Sustaining and Embedding: A Strategic and Dynamic Approach to Workplace Wellbeing

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Acknowledgements. This work was supported by Economic and Social Research Council Grants ES/N003586/1 and ES/S012648/1.

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For: Wellbeing at Work in a Turbulent Era, eds. Brough & Kinman

Abstract

Much research on practices to improve workplace health and wellbeing focuses on specific ‘interventions’ or combinations of ‘interventions’. In this stream of research, an intervention is a specific and discrete organisational action mandated by management with a planned and specific target. However, organisations typically can and do adopt multiple workplace health and wellbeing practices in a strategic and evolving programme. In the current chapter, we outline a model of how organisations sustain, embed and change patterns of workplace health and wellbeing practices over the longer term in coherent and strategic programmes. We suggest that this adaption of programmes is especially relevant in the current turbulent era we find ourselves in, post-Covid.

Much of the current literature on health and wellbeing interventions focuses on discrete interventions and individual health and wellbeing outcomes (Burgess et al., 2020) underpinned by rational models of planned change (cf. Mintzberg, 1994) with a tendency to view the organization as a field or context within which workplace health and wellbeing practices take place (Russell et al., 2016), rather than seeing an intervention as one element of a stream of organisational actions that address multiple, sometimes conflicting priorities (Fuller et al., 2019). In contrast, in the current chapter, we outline a model of how organisations sustain and embed patterns of workplace wellbeing practices over the longer term in coherent and strategic programmes.

The rationale for a model concerned with longer term strategic health and wellbeing programmes is three-fold. First, best practice guidelines for workplace health and wellbeing advocate the use of multiple health and wellbeing practices addressing both prevention and rehabilitation that are actively managed and subject to continuous improvement processes, rather than stand-alone interventions (ISO, 2018; LaMontagne et al., 2014). Second, and consistent with best practice guidelines, quantitative surveys of organisational practices (Batorsky et al. 2016; Mattke et al., 2015) and case study evidence (Daniels et al., 2022a; Johnson et al., 2018; Jordan et al., 2003) indicate some organisations do indeed adopt multiple health and wellbeing practices in managed and evolving programmes. Third, to help organisations sustain employee health and wellbeing over the longer term, it is important to understand how organisations adjust their health and wellbeing activities to changing environments and priorities, both during periods of slow, incremental change and during turbulent periods of radical change.

Our model provides a complementary perspective to intervention research. Intervention research is primarily focused on understanding whether, how, why and in which circumstances specific interventions (e.g., job redesign) or combinations of interventions

(e.g., job redesign introduced alongside health promotion and resilience training) have effects (Fridrich et al., 2015; Nielsen & Randall, 2013; Nielsen & Miraglia, 2017). Our complementary perspective focuses on how programmes of interventions develop, evolve and change over time. This complementary perspective is able to subsume the practices that are part of a planned organisational approach that form the basis of the vast majority of studies on interventions (Daniels et al., 2021). The perspective is also able to incorporate workplace health and wellbeing practices that emerge from outside of a planned approach and the awareness of key managerial decision makers but that become subsumed into the overall programme over time.

The chapter proceeds as follows. First, to frame the gap in our understanding of health and wellbeing programmes that our complementary approach addresses, we provide a brief overview of research on the implementation of specific interventions. We then introduce the major elements of our model. Finally, we consider how rapid organisational change and turbulence can affect organisational actions around worker health and wellbeing. Rapid change and turbulence may bring or be caused by new threats to employee health and wellbeing. However, organisations may also struggle to maintain a focus on employee health and wellbeing during periods of turbulence and rapid change because of competing priorities (e.g., organisational survival) and/or resource constraints.

The case for complementing intervention research

Classifications of workplace health and wellbeing practices (e.g., Daniels et al. 2021; LaMontagne et al., 2007; Richardson & Rothstein, 2008) typically differentiate: i) primary interventions focused on job/organisational redesign; ii) primary interventions focused on workplace health promotion; iii) secondary interventions focused on training individuals to manage their on exposure to risks; iv) tertiary interventions focused on rehabilitation of

workers that have developed health conditions; v) multicomponent interventions that combine elements of other interventions.

