Number of follow-up visits conducted	11	1	6	9	7	34
Number of follow up visit letters/report updates issued	8	1	4	11	7	31
Number of final (three-month) follow-up calls completed	0	1	4	2	0	7
Referrals called back within one hour, or at time requested (%)	100	100	100	97.5	100	99.5
Initial visits offered within 5 working days (%)	100	95.0	100	97.5	100	98.5
Initial visit reports issued within 5 working days (%)	100	100	100	100	100	100
Number of visits cancelled or resulting in a wasted trip (estimate)	13	1	0	6	2	22
No. of employees visited	894	1,189	656	512	238	3,489

*Source: PMC Monthly Report May 06*

### 7.1.1 Completing the data

The most recent Project Management Contractor (PMC) report (at the time of this report) suggested that there were still a few Pathfinder areas where data completion is slower than expected, such that central reporting and evaluation data collection is a time-consuming manual process. This topic will also be addressed further in the coming month, with a training consolidation/ review day planned for administrators and service managers.

In addition, there have been some early problems for the adviceline in completing their data requirements. This is an issue because they have to collect a lot of data on callers and there are different requirements depending on whether the person accepted a visit or not. This data then serves two purposes, it goes forward to the PMC to map onto the CMS for monitoring and evaluation purposes, and secondly it goes straight to pathfinders to allow them to contact employers direct.

There have been a number of problems which have been resolved or are currently in the process of being resolved, these include:

- The mapping between the adviceline and CMS systems wasn't exact, such that differences in data definitions existed between the two, but this has now been ratified.
- The interpretation of which data fields were mandatory took some time to check through and determine, but this is now clear.

- Missing and incorrect data existed within a number of fields. Advisers have now been fully briefed on the purpose of each data field and now feel more confident in collecting data which has been reflected in improved accuracy (from 50 per cent to over 90 per cent accuracy by June 2006), although this has meant that more time needs to be spent in manually checking records.
- The data definitions were changed a number of times leading up to and following the service launch (as a response to emerging issues), although the final data definitions now seem to be in place.

## 7.2 Reflections on quality issues

During visits to the pathfinders, a number of issues related to meeting and monitoring quality standards were raised. These relate to data and administrative issues, follow ups with employers and the checking of the quality of advice received.

### 7.2.1 Data transfer

A number of pathfinders identified problems with the data they receive about potential clients. Sometimes there are inaccuracies, or insufficient detail, and this can affect how they start their relationship with employers. There has been some criticism of the lack of a direct communication route to the adviceline (Level 2 advisers are not allowed to contact Level 1 advisers directly), all queries need to go through the PMC, meaning that it is not possible to quickly check details. However, there are concerns that allowing this type of communication could tie up Level 1 advisers so it is unlikely that this will change, despite the obvious frustrations.

### 7.2.2 Setting up visits

The process of setting up visits, does appear to have run fairly smoothly, but it can be difficult to get hold of employers within one hour of their call to the adviceline. Normally when visits take place out of the specified time frames this is due to the requirements of employers rather than administrative pressures at the pathfinder level. However, the need to make a further call in advance of the visit is sometimes thought to be unnecessary and/or clumsy as employers are often not available to take that call. There have also been some complaints from small businesses in some areas that they receive too many phone calls before they receive a visit.

*'I sometimes think that's an excuse for them to cancel the visit.'*

(Level 2 adviser)

### 7.2.3 Follow up visits

Follow up visits are proving more difficult to organise and some pathfinders identify employers as trying to cancel or postpone fairly regularly. In a number of pathfinders the time between first and follow up visits tends to be longer than the suggested one month as employers do not feel able to action all the points made in the first report within one month. Typically the follow up visits appear to be taking place around six weeks after the first visit in some areas. Some pathfinders are also making efforts to 'sell' the follow up visits by ensuring that employers are clear that the meeting is to review actions rather than inspect progress in any formal sense. One adviser identified the reasons why employers are less keen on follow up visits as:

*'Often because they feel as if they've done everything they need to do, or they feel that they haven't done it and they feel under pressure.'*

(Level 2 adviser)

There was also a sense from employers that the time between the first and follow up visits was insufficient in some cases. One respondent would have preferred to have received a follow-up visit at a much later date and suggested more flexibility around visit dates.

