

Working Paper 77



Organisational roles and responsibilities for health: interviews with representatives from the statutory and non-statutory sectors

**Report prepared for the Welsh Assembly
Government by Sarah MacDonald, Emily Harrop,
Heather Rothwell and Simon Murphy**

September, 2006

ISBN: 1-904815-43-X

On-Line Papers – Copyright and Citation

Copyrights of this Working Paper remain with the author(s). You may download it for your own personal use. The paper must not be published elsewhere (e.g. to mailing lists, bulletin boards etc) without the author's written permission. If you copy this paper you must:

- Include this copyright note.
- Not use the paper for commercial purposes or gain in any way.

This paper may be cited or briefly quoted in line with the usual academic conventions.

- Citation of Cardiff School of Social Sciences Working Papers should use a version of the following format:

Housley, William (2003) 'Art, Wales, Discourse and Devolution', Working Paper 38, Cardiff School of Social Sciences, Cardiff University. <http://www.cf.ac.uk/socsi/publications/workingpapers/pdf-files/wrkgpaper38.pdf>

Cardiff Institute of Society, Health & Ethics (CISHE)

The Cardiff Institute of Society, Health & Ethics (CISHE) conducts and co-ordinates methodologically innovative multidisciplinary research, with a strong contribution from the social sciences and within the related domains of biomedicine, health services, public health and bioethics. The Institute undertakes and facilitates research of international excellence, placing emphasis on tackling health inequalities and ensuring that our research has an impact on policy and practice in Wales and beyond.

CISHE is a collaborative venture in Cardiff University between the Cardiff School of Social Sciences, Cardiff Law School and the Centre for Health Sciences Research. The establishment of the Institute in 2003 was funded by the Higher Education Funding Council for Wales.

For further information see: <http://www.cf.ac.uk/socsi/cishe/index.html>

Author contact details: Simon Murphy murphys7@cardiff.ac.uk

Mae CISHE yn gwneud ymchwil rhyngddisgyblaethol sy'n arloesol o ran ei methodoleg. Mae hefyd yn cydlynu'r ymchwil honno, gyda chyfraniad cryf o'r gwyddorau cymdeithasol ac ym meysydd perthynol biofeddygaeth, gwasanaethau iechyd, iechyd cyhoeddus a biofoeseg. Rydym yn gwneud ymchwil o'r radd flaenaf yn rhyngwladol ac yn ei hyrwyddo, gan roi pwyslais ar fynd i'r afael ag anghydraddoldebau iechyd a sicrhau bod ein hymchwil yn cael effaith ar bolisi ac ymarfer yng Nghymru a thu hwnt.

Abstract:

The idea of organisations taking responsibilities for health has both theoretical and political relevance. However, there is a need to develop a clearer understanding of how organisations conceptualise and respond to such policy initiatives across a range of sectors. Research was commissioned by the Welsh Assembly Government to explore perceptions of responsibility at different levels including individual, organisational and state roles and responsibilities for health improvement amongst the general public and key stake holders. This report focuses on the in-depth interviews with representatives across the health, local government, education, voluntary and community, business and media sectors in Wales.

This study provided further insights into who is acting to improve health and well-being, why these actions are being taken, how health improvement is being enacted and who organisations are working with to achieve this. Although overall, responsibility for improving health is largely taken and enacted by the statutory sector, there is a spectrum of more and less active organisations within all of the sectors. This study has highlighted a number of good examples of work undertaken within different spheres of influence but there are policy implications for the way in which the more active organisations could be better supported. Also, developing an evidence base on what works in terms of health improvement could quickly be put into motion across different sectors and the effectiveness of this would be optimised by building in an element of good practice sharing and peer support between local level organisations.

In terms of ongoing research priorities there is still a need to understand more fully the drivers behind the actions of more active organisations, understand the nature of corporate responsibility in the less active organisations and unpack influences on management perspectives.

Keywords: Health inequalities; interviews; health improvement; corporate social responsibility; workplace health.

An overview of the three studies on the views of the general public and statutory and non statutory organisations can be found at:

www.wales.gov.uk/cmresearch

Contents

<i>Acknowledgements</i>	<i>i</i>
<i>Executive Summary</i>	<i>ii</i>
1. Background.....	1
1.1 The policy context	1
1.2 The theoretical context	1
1.3 The organisational context	1
2. Methods.....	2
2.1 Research Design and Sampling	2
2.2 Data Collection and analysis	3
3. Results.....	4
3.1 The Local Government Sector.....	4
3.1.1 <i>Perspectives on roles and responsibilities</i>	4
<i>Roles and responsibilities in society generally</i>	4
<i>Roles for local authorities</i>	5
3.1.2 <i>Organisational relationships</i>	6
(a) <i>Within sector relationships</i>	6
(b) <i>Across sector relationships</i>	7
3.1.3 <i>Actions to improve the health of employees</i>	9
<i>Factors influencing activity</i>	10
3.1.4 <i>Actions to improve the health of local communities</i>	11
<i>Factors influencing activity</i>	12
3.1.5 <i>Actions to improve the health of wider communities</i>	12
<i>Factors influencing activity</i>	13
3.1.6 <i>Conclusion</i>	13
3.2 The Education Sector	14
3.2.1 <i>Perspectives on roles and responsibilities</i>	14
<i>Roles and responsibilities in society generally</i>	14
<i>Roles for schools</i>	14
3.2.2 <i>Organisational relationships</i>	14
(a) <i>Within sector relationships</i>	14
(b) <i>Across sector relationships</i>	15
3.2.3 <i>Actions to improve the health of employees</i>	16
<i>Factors influencing activity</i>	17
3.2.4 <i>Actions to improve the health of pupils</i>	19
<i>Factors influencing activity</i>	20
3.2.5 <i>Actions to improve the health of local communities</i>	23
<i>Factors influencing activity</i>	24
3.2.6 <i>Actions to improve the health of wider communities</i>	25
<i>Factors influencing activity</i>	26
3.2.7 <i>Conclusion</i>	26
3.3 The Health Sector.....	27
3.3.1 <i>Perspectives on roles and responsibilities</i>	27
<i>Roles and responsibilities in society generally</i>	27
<i>Roles for the health sector</i>	28
3.3.2 <i>Organisational relationships</i>	29
(a) <i>Within sector relationships</i>	29

(b) <i>Across sector relationships</i>	32
3.3.3 <i>Actions to improve the health of employees</i>	32
<i>Factors influencing activity</i>	34
3.3.4 <i>Actions to improve the health of local communities</i>	35
<i>Factors influencing activity</i>	36
3.3.5 <i>Actions to improve the health of wider communities</i>	37
<i>Factors influencing activity</i>	38
3.3.6 <i>Conclusion</i>	39
3.4 <i>The Business Sector</i>	40
3.4.1 <i>Perspectives on roles and responsibilities</i>	40
<i>Roles and responsibilities in society generally</i>	40
<i>Roles for businesses</i>	40
3.4.2 <i>Organisational relationships</i>	43
(a) <i>Within sector relationships</i>	43
(b) <i>Across sector relationships</i>	45
3.4.3 <i>Actions to improve the health of employees</i>	46
<i>Factors influencing activity</i>	47
3.4.4 <i>Actions to improve the health of customers</i>	48
<i>Factors influencing activity</i>	49
3.4.5 <i>Actions to improve the health of the wider community</i>	50
<i>Factors influencing activity</i>	51
3.4.6 <i>Conclusion</i>	52
3.5 <i>The Voluntary and Community Sector</i>	52
3.5.1 <i>Perspectives on roles and responsibilities</i>	52
<i>Roles and responsibilities in society generally</i>	52
<i>Roles for voluntary and community organisations</i>	53
3.5.2 <i>Organisational relationships</i>	54
(a) <i>Within sector relationships</i>	54
(b) <i>Across sector relationships</i>	56
3.5.3 <i>Actions to improve the health of employees and volunteers</i>	58
<i>Factors influencing activity</i>	59
3.5.4 <i>Actions to improve the health of local communities</i>	60
<i>Factors influencing activity</i>	62
3.5.5 <i>Actions to improve the health of wider communities</i>	64
<i>Factors influencing activity</i>	65
3.5.6 <i>Conclusion</i>	65
3.6 <i>The Media Sector</i>	66
3.6.1 <i>Perspectives on roles and responsibilities</i>	66
<i>Roles and responsibilities in society generally</i>	66
<i>Roles for media organisations</i>	66
3.6.2 <i>Organisational relationships</i>	67
3.6.3 <i>Actions to improve the health of employees</i>	68
<i>Factors influencing activity</i>	69
3.6.4 <i>Actions to improve the health of consumers</i>	70
<i>Factors influencing activity</i>	71
3.6.5 <i>Actions to improve the health of wider communities</i>	75
<i>Factors influencing activity</i>	77
3.6.6 <i>Conclusion</i>	78
4. <i>Conclusion</i>	79
4.1 <i>Roles and responsibilities in society generally</i>	79

4.2	The role of organisations in improving health	79
4.3	Organisational relationships	79
	<i>Within sector relationships</i>	79
	<i>Across sector relationships</i>	80
4.4	Actions to improve the health of employees	80
4.5	Actions to improve the health of communities served.....	81
4.6	Action to improve the health of the wider community.....	81
4.7	Implications.....	81
5.	References	83

Acknowledgements

We thank Eva Elliott (CISHE) and Odette Parry (NEWI) for contributions to project management and data. Thanks also to Iolo Madoc-Jones (NEWI) and Joan Ashdown-Lambert for help with data collection and Lorelei Simon (CISHE) for administrative assistance. We would also like to thank and acknowledge all those who gave of their time to participate in these this project, to the guidance provided by the CISHE Project Advisory Board (Soren Holm, Laurence Moore, Chris Shaw and Gareth Williams) and to Nina Parry-Langdon and Chris Roberts at Welsh Assembly Government for their continued support.

The views expressed in this report are those of the authors, not necessarily those of the Welsh Assembly Government.