Intervention research, focused on examining the effects of specific and discrete interventions or combinations of interventions, is important for several reasons. First, with appropriate counter-factuals, intervention studies have the potential to provide some of the most robust, ecologically valid inferences on the causes of different facets of health and wellbeing in working age adults (cf. Cook et al., 1990). For example, randomised control trials or quasi-experiments of job redesign can therefore potentially provide robust evidence on whether psychosocial hazards are causes of poor psychological wellbeing. Second, intervention research can provide sound evidenced-based arguments to aid decision makers (e.g., governments, organisational managers) in deciding on what types of interventions can be effective in workplaces. Third, if intervention studies also analyse the impact on a range of indicators of productivity, including factors such as absence or staff turnover, (Daniels et al, 2022b; Patey et al., 2022), the cost-effectiveness of interventions can be established, providing an economic case for choosing some interventions ahead of others. Finally, with appropriate analyses of the processes of implementation, intervention studies can provide decision makers with guidance on how best to implement and manage specific interventions (e.g., Murta et al., 2007).

Intervention research does indicate a range of interventions can be effective in protecting and promoting workers' health and wellbeing, although these benefits are dependent on how the interventions were implemented (Daniels et al., 2021; Egan et al., 2009; Fridrich et al., 2015; Nielsen & Randall, 2013). Implementation is 'the dynamic process of adapting the program to the context of action while maintaining the intervention's core principles' (Herrera-Sanchez et al., 2017: 4). In a systematic review covering all of the categories of workplace health and wellbeing interventions identified above, Daniels et al.

(2021) identified a number of critical success factors for interventions to produce beneficial effects for workers' health and wellbeing.

One of the factors identified by Daniels et al. (2021) was that tangible changes in workplaces were required for interventions to produce benefits. Put another way, managerial rhetoric and statements to the effect of action will be taken in the future are insufficient to produce benefits. Tangible actions may unlock the theoretical mechanisms that underpin intervention design: That is interventions may work as they were intended to.[1] However, Daniels et al. (2021) found evidence that a range of other processes could explain why interventions have beneficial effects. Studies indicate that interventions can have benefits through unintended mechanisms including promoting self-care (Daniels et al., 2022a; Fitzhugh et al., in press), changes in workplace norms around health behaviours (Daniels et al., 2021, 2022a), and a range of social processes that promote social support, social identity and psychological safety (Daniels et al., 2021, 2022a; Musgrove, 2023; Haynes et al., 2022). In their review, Daniels et al (2021) also found that other factors related to successful implementation of workplace health and wellbeing interventions were: "continuity of effort and adaptation of interventions, supported by functional learning and governance structures" (p 11). Another important finding was that a range of barriers to implementation did not necessarily prevent interventions from having beneficial effects. Barriers included constrained resources, wider economic pressures and unfavourable attitudes held by workers, middle or senior managers.

The main factors that support implementation of specific interventions identified by Daniels et al. (2021) might generalise to whole programmes of practices that evolve over time (Daniels et al., 2022a). Indeed, within evolving programmes, some of the mechanisms

[1] If interventions work in the manner intended, this provides ecologically valid evidence for the theory or model underpinning intervention design.

that promote the success of specific interventions could be magnified in wider programmes by consistent and authentic signalling by the organisation of the importance of worker health and wellbeing (Nayani et al., 2022, see below). However, there are also reasons to suspect that applying lessons from intervention research to wider programmes may not provide the whole picture (Daniels et al., 2022a). What applies to a specific intervention may not apply to a wider programme of practices that evolves over time, perhaps many years.[2] This pertains not just to the added complexity of managing a programme of practices as compared to time-limited discrete interventions, but also to phasing out interventions that are no longer needed and introducing new interventions as they are needed or emerge as solutions to previously intractable problems. Further, over extended periods of time, organisations themselves will change and evolve, and there needs to be some exploration of how changing workplace health and wellbeing practices come to be accommodated with changes in other aspects of the organisation. In contrast, intervention research is concerned with investigating specific and pre-defined interventions with a limited timeframe,[3] wherein which the organisation is assumed to be in a steady state excepting any changes directly made to implement the intervention (Russell et al., 2016). Any other organisational changes that occur during the limited timeframe of an intervention study may be treated as contextual noise or a nuisance that has affected the fidelity with which an intervention was implemented, rather than a naturally occurring aspect of organisations. Further, by focusing on a specific intervention, researchers may understandably conclude that contextual factors led to failure to implement the focal intervention yet not notice that another health and wellbeing intervention was

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[2] Although we are unaware of any research data on the topic of longevity of health and wellbeing programmes, some of the organisations we have worked with or are otherwise familiar with have pursued health and wellbeing strategies over several years, in some cases decades.