*'I like, I mean I would love, it would have been better if it were worked out if I had started filming and he could have come out again, which would have been great. And maybe by then we would have had some of our locations that he could have looked at. But, so ideally you know I'd like somebody to come again once we're nearer filming but apart from that, I think it was really helpful'*

(Line Producer, Film Company)

Another employer felt that the gap between the first and second visit was too long and that this may lead to things being put to one side.

*'I would have liked to have been contacted a little bit more because they left, I think it was a couple of months something or, they left quite a gap in between the first visit and the second visit. And obviously things get left and things get put to one side'*

(Manager, Education and Social Care Services)

Overall, the eight employers interviewed for this evaluation report found the feedback report and follow-up visit useful for providing a deadline, and a motivation to address the issues highlighted in the first visit. Respondents found the information in the report provided to be accurate, comprehensive and useful. Some stated that it was useful to have an action plan and something to refer back to/work from. It provided minutes of the discussion, things to do, where to get further information.

*'I mean I think it's a case when you know, she highlights certain things and advises you how to get it and I mean it's like minuting the meeting isn't it really. I'm thinking when's the next meeting, right I've got to get this sorted out for her coming back. You know so it*

*gave us a little bit, where it's pushing us to get these things done, which you really need to get, you really need that'*

(Managing Partner, Manufacturing Company)

#### 7.2.4 Monitoring the quality of advice

An additional concern for the HSE, aside from these data issues, is ensuring that the quality of advice given on employer visits meets WHC standards. The main tool for checking this has so far been the reports issued by pathfinders to employers, but there are problems with this. The report itself is designed to address the needs of users specifically and should therefore be relatively short, easy to interpret and clearly outline the type of steps that need to be taken to deal with specific issues identified. What it doesn't contain is the detailed background information required for inspectors to check that the advice given is fit for purpose (eg it doesn't tell the employer the size of their company or detail the type of work undertaken on site because the employer already knows this).

It is not possible for HSE staff to accompany advisers on visits, as there is potential conflict with warranted inspectors going on to employer premises and seeing problems that need to be dealt with as matters of evident concern. This could jeopardise the relationship that pathfinders have built up with employers. There are plans to recruit or second non-warranted occupational health experts onto the WHC team who could conduct these visit observations, and this could begin during Autumn 2006.

In order to monitor the quality of advice provided to adviceline callers, there are also plans to implement a 'mystery shopper' system. Around 100 calls per quarter will be made to the adviceline with a range of scenarios provided by the HSE alongside the type of responses that would reflect a high quality response from the Level 1 advisers reflecting the key topics (rather than the detail) that need to be dealt with. Mystery shoppers will also rate the soft skills of advisers by considering their overall experience (eg are they reassured, was the person patronising, was the advice provided at the right level, did they feel listened to?). This approach will also allow quality checking of the data inputting of advisers.

All pathfinders are also undertaking some form of quality assurance themselves. Adviser reports are often checked through by service managers, in some areas all reports are checked, whereas in others this is a sample. Service managers often accompany advisers on some visits, and new staff are allowed to extensively shadow visits during their first few weeks in some areas. In one area there are plans to introduce adviser checklists to check quality and determine whether some are providing better results for their clients than others.

## 7.3 Chapter Summary

Overall, the Level 1 and Level 2 services are meeting their quality targets. There have been some issues in completing the necessary data, particularly amongst Level 1 advisers who are required to feed information to the evaluation team and provide referrals information for Level 2. However, the accuracy levels are now increasing, although this does take up more adviser time than had been anticipated. 'Mystery shopper' calls have recently started which will provide some checking of both the accuracy of data entry, but also and more importantly the quality and relevance of advice given at Level 1.

At Level 2, it has been difficult to assess in any depth the quality of visits as HSE warranted inspectors cannot observe actual visits due to confidentiality and trust issues. They are therefore reliant on visit reports so far to check quality, but these do not provide the depth of information required for this purpose as they are designed to provide focussed feedback to employers. However, recruitment is underway for occupational health and safety experts who could undertake this observation on HSE's behalf. Further data on quality issues for both Levels 1 and 2 will therefore be available in future evaluation reports.

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## 8 Conclusions So Far

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This evaluation report discusses just four months of the operation of a totally new service. To date the majority of data collected for the evaluation is concerned with process issues rather than impact. It is therefore difficult to draw any definitive conclusions about the service at this very early stage, but we raise some general points in this final chapter.