Executive Summary

Background

The idea of organisations taking responsibilities for health appears to have both theoretical and political relevance. However, there is a need to develop a clearer understanding of how organisations conceptualise and respond to such policy initiatives across a range of sectors. Work in this area has traditionally focussed on a 'settings approach' to understand health improvement action as reflected in terms such as 'healthy schools', 'healthy workplaces' and 'healthy hospitals'. The approach adopted in this study builds on this by examining perspectives at different levels within the sectors where such settings are located and by facilitating cross-sector comparisons.

Methods

Interviews were conducted with organisations across Wales at three different levels: the strategic level; regional or intermediary level; and organisational or local level. Altogether 59 interviews were completed across six sectors (local government, education, health, business, voluntary and community, and media). Interviewees were identified through a process of hierarchical snowballing and selection was on the basis of health improvement experiences and geography. A semi-structured guide was used in a mixture of face-to-face and telephone interviews. Transcripts were subject to content analysis, with dominant themes identified and agreement reached between two researchers.

Results

The Local Government Sector

Local government was seen to have a prominent role in health improvement influencing the determinants of health and the potential to influence upstream health prevention at the community level. Regarding within sector working, the main concern at the local level was the existence of 'too many tiers' and the need for national level organisations to have more direct contact with the local level. Communications within local level organisations was also highlighted as an area for improvement as the lack of co-ordination between some council divisions meant there were 'missed opportunities' for health improvement action.

Addressing the needs of local communities was seen as a core area of concern for the local government sector. The general view was that the sector still had some way to go in terms of addressing the health of the wider community and issues around corporate social responsibility. However, mechanisms were being put in place at a strategic and intermediate level to provide local authorities with frameworks and support.

The Education Sector

With regard to the role of schools in promoting health and well being the most common suggestion was that schools should be 'educating for a healthy lifestyle'. In the majority of interviews, national government and Local Education Authorities (LEAs) were seen to have a crucial role in supporting and guiding schools. However, a need for more

reciprocal relationships was also mentioned, in particular by heads and there was criticism of government directives for the extra pressure that they put on schools without the right support levels.

Across all interviews there was strong acceptance of a role for schools in improving pupil health. Common drivers, barriers and facilitators also seemed to be experienced across schools, largely in terms of resources. However, there were also considerable differences between schools, with some schools pursuing more holistic approaches to health improvement. The overwhelming factor coming across to explain apparent differences was the perspectives of heads and their relative levels of belief in both the place of the school in promoting health and the power of the school to make a difference to health.

The Health Sector

There was consensus across the sector about a need for collective efforts to address health improvement which extended beyond the health sector. In terms of a specific role for the health sector, public health organisations were seen to be well placed for health improvement by providing organisations and individuals with access to specialist public health expertise. The health care services were also seen to have a role in health improvement, although this was not as pivotal a role as that for public health. They were seen to have an increasing role in health improvement in the future driven by policy discourses but limited capacity to take on this wider health improvement role was recognised across the different levels.

The main drivers for health improvement at a strategic level were identified as non-health economic and fiscal policies, mostly originating in Whitehall. At a local level, bottom-up influences were more prominent with public health organisations in particular driven by local level needs expressed in Health Social Care and Well Being strategies, for example. Some involved in participatory work at a local level were keen for this type of approach to continue. Some documented effective communication flows between a strategic and local level but others noted a different story with limited pro-active intra-sector working, limited sharing of good practice across the sector and lack of understanding about implementation at the regional and national levels. Other challenges to ongoing intra-sector relationships included different organisational priorities and the variation in professional expertise at a local level. Action to address employee health was seen as a weakness of the sector and addressing employee stress was a main area of concern.

The Business Sector

The main role for businesses was thought to be providing employment, with better health an unintended outcome of this. Action targeted at improving health was not seen as a priority as it threatened profitability. Compliance with Health and Safety laws and national and international regulations appeared to be the most important way in which business practice affects the health of employees, customers and the wider community. Interviewees saw international laws having more impact on health than national policies.

There was little evidence of joint action to improve health by government or business organisations. A minority at national and local levels felt there was scope for businesses

to work to improve workforce health. It was acknowledged that companies had a duty to comply with regulations governing the safety and quality of their products. Overall, companies who had taken voluntary action to improve health appeared to have a particular corporate culture and had developed relationships with customers and the wider community.

The Voluntary and Community Sector

Interviewees identified a significant role for the voluntary and community sector in health improvement which included education and campaigns as well as some direct service provision and the sector's indirect contribution to health improvement was also discussed with health and well-being incorporated into most of the work they do at a local level. National level organisations were seen to promote the profile of the voluntary and community sector but there was limited recognition of the role played by intermediaries with a preference for local level voices to be heard first hand. Different organisational structures and ways of working, particularly in the independent voluntary sector pose some issues for joint working across the sector, such as the absence of coterminosity with statutory sector boundaries.