[3] This may reflect either the resource constraints of intervention research and/or that a typical intervention study is concerned with whether a specific intervention works, how it may work and how it can be made to work. In the latter case, researchers may, resources permitting, only stay in the field for as long as it reasonable for an intervention to have an effect. In the case of interventions included in Daniels et al.'s (2021) review, some 70% of studies had a follow-up of 12 months or less, 92% had a follow-up of 24 months or less and 99% had a follow-up of 48 months or less.

implemented instead to suit changing circumstances. Indeed, researchers may not even be engaged in the field after the focal intervention for the research has been abandoned.

In sum, although there are clear benefits advantages for pursuing research on specific interventions, there is also a case for examining how programmes of health and wellbeing practices develop, are sustained and evolve over extended periods. This is because it cannot be assumed that findings from intervention research can be readily transferred to wider programmes and/or that other factors need to be considered. Moreover, by examining health and wellbeing programmes over the longer term, it may become more readily apparent how organisations are able to negotiate any tensions that occur between evolving workplace health and wellbeing programmes and other dynamic aspects of organisations.

A model of implementing workplace health and wellbeing programmes

To develop our understanding of the actions organisations can take to protect and enhance worker health and wellbeing over the longer term, we developed a model that, compared to traditional intervention research, is focused more on the organisation and the range of practices (discrete interventions) that could be integrated into a programme of workplace health and wellbeing practices (see Daniels et al., 2022a for a more detailed explanation of the model). Some of these practices could be focused on the entire organisation, others on specific locations, departments, occupational or demographic groups. Figure 1 illustrates the model.

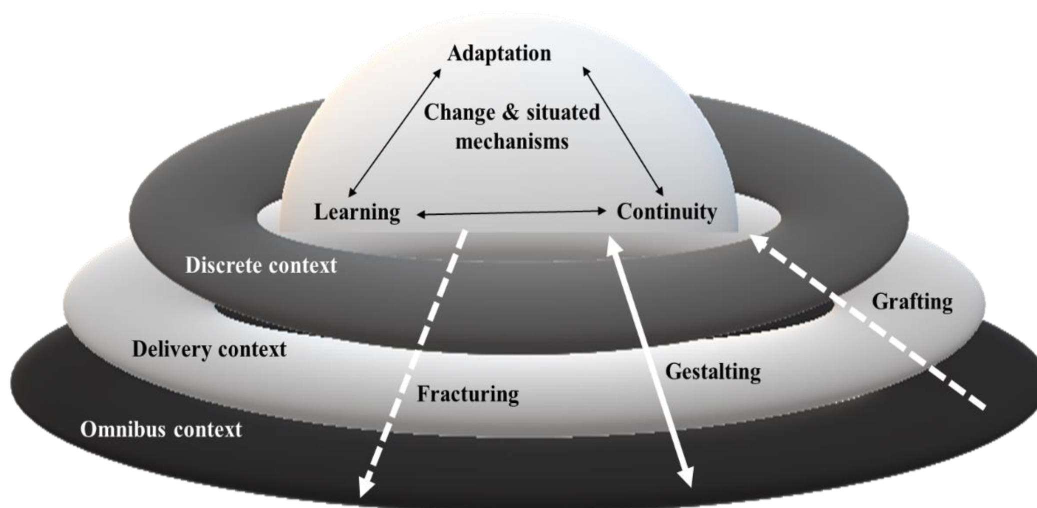

Figure 1. A model of how organisations implement and sustain workplace health and wellbeing programmes.

Adapted from: Daniels, K., Tregaskis, O., Nayani, R., Watson, D., (2022a). *Achieving Sustainable Workplace Wellbeing*. Dordrecht: Springer Nature.