### 8.1 Reflections

The first point to note is that the evidence so far available does suggest that the WHC model (both Levels 1 and 2) is extremely successful in:

- receiving positive responses from these employers, customers are 'satisfied' so far
- tailoring the overall model to meet the needs of employers, as employers see them
- engaging advisers who appreciate the opportunity to work within the model and believe it is successful overall
- building relationships with employers where they are able to be open about the health and safety issues they face.

While there are some very positive messages emerging therefore about employer responses to the service, it needs to be stressed that these are based on only very limited evidence so far. On the same basis, it appears that the WHC offer is appreciated because it is free, credible and does not adopt a punitive approach. Monitoring employer views over the longer term and providing more supporting evidence for these claims will take place as part of the overall evaluation, starting in September 2006.

### 8.2 Level 1

The main issues so far for the Level 1 service appear practical. The first of these has been completing the necessary data for use by the evaluators and Level 2 advisers.

There has, however, been a dramatic improvement in the quality of information provided by Level 1, but this is not without costs, and advisers are required to spend much longer per call than had been anticipated as they need to check through data they submit carefully. Another issue is the low numbers of callers coming through central marketing. In response to this the marketing for Level 1 has been changed both in terms of message (safety from health) and targeting (national from regional) which it is hoped will generate greater call volumes.

Overall, satisfaction with Level 1 appears very high, although it will be necessary to check this when independent data becomes available at a later date. It is also very encouraging that the referral rate to Level 2 is almost double what had been predicted, demonstrating that there is a high level of interest in the service and that Level 1 advisers are successfully 'selling' Level 2. Mystery shopper activities will also provide further validation of the quality of advice provided in future.

### 8.3 Level 2

The challenge for Level 2 providers in contrast is more fundamental. There is no longer a lack of referrals, despite a relatively slow start. The challenge now is therefore ensuring that the WHC offer meets the needs of employers but also delivers in terms of the overall model set out by the HSE. Employers want advisers to focus on issues that they have identified for themselves as a first priority, an exercise which builds adviser credibility and trust, only then can advisers move onto new issues and primarily health issues. In some cases, therefore, the focus on health may not happen until the second visit. This does have implications for the overall success of the service.

Some employers are reluctant to take up second visits, perhaps more so in cases where they have been able to make little progress since the first visit. There are therefore two issues here, firstly that employers most in need of a second visit (because they are the ones with the least developed awareness or most limited resources) may be the ones reluctant to take them up affecting the degree to which WHC can have an impact. Secondly, the absence of a second visit for some employers may mean that some health issues are not discussed in detail at all in some cases.

### 8.4 Messages

Despite the use of a number of specialist consultancies, getting the marketing right for the service has been difficult, but lessons have been learnt and the approach adapted accordingly. What is interesting is the concerns which employers identify with and those they do not. The main focus of the service is obviously workplace health, but employers are not calling for help with health or back to work issues in any great numbers.

This leaves WHC with three options:

1. *Introduce health issues largely 'through the back door' by dealing with them during the second visit and not making health the focus of the service in a visible way.* The issues for this approach are to understand the prompts which switch employers onto occupational health. Regional outreach, for example, could be a more effective method of putting forward health messages than is the case for central marketing. This is because it has the potential for advisers to build closer connections with employers, allowing advisers/outreach workers to discuss the benefits to employers of fixing occupational health issues on their agendas.
2. *Move away from health because employers aren't interested, focussing on the safety issues that present themselves.* This approach would hope to develop greater generic awareness amongst employers about health and safety issues, and accept (or hope) that health will eventually move up the agenda.
- 3 *Carry on pushing health, effectively 'holding your nerve'.* Work on other initiatives (eg Constructing Better Health) show that selling a 'health' service to employers is very difficult but that it can be achieved (within a specific sector) with repeated approaches which push home the importance of health. This does, however, take significant time and resources.

There is clearly a role for WHC not only in tackling the incidence of ill health in UK workplaces, but also in spotlighting occupational health more generally. The work of the WHC pilot activities will help to develop a better understanding of this can be taken forward most effectively.

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## Appendix A

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The eight employers who were interviewed to provide some early user feedback included representatives of:

- A horticultural company employing 23 staff.
- A sheet metalwork and material handling manufacturer with 17 employees.
- A Film company with 70-80 people onsite at each location filmed at numerous locations.
- A manufacturer of high-tech 3D imaging devices with 12 employees.
- A financial advice company with 11 employees.
- The UK branch of a foreign-owned bank with 25 employees in the UK.
- Plane cutters employing 100 people.
- An extended schools programme at a primary school employing 22 staff.