Local level interviewees raised issues of joint working with the business sector, and in particular with the health sector where the low profile of the voluntary and community sector, as well as competing agendas, were identified as the main barriers. At a national level there was limited awareness of any specific actions taken to address employee or volunteer health although there was an acknowledgement that financial resources might limit what the sector can provide for this group. Local level interviewees highlighted some specific actions that had been taken but in the main these were ad hoc and not set within formalised frameworks for action.

The Media Sector

All of the respondents recognised the influence that the media can have through reporting on health issues. However, the journalists interviewed were also quite clear that the role of the media was to be 'neutral informers' who 'report on issues within the health community as they arise.' Although they did not see themselves as having a necessarily health promoting role they were able to offer examples of how their activities contribute to the health of consumers and to a lesser extent the health of wider communities. By contrast they had relatively little to say about the health of employees, where it seems only a few positive actions were being taken by employers.

Insights were also gained into common factors influencing media approaches and activities. The key influences to come across in all sections were the fundamental business principles of media organisations and their underlying concerns with productivity. The individual character of editors, journalists and different companies (such as size, ethos and public service function) was also suggested to have some influence on approaches.

Conclusions and implications

This study has provided further insights into who is acting to improve health and well-being, why these actions are being taken, how health improvement is being enacted and who organisations are working with to achieve this. The gaps and weak points in this framework for action should be the focus of future research and policy development.

Although overall, responsibility for improving health is largely taken and enacted by the statutory sector, there is a spectrum of more and less active organisations within all of the sectors. In terms of policy implications this suggests that one area of focus should be on the more active organisations with a different approach needed for the harder to reach organisations. In terms of ongoing research priorities there is still a need to understand more fully the drivers behind the actions of more active organisations, understand the nature of corporate responsibility in the less active organisations and unpack influences on management perspectives.

This study has highlighted a number of good examples of work undertaken within different spheres of influence but there are policy implications for the way in which the more active organisations could be better supported. Also, developing an evidence base on what works in terms of health improvement could quickly be put into motion across different sectors and the effectiveness of this would be optimised by building in an element of good practice sharing and peer support between local level organisations.

1. Background

1.1 The policy context

The question of organisations and health is one that is at the heart of contemporary political and academic debates over roles and responsibilities for a range of social issues, including health. The distinction between public and private sector responsibilities is becoming increasingly blurred and this is matched by shifting conceptualisations of the roles of the individual, organisations and the state, as seen in changing political, public and academic discourses. Examples can be seen in the significant increase in the number of companies engaging in corporate sustainability reporting (KPMG, 2002, cf Jenkins, 2004) and in influential social documents from the World Health Organisation which suggest that 'business, government, voluntary organisations and individuals have a shared responsibility for maintaining a healthy community' (Leat et al, 2000, cf Goddard, 2004, 106). In terms of health policy in Wales, there is a clear recognition of the need to address both lifestyle factors and the wider determinants of health. For example, 'Well Being in Wales' (Welsh Assembly Government, 2002b) points out that people's health depends upon balancing the economic, social and environmental dimensions of sustainable development. The Health Challenge Wales Concept challenges individuals *and* organisations to take action to improve health, and there seems to be a growing recognition of a role for 'lay people', 'citizens', 'the community' or 'the public' in health improvement, as seen in moves to develop Health Impact Assessment (HIA) throughout Wales.

1.2 The theoretical context

Work examining health inequalities has highlighted how individual, community, environmental and structural factors all interact to produce diverging experiences of health (Dahlgren and Whitehead 1991). This model suggests that the case for increased social responsibility on the part of organisations has considerable practical relevance with regard to the roles that organisations might play in generating health improving contexts. Indeed, a focus on corporate behaviour offers new insights into the determinants of health depicted in Dahlgren and Whitehead's diagram. Organisations can influence the determinants of health at all four levels. For example, individual lifestyle factors can be affected by the workplace context; social and community networks by support for local projects, general socioeconomic, cultural and environmental conditions by waste-disposal practices, using local suppliers. Organisations also have a direct effect on their employees' living and working conditions through remuneration (Joseph Rowntree Foundation, 1999), health and safety measures (Health and Safety Executive, 1992) or flexible working.

1.3 The organisational context

Whilst the idea of organisations taking responsibilities for health as a general principle appears to have both theoretical and political relevance, there is a need to develop a clearer understanding of how organisations conceptualise and respond to such policy initiatives across a range of sectors. Work in this area has traditionally adopted a 'settings approach' to understanding health improvement (Baric, 1993), something which is reflected in such terms as 'healthy schools', 'healthy hospitals', 'healthy workplaces.' The importance of the setting approach was further emphasised by the Jakarta Declaration (WHO, 1997), which highlights the evidence for adopting such an approach and outlines the priorities for future health promotion.