One important basis of the model was the recognition that organisational strategies reflect a pattern in a stream of decisions, behaviours and practices (Mintzberg & Waters, 1985, p 257). Following Mintzberg and Waters, and Fuller et al.'s (2019) application of these ideas to workplace safety, we recognise that workplace health and wellbeing strategies do not need to follow rational planning approaches advocated in much of the intervention literature (see Daniels et al., 2022a, chapter 2 for a review). Rather, some planned practices may never be realised, and some practices may emerge from the behaviours of organisational actors without explicit planning, but which may come to be adopted when recognised as useful by key decision makers.[4] Therefore, we can conceptualise a strategic approach to workplace

[4] We prefer the term health and wellbeing practice to the term health and wellbeing intervention in this context. This reflects both that such practices need not be planned 'interventions' as such and that the interventions literature itself is concerned with formal evaluation by scientific research teams. In many organisations, formal evaluation by scientific research teams or consultants may be the exception, and many organisations may not even evaluate the effects of specific practices in ways that would be considered scientifically appropriate.

health and wellbeing as one that reflects an on-going pattern of health and wellbeing practices in a workplace that is formally managed to a greater or lesser extent and can include elements that are planned, some elements that are never implemented even if planned and some unplanned elements that are brought into an overall organisational approach to health and wellbeing. Importantly, the definition of a strategic approach to workplace health and wellbeing as an *on-going* pattern of practices implies dynamism, rather than just the introduction of discrete interventions.

At the centre of the model are continuity, learning and adaptation. These are three key processes identified by Daniels et al. (2021) that explain how a health and wellbeing practice or series of connected practices are implemented and the consequent activation of contextually situated mechanisms. Continuity, learning and adaptation are reciprocally related. For example, efforts directed toward continuity and learning enable adaptations to unanticipated and/or changing circumstances. Adaptations enable further continuity and further learning. It is activated mechanisms that confer health and wellbeing benefits to workers, although as noted above, these mechanisms may or may not reflect the mechanisms intended by the practice's designers. Without continuity, learning and adaptation, other contextual factors such as senior manager or line manager antipathy, resource constraints or disruptions can inhibit either implementation and/or the activation of mechanisms. In the following sections, we outline some of the key, novel components of the model in more detail. These relate levels of context, grafting, fracturing and Gestalting.

Levels of context. Drawing from intervention research (e.g., Nielsen & Randall, 2013; Fridrich et al., 2015), our model also builds on Johns' (2006) distinction between discrete and omnibus contexts. The omnibus context represents the wider organisation and its environment (operational procedures, overall strategy, economic conditions). The implementation of specific health and wellbeing practices represents the discrete context

(such as service provider characteristics, employee attitudes to the intervention). For specific practices, it is the discrete context where tangible changes activate mechanisms, supported by continuity, adaptation and learning.

However, because our model is concerned with implementation (and possibly modification or withdrawal) of multiple practices over time, in between the omnibus and discrete contexts, we introduce the notion of the delivery context. The delivery context is the space through which multiple practices are implemented and co-ordinated by key actors (e.g., occupational health and human resources professionals, other managers and workers with responsibilities for health and wellbeing). Governance structures and consultative processes in the delivery context provide the means to transfer learning from implementing other health and wellbeing practices (i.e., other discrete contexts, past or present, e.g., other practices, from other locations) to a given discrete context (i.e., specific, current intervention) so that it is adapted. Moreover, governance structures and consultative processes in the delivery context are a means of capturing learning from a focal intervention to apply to future interventions. In this way, capabilities can be developed through longevity of programmes (see also von Thiele-Schwarz et al. 2016; Zollo & Winter, 2002), so that resources (financial and material, symbolic and discursive) can be leveraged to aid more efficient implementation.

We (Daniels et al., 2022a) have identified a range of implementation and co-ordination functions of the delivery context. These relate to: the preparatory work of needs assessments; informing relevant stakeholders of the actions that will be taken; programme planning; ensuring appropriate levels of resourcing; communications and information provision; co-ordinating multiple practices or service providers; incorporating practices initiated by workers and not included in initial programme plans; managing the tension between implementing standardised practices across an organisation and tailoring practices to specific groups or locations, and monitoring progress.

However, we (Daniels et al., 2022a) also identified political and symbolic functions of the delivery context, which relate to the political and symbolic processes required to initiate and implement change (see e.g., Gersick, 1991; Johnson, 1987, 1990; Westover, 2010). One of most straightforward political tactics relates to involvement of a range of stakeholders in programme design and/or implementation. Involvement is important for tailoring and adapting (Cherns, 1987) but is also important for discerning the acceptability of different options to different stakeholder groups, as a mean of signalling the importance of health and wellbeing to stakeholders (Johnson, 1987) and as a means to overcome resistance through co-opting resistant stakeholders into learning and governance structures (Swan & Fox, 2010). As key enablers or blockers of change (Balogun, 2003; Currie & Proctor, 2005), we identified another symbolic tactic of programme designers promoting early adopting line managers of new practices as role models to other managers. Routinised practices can symbolise what is important and valued by an organisation (Schein, 1985; Johnson, 1987). Regular consultations around wellbeing (e.g. staff question and answer sessions, toolbox talks) and incorporation of health and wellbeing concerns into other organisational routines (e.g., performance appraisals in our study, Kaizen procedures in von Thiele Schwarz et al., 2016) can perform these symbolic functions and therefore help with implementation of a range of health and wellbeing practices.

The delivery context itself can influence worker health and wellbeing over and above that of the constituent components. Organisations that adopt multiple health and wellbeing practices send stronger signals of care for employee health and wellbeing. In turn, such signals may influence workers to adopt healthier behaviours through changing workplace norms (Jia et al., 2018) and improve perceptions of organisational support (Haynes et al., 2022) that enhance (psychological) wellbeing. Such signals can be magnified if accompanied by management actions that communicate, reinforce and legitimise the implementation of

workplace health and wellbeing practices (Bowen & Ostroff, 2004). Examples might be senior managers giving speeches about their own wellbeing and being visibly engaged in programme governance.

Grafting, fracturing and Gestalting. The delivery context is also the space in which factors in the omnibus context and discrete contexts are reconciled. Mechanisms and variables that might be important in the discrete context of health and wellbeing practices must be aligned or take account of influences of the omnibus context, but this is not a uni-directional relationship. There are three processes that link the discrete context to the omnibus context through the delivery context. These are *grafting, fracturing* and *Gestalting*.

Grafting is defined as adapting a health and wellbeing practice (or practices) so that it is implemented in a way that is compatible with other organisational procedures, practices and structures. That is the omnibus context influences the discrete context. Grafting enables multiple objectives to be pursued in ways that are compatible with each other (e.g., productivity, wellbeing) rather than in conflict with each other. Ensuring compatibility with existing procedures, practices and structures has been recommended in prior reviews and conceptual models focused on workplace wellbeing interventions (e.g.,, Daniels et al., 2017; Knight et al. 2019; Nielsen & Noblet, 2018; von Thiele Schwarz, et al., 2021) as well as in several generic models of organisational change (e.g., Armenakis et al, 1993; Kotter, 1995). Grafting also appears to be the default approach adopted in organisations to the implementation of health and wellbeing practices (Daniels et al., 2022a) presumably because it offers the route of least resistance to implementation.

Examples of grafting include the use of existing meeting structures to discuss how to improve health and wellbeing (von Thiele Schwarz et al., 2017), formalising an already informal peer support process by having peer supporters nominated by colleagues (Busch et al., 2017), developing interventions to ensure compatibility with existing social norms or

routines (Braganza et al. 2018); and, adding a decision aid to the usual diagnostics used by occupational health physicians (Volker et al., 2015, 2017). In our empirical research (Daniels et al., 2022a), we found grafting can also involves repurposing existing practices or resources for health and wellbeing practices, such as staff intranets, meetings or meeting rooms.

Fracturing is defined as changing the organisation to be compatible with a health and wellbeing practice (or practices) by replacing old processes, structures and structures with new ones. That is the omnibus context is influenced by the discrete context, so that there is a break with existing ways of doing these. Fracturing is about seeking conflict. Conflict may be inevitable during change (Johnson, 1990), but also seen as manageable (Westover, 2010). Fracturing itself may therefore represent changing organisational practices, for example in our research we found examples of redesigning performance appraisals systems or even entire HR systems (Daniels et al., 2022a). Other examples include openly challenging behavioural norms, around for example existing work routines (Chapleau et al, 2011) or other workers' performance (Daniels et al., 2022a). Fracturing may be more salient where harmful behaviours and norms are prevalent (e.g., unsafe working practices, abusive supervision, long hours cultures). One example from the literature is an intervention that included training in how to challenge others' unsafe behaviours in a high hazard manufacturing environment (Tregaskis et al., 2013).