Organisations within different sectors may vary in their perceived roles and responsibilities and the issues they face when engaging in health improvement action, but it could be argued that two areas, corporate social responsibility and promoting a healthy workforce have relevance for all. For example the King's Fund has highlighted how the NHS deployment of its' corporate resources

can have a significant impact on health (King's Fund, 2004). In terms of promoting workplace health, approaches such as the government's 'Healthy Workplace Setting' highlights the potential for action firstly in ensuring that people are protected from workplace hazards and secondly to improve the overall health of the workforce. Examples here could include workplace smoking bans and cessation support (see Parry et al, 2000). However, it is important to recognise that organisations in different sectors may face a variety of issues in this area. This study explored perceptions of organisational roles and responsibilities, intentions and actions for health improvement with key stake holders across six sectors. These were health, local government, education, voluntary and community groups, business and the media. Stakeholders were drawn from national, intermediate and local levels so that areas of consensus and disagreement could be identified.

2. Methods

2.1 Research Design and Sampling

Ethical approval for the study was obtained from the School of Social Sciences, Cardiff University Ethics Committees and from the multi-centre research ethics committee (MREC) in relation to NHS employees. Interviews were conducted with organisations across Wales at three different levels in each sector (see table 1): tier 1 (strategy level in the Welsh Assembly); tier 2 (regional or intermediary level); tier 3 (organisational/local level). Respondents were identified through a process of hierarchical snowballing. Potential respondents at tier 1 were identified through discussion with the funders of the study. Once a pool of interviewees had been identified they were sampled on the basis of geography (to cover all NPHS areas) and in terms of approach to health improvement activity. The aim was to achieve a range of more and less active organisations – those who had undertaken actions and those who faced barriers in doing so. Once they were identified they were contacted by email and provided with study information sheets and details of ethical procedures. A follow up phone call was used to provide further study details and to establish whether they wished to participate. For those wishing to participate, once formal consent had been obtained a mutually convenient date was arranged to conduct either a face to face or telephone semi structured interview. At the end of the interviews, tier 1 respondents were asked to identify a number of potential respondents for tier 2 interviews in their sector. They were asked to identify those with both positive and negative experiences in relation to health improvement action. In this way a pool of potential interviewees was established who were then sampled to ensure a range of views and experiences were obtained for each sector. Potential respondents were approached in the same way as those in tier 1. A similar approach was used with tier 2 interviewees to identify a sample pool for tier 3 interviews. They were in turn approached and recruited using the same methodology as used in the previous two tiers. All respondents were offered the opportunity to conduct interviews in Welsh, but none took this up.

Table 1: Key stakeholders sample

Sector (59)	Tier 1 (10)	Tier 2 (12)	Tier 3 (37)	Format	Tape recorded
Local government (5)	1 (LG1-1) ¹	1 (LG2-2)	3 (LG3-1 to LG3-3)	4 in person, 1 by telephone	All tape recorded apart from 1
Education (16)	1 (ED1-1)	3 (ED2-1 to ED2-3)	12 (ED3-1 to ED3-12) ²	1 in person, 15 by telephone	All tape recorded
Health (12)	3 (HS1-1 to HS1-3)	4 (HS2-1 to HS2-4)	5 (HS3-1 to HS3-5)	5 in person, 7 by telephone	All tape recorded apart from 1
Private employers (9)	1 (BS1-1)	2 (BS2-1 to BS2-2)	6 (BS3-1 to BS3-7) ³	2 in person, 7 by telephone	All tape recorded apart from 1
Voluntary and community (10)	3 (VC1-1 to VC1-3)	1 (VC2-1)	6 (VC3-1 to VC3-6)	3 in person, 7 by telephone	All tape recorded apart from 1
Media (7)	1 (Med1-1)	1 (Med2-1)	5 (Med3-1 to Med3-5)	2 face to face, 5 by telephone	All tape recorded apart from 1

¹ Interviewees' identification includes reference to the sector (e.g., 'LG' for local government), followed by the tier, (1,2 or 3) and finally the interviewee number (1, 2, 3 etc).

² Six were primary schools (ED3-1 to ED3-6) and six secondary (ED3-7 to ED3-12).

³ It should be noted that one interviewee spoke from two different perspectives and the data has been coded with two separate identifiers (BS3-5 and BS3-6).

2.2 Data Collection and analysis

Tailored semi-structured interview schedules were designed for respondents at each tier within each sector which examined the following areas:

- Clarification of the organisations and sectors that are influenced by them
- Understandings of roles and responsibilities for health in general
- Views on roles and responsibilities for health in their organisation and sector
- Views on policies that are likely to have an impact on health within their organisations and sectors
- Awareness and understanding of Health Challenge Wales
- Views on working relationships for health improvement between tiers within sectors (intra-sectoral relationships) and across sectors (inter-sectoral relationships)
- Organisation and sector actions to improve the health of workforces, communities served and the wider population.
- The key facilitators, obstacles, benefits and disadvantages of these actions
- Views on actions that encompass health promotion, corporate social responsibility and environmental responsibility.

The schedule was administered by one of nine researchers with interviews lasting between 30 and 60 minutes. Three researchers were allocated as sector leads. They conducted at least one interview at each tier in their sector to facilitate comparability within the sectors. To ensure comparability across sections, two researchers conducted at least one interview in each of the six sectors. Question responses were recorded on the interview schedule by the researcher. This was then subject to content analysis, with dominant themes identified independently and agreement reached between two researchers (Bowling, 1997). Interviews were also audio taped and referred to for illustrative quotations and to highlight comparisons between and within organisational hierarchies.