Gestalting is defined as bringing different wellbeing practices and other organisational procedures, practices and structures together for simultaneous change in order both to meet common goals or interpretation and hence reduce conflict. That is the omnibus and discrete contexts mutually influence each other. Gestalting processes may be focused on sensemaking/sensegiving (from the work of Weick, 1995) i.e., through visionary and symbolic leadership (Westley and Mintzberg, 1989) and experiential learning (Lewin, 1944; Burnes and Cooke, 2013). One example in our research was an organisation that incorporated

health and wellbeing as a core value of the business and therefore part of the underpinning business model (Daniels et al., 2022a). Other examples include bringing together corporate social responsibility and wellbeing initiatives under a single steering group (Daniels et al., 2022a), integrative workshops to bring together elements of a complex intervention (von Thiele Schwarz et al., 2017) and bringing different stakeholder groups together in communities of practice for shared learning (Mabry et al., 2018). In addition, having an integrated, coherent and communication health and wellbeing strategy is itself an example of Gestalting.

It should be noted that grafting, fracturing and Gestalting are not mutually exclusive, but can co-occur or occur in sequence. For example, workplace health promotion may have a role to play triggering changes to cultural norms around health and wellbeing (fracturing existing norms), therefore making it easier/more acceptable to implement more complex practices around job and process design (grafting onto new norms).

It is possible to think of grafting, fracturing and Gestalting as means of managing tensions and conflicts between workplace health and wellbeing practices and other organisational processes. It is also possible to think of these processes as reflecting means of managing the tensions and conflicts between the logics underpinning the choices in regard to addressing employee health and wellbeing and the logics underpinning other choices concerning organisational processes. Following Prahalad and Bettis (1986), we view logics as organisational actors' cognitive schemas of the organisation, its environment, goals and priorities. Different logics can be shared to a greater or lesser extent across an organisation or across separate groups (Daniels et al., 2002). Because organisations, their environments and their employees change, so do different logics (including logics related to health and wellbeing), so that there is a continual need to find ways of managing the tensions and conflicts between health and wellbeing logics and other competing logics. One approach to

managing tensions between logics is to make material changes to health and wellbeing practices or other organisational processes. However, given that logics are social-psychological phenomena, stakeholders can also deploy symbolic and discursive devices to manage tensions (Lawrence & Phillips, 2019)

Health and wellbeing programmes during periods of disruption

One reason organisations may adopt workplace health and wellbeing strategies is to develop a sense of reciprocal exchange between employees and the employer. In this line of thinking, an employer provides a workplace that protects or even enhances employee health and wellbeing (through the way the work is organised, social relations at work, terms and conditions as well as overtly wellbeing/health focused practices such as mindfulness training), then employees will respond positively with enhanced commitment, motivation and performance (Guest, 2017). However, during times of turbulence in the omnibus context, positive and progressive approaches to employment relations can come under threat (Dobbins & Dundon, 2017) with employers shifting towards their own interests at the expense of employee interests, for example, through intensification of work (Cook et al., 2016; Johnstone & Wilkinson, 2018).

In respect of workplace health and wellbeing practices, it is widely thought that external shocks in the omnibus context can 'derail' those practices (cf. Biron & Karanika-Murray, 2015). This may because external shocks impose resource constraints or influence how organisations prioritise goals (e.g., survival may become more important). A more fundamental reason is that shocks may surface competing logics, so that decisions about where to allocate scarce resources or what to prioritise reflect less of health and wellbeing logics and more of competing logics (Daniels et al., 2022a). Although external shocks can affect the implementation of workplace health and wellbeing practices, it may not always be the case external shocks do so if organisations adapt their internal processes to the external

shocks in a way that does not threaten health and wellbeing practices (Daniels et al., 2021). There is a key role here for the delivery context in how the discrete contexts of specific practices or the wider omnibus context are adjusted, and whether these adjustments enable continuity, learning and adaptation. The adjustments may require different elements of grafting, fracturing or Gestalting.

In respect of mainstream occupational intervention research, it may also be the case that shocks appear to derail health and wellbeing practices because of how intervention studies are designed: Interventions that are the focus of a specific study may be abandoned because they are no longer suitable for a changed organisational context, but other health and wellbeing practices more suited to the changed context may be introduced as substitutes. Such substitution may not be noticed by intervention researchers that have a specific focus and remit.

The Covid-19 pandemic presented an opportunity to study the effects of external shocks on workplace health and wellbeing programmes. Perhaps uniquely, the Covid-19 pandemic affected organisations' economic priorities (business continuity, survival) and at the same time presenting very salient challenges for the health and wellbeing of employees (e.g., the virus itself, fear of the virus, various mental health challenges associated with lockdowns and homeworking/schooling). As part of our on-going research, during the first lockdown in the UK in March 2020, we had already started fieldwork to examine how organisations develop, implement and sustain workplace health and wellbeing programmes (see Nayani et al., 2022). The study has revealed that although some organisations do struggle with maintaining a focus on health and wellbeing during external shocks, others actively develop their programme of practices to be suited to changing contexts.

Nayani et al. (2022) found that underpinning employee perceptions of whether their employer had genuine concerns for their health and wellbeing was the authenticity with

which employers acted towards worker health and wellbeing. Organisations that are authentic about worker health and wellbeing match espoused these values with tangible actions and practices (Lehman et al., 2019; Hahl, 2016; Cording *et al.*, 2014) and this contrasts with organisations who merely pay ‘lip service’ to employee wellbeing (Guest, 2017, p 33). Nayani et al. found that organisations that appeared to maintain health and wellbeing strategies through the pandemic did so through an effortful process of authenticity work, namely such organisations notice changes to employee concerns about their health and wellbeing and understand and act on new health and wellbeing concerns.

Authenticity work can ensure health and wellbeing programmes are developed to match new circumstances (see learning and adaptability above), but also have symbolic value for the importance of employee health and wellbeing because adapting and changing practices is effortful. Authenticity work underpins the construct of ‘authenticity building’ which is defined as “past and present activities through which organisations channel efforts to be interpreted as authentic in their concern for their employees’ interests” (p. 1150), which implies that authenticity work is an on-going process. In this respect, authenticity building is part of the process of continuity of specific practices, but also underpins continuity, learning and adaptation of the delivery context. Authenticity work and authenticity building may also be required to realise the benefits of the signalling effects of health and wellbeing practices.

From the point of view of some organisation’s responses to the Covid-19 pandemic, organisational shocks are not terminal for workplace health and wellbeing practices, rather shocks can provide an opportunity for organisations to demonstrate authentic care for employees through adapting their health and wellbeing programmes to both the changing circumstances and employee concerns.

Conclusions

An approach focused on workplace health and wellbeing strategies is complementary to research focused on interventions. A focus on strategy, especially because it needs to include unpredictable elements, practices that were not implemented as planned (or at all) and practices that were never intended to be implemented, necessarily implies using alternative methods to those used in intervention research (Patey et al., 2022). Such alternative methods could include longitudinal case studies that capture longer term changes not just in espoused strategies but also from the organisational cultural elements associated with sustained strategies and their development (Johnson, 1987, cf. Dollard & Karasek, 2010).

Focusing on health and wellbeing strategies enables new research approaches and new research questions. As well as examining the factors that sustain and embed programmes of practices over an extended period, other questions could relate to, for example: *How tensions with other organisational processes, goals and logics are managed over extended periods, especially as competing logics evolve, or events make competing logics more salient? How do new practices emerge, become noticed by key decision-makers and become incorporated (or not) into an overall strategic programme? How a strategic health and wellbeing programme influences the whole organisation, including organisational culture and any other factors that may promote health and wellbeing that are not tied specifically to a single intervention?*

To restate earlier points, many organisations adopt multiple health and wellbeing practices in coherent programmes and many organisations now find themselves in a state of flux. Adopting a strategic lens to workplace health and wellbeing enables research on how programmes are managed and can be best adapted to other organisational changes. This is especially relevant for the turbulent times we find ourselves in the current post-Covid era.

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