The next section of this report presents the results for each sector including examples and illustrative quotations. Each sector write up is structured in the same way. An introductory section presents the sector's overall perspective on roles and responsibilities for health. After this, the focus turns to organisational relationships within the sector (intra sectoral relationships) and with other sectors (inter-sectoral relationships). The discussion then looks at the sector's roles and responsibilities amongst three main spheres – employees, local communities served and wider communities. A conclusion is presented at the end of each sector write up and overall conclusions and implications are presented at the end of this report.

3. Results

3.1 The Local Government Sector

3.1.1 Perspectives on roles and responsibilities

Roles and responsibilities in society generally

Overall, interviewees agreed that taking responsibility for health should be a collective endeavour and when asked about who has a role for improving health, a number of different sectors were referred to:

'Health is everybody's business – from individuals, communities, business, media agencies, local authority, voluntary, NHS, Trusts, back down to community care' (LG2-1)

Two interviewees (one at national level and another at intermediate level) commented on the role of the Welsh Assembly Government in tackling health improvement. In both cases they talked about an Assembly-wide approach to tackling health improvement – not something that was just the responsibility of departments which have health as their main focus. As the national level interviewee noted:

'I think all the divisions across the Assembly have a role in health whether they know it or not' (LG1-1)

The second interviewee identified the health related divisions playing a key role in leading the approach, but saw other divisions also being brought into this process, ultimately leading to a situation where 'health consciousness' was part of all policies, across all divisions. The health sector was listed amongst those with a role in health improvement but one interviewee commented quite extensively on the role of the health sector, which reflects their role in working with a range of public sector organisations including local government and the health sector. In terms of the current role played by the health sector they were regarded as having more pressing priorities to deal with and as a result health improvement was not viewed as its main business. The health sector was viewed as a partner in health improvement but their main area of concern at the present time is dealing with the care sector and the acute sector. However, later in this same interview, it was noted that there was potential for the health sector to have a wider role in health improvement which goes beyond treatment and care. This had less to do with its core activities as a health treatment provider and more to do with it acting as a role model in the way in which it conducts its main business. For example, it was recognised that the way in which it purchases supplies and locates hospitals could all contribute to health improvement. In terms of the role played by individuals, there was general agreement at all levels that individuals were limited by opportunities available to them and solutions needed to go beyond a lifestyles approach:

'Individuals have a role but I think we need to focus more on their opportunities and the barriers to health rather than necessarily them needing to take more exercise, smoke less, in isolation ...so we need to remove more barriers and create more opportunities structurally, rather than it just being about providing a cooking club or a get fit class because that's not going to make long-term change. But that isn't very popular when I say that sometimes' (LG1-1)

The response from one local level interviewee provided a more in-depth account which illustrates their recognition of the competing rationalities that individuals and communities negotiate in choosing health as a result of social and cultural changes. This interviewee gave quite extended

narratives about changes in their own local area. For example, the interviewee talked about the emergence of a culture of insularity with many local people *'not working nine to five'* but being out of work and having little to structure their days. Local services had responded to this changing societal structure. For example, the councillor referred to the local fish and chip shop being open on Sundays and at eight in the mornings. Issues for specific groups within the community were also referred to. For example, for the teenage age group he highlighted the high rates of male suicide and the lack of aspirations which were seen to contribute to the anti-work culture and *'youngsters not knowing how to get up in the morning'* (LG3-1).

Roles for local authorities

The national level interviewee saw local government as having a prominent role in health improvement especially in terms of controlling the wider determinants of health, a domain which was seen as being beyond the control of the health sector.

'Local government has a huge role in promoting health. They have influence and control over most of the determinants of health. If they don't have them, then the Assembly has them or people like the police have them...whereas the NHS doesn't have control of those things' (LG1-1)

Compared with the health sector local authorities were seen as being able to influence health at the community level:

'Local government...has a duty as a community leader...and in that duty it has that collective role to social well-being...local government's duty for well-being is about communities. The health service duty is about individuals...' (LG1-1)

Similarly, the intermediate level interviewee identified a leading role for local government and thought they should have an 'up-stream' role in health promotion and prevention and less of a role in health care although they have a role with some vulnerable groups:

'Upstream prevention and promotion of health. Less on the treatment and care side. There are obviously services that provide care particularly for vulnerable groups. Social services stuff for adults and for provision, is care provision...but the majority would be upstream prevention' (LG2-1).

Changing times for local government was also discussed and interviewees talked about the *'re-energization'* of the sector's role brought about because the *'NHS is on it's knees'*. One local level interviewee noted there has been an historical development in awareness and priorities – the traditional role for local government in improving health was largely seen as social services in the communities whether they be for young children in care or the elderly. In terms of public health, this was traditionally the concern of environmental health services. Now there is a recognition *'that almost everything we do has an impact on health'*, from service aimed at the individual to those addressing more structural issues –from the provision of leisure services – *'keeping people active and participating socially'* (LG3-2) to more structural influences such as the provision of good quality housing.

Local authority interviewees suggested that local authority officers or councillors should be involved in assessing the feasibility of implementation at the policy development stage. One local councillor felt there was a need for local authorities to provide a more supportive role for the health improvement agenda, rather than a leadership role as suggested above. Another local interviewee questioned the credibility of the local authority to work effectively at a local level. They talked about the *'us and them'* mentality at a local level and how local councillors were not trusted

compared with some other community figures. For example, they referred to one community figure that had *'credibility in the community'*. The interviewee referred to their own status as councillor and how local people referred to them as *'one of them – as a 'statutory'* (LG3-1).

3.1.2 Organisational relationships

(a) Within sector relationships

The main criticism put forward by the national level interviewee in terms of relationships within the local government sector, was the relationship between national and intermediate bodies. They commented that the national engages with the intermediate bodies but this is not reciprocated.

'... they don't always engage when they're offered an engagement role, or if they do and they come and get involved and that's fine. But when they develop anything they just go off and develop it and they don't actually involve us' (LG1-1)

However, this problem was not identified at the intermediate level– they saw *'the two way flow of ideas'* (LG2-1). The main criticism of the inter-sectoral links put forward by one local level interviewee was the difficulty of involving *'too many tiers'* (LG3-1). They claimed this led to a situation where the Assembly would be *'talking to the wrong people'* and instead of getting messages second or third hand they *'need to be engaged to the nearest form of what they're trying to deliver'* otherwise they would not get *'the right perception of what is needed.'* They went on to talk about the way in which funding was not getting through to the right people. They described the current set up as:

'an industry of officers within health who is consuming all the resources and Mrs Jones down by there haven't got a chance' (LG3-1)

Another criticism put forward by this interviewee centred around talking not doing. They claimed that there was too much *'aspirational talk'* instead of focusing on simple things that could help (LG3-1). They alluded to the free swimming programme which sounded fine but in practice the interviewee had to lobby for better bus service to get down to the leisure centre, so access to this sort of provision was an issue which had been overlooked. A further criticism was the problematic relationship between local and central government as it was felt that real power lay with the Welsh Assembly to determine strategy and to facilitate implementation. They felt that local government needed to be pro-active in influencing the agenda of central government as they controlled resources. The relationship between central and local government was seen as being largely determined by funding leading to a situation where the local government:

'is in an almost constant lobbying situation with the Assembly to get the funding we need' (LG3-2)

There was also recognition of the need for better joint working on health *within* the local authority. One local level interviewee commented on this and noted that there were some departments within their local authority which were not working together and this was contributing to *'missed opportunities'*. For example, they noted that the council could be making better use of open spaces for leisure facilities. Overall, they thought there were more opportunities for joint working within the local authority than were currently being realised. Four out of five interviewees had heard of Health Challenge Wales. One local level interviewee was not aware of it. The main focus of discussions about Health Challenge Wales related to its shortcomings. The national level interviewee noted that the lifestyle focus has made it difficult to push ahead with work on wider determinants:

'...the focus seems to be around individual choice as oppose to making fundamental changes and so that's been quite difficult for me because people think they're doing what they're doing, they're doing the Health Challenge Wales stuff then isn't that enough, by sticking something on the end rather than fundamentally looking at the wider working' (LG1-1)

The intermediate level interviewee also recognised that Health Challenge Wales had not generated any new work, but went onto note that it was not designed for that anyway. Their main concern was about how its impact would be measured:

'And the impact of it needs to be measured much more objectively that 33% of the population recognise a little yellow man...the measurement of it is not right...they talk about brand recognition is not right...the idea perhaps will work that you set a challenge to somebody to improve their lifestyle. How they respond to the challenge is a different thing. I don't think they're measuring how people are responding to the challenge' (LG1-1)

The interviewee noted that these were personal views and not that of the organisation which they represented. One local level interviewee commented more favourably on the implementation of Health Challenge Wales and felt that local authority leaders and Chairmen of the Local Health Boards were joint champions of local implementation. They referred to branding initiatives that were already taking place that focussed on healthy living *'to get it across to people that a healthy lifestyle is important to them'* (LG3-2). However, as this was at an early stage of implementation it was difficult to establish effectiveness of these activities. One local councillor had limited involvement with Health Challenge Wales. They saw it as *'just another initiative doing typical health promotion stuff, draining resources from the local level'* (LG3-1). They suggested that perhaps if it had been delivered in a slightly different way with greater ownership at a local level, then it might have made more of an impact. They felt that local people would have owned it if it had been introduced to them at an earlier stage of its evolution. Another councillor also viewed Health Challenge Wales as a top down initiative coming from the first minister and recognised that for it to work it would require constant work from the local health and government services.

(b) Across sector relationships

Despite the importance of organisations working together to improve health interviewees recognised the difficulties of working collectively across sectors. For example, one interviewee highlighted a limitation to joint working in relation to their own experience of trying to work on health at the national level. In particular they highlighted health terminology as a key barrier to working across divisions.

'... although I'm increasingly using the word well-being rather than health. Because it's just...I think it makes it quite difficult otherwise...' (LG1-1)

However, it was noted that there had been improved joint working in recent times. Recently there has been a move towards partnership working and for all public bodies to be responsible for and work together to improve health. In particular this has seen local government working with the health sector on joint social care and well being strategy which has elements of prevention and treatment integrated across services and sectors. This was seen as a model of good practice and copies of their local service agreement are available for others on the web. The Making Connections document set the foundations for this and the process is well under way with joint planning and commissioning of services. For the future this needed to be developed with more links between local authorities and between local authorities and the health sector, with 'pooled budgets' a potential facilitator:

'what that might lead to is pooled budgets, but that would require giving up part of your pot of money to put into someone else's' (LG3-2)

Health Social Care and Well-Being Strategies were identified as one potential mechanism for driving forward cross-sector working at a local level and Wales was seen to be leading the way. It was acknowledged that although there was something similar in Scotland, the Welsh set up was seen as being quite innovative. The coterminosity of local government and health service structures in Wales was considered helpful in taking this forward. At a local level one interviewee felt that these strategies were working well and noted that at the local level the Health and Well Being Strategy was seen as key bringing together sectors and integrating treatment and prevention agendas. However, two interviewees referred to limitations of Health Social Care and Well-being strategies. They were viewed as being too focussed on health and social care and not well-being. They were also criticised for not asking the right questions during the consultation phase – questions about health needs produced responses related to service provision rather than structural determinants of health.

Another interviewee commented on the problems of implementing the strategies mainly as a result of the fact that health care services are leading the way resulting in a situation where *'services are the focus and not needs'* so attempts to identify and then address needs at a local level are not being realised. *'So the services are 'king' at the minute, not the needs and the individuals'* (LG2-1). The interviewee went on to note that they are trying to address this problem but felt that the real problem goes much deeper into cultures and ways of working within the organisations and referred to the *'well established tribalism, professional groups, funding streams, modes of behaviour, that we can't just change over night.'* Interviewees referred to a number of other mechanisms which seemed to have the potential to promote joint working. This included the Power of Well-Being and the Policy Integration Tool. The Power of Well-being was viewed as something which has potential to influence the work of local government but currently was not extensively used, (Welsh Assembly Government, 2005). Under the Local Government Act 2000 local authorities were given the power to do anything they consider likely to promote or improve the economic, social or environmental well-being of their areas. This came into force on 9th April, 2001. The idea is that local government leads it in partnership with all the other agencies that will contribute to the community. Through this local government has the *'power of well-being'* and the power to promote social, environmental and economic well-being of their area. However, the interviewee did note that to date this had been an underutilised tool by local government. But not a lot of them have used it yet:

'As far as I'm concerned, that's health, that's why I've made an effort to work with them' (LG1-1)

The Policy Integration Tool which was set up for testing the Assembly's policies against its strategic agenda, serves as a key mechanism for assessing health impacts of new policies – both explicitly (section on health) and implicitly in each of the other policy areas :

'...there is a health section which is the usual stuff around inequalities and lifestyle, but I've got health in the environment bit, there's health in the economic development bit...so its everywhere really, so its quite good that people don't necessarily recognise that they're being asked a health question because they make different assumptions about that ...' (LG1-1)

However, in practice the interviewee admitted that *'a lot of people think it's an unnecessary imposition.'* However they went on to note that although *'it's not perfect...it's the best we've got at the moment.'* These sorts of tools could help take forward the effectiveness of partnership working at the strategic and local level. However, the move towards greater partnership working to improve health was balanced with recognition that there could be *'too much move towards a partnership solution to everything'* (LG2-1). This envisages a situation where local authorities are

able to exert an independent impact on health which is distinguished from the impact of others sectors, such as health.

'We are seeing local authorities as health improvement agencies in their own right. They don't have to do everything in partnership. They can have a big impact through all the services they provide and they don't need to deliver those in partnership. I mean that's the same for the NHS, we're not saying that its any different for any other sector. The NHS has a massive impact on health, broadly and they don't need to deliver everything in partnership' (LG2-1)

3.1.3 Actions to improve the health of employees

Twenty-one of the twenty-two local authorities in Wales hold a Corporate Health Standard Award (Welsh Assembly Government Health Promotion Division, 2005). Although according to one interviewee the Standard did not really challenge local authorities. They commented on their own personal experiences of previously having worked in a local authority which was awarded the Corporate Health Standard and all they had *'was a book of health promotion messages that I didn't read'*. They noted that overall they were probably *'not that effective'* in terms of *'ultimate outcomes on individuals'*. However, it was noted that a new version of the Corporate Health Standard was due to be set up and it was felt that this would incorporate greater challenges and address issues of wider corporate social responsibility.

'you're looking at how much waste they use, the effect on the environment, what are the buildings, how are they built, how are they using them? But there's a social dimension – how have you engaged with you community? Not just about health issues, but do you employ people locally, do you train people locally, do you buy local goods, so there's a whole dimension which is increasingly part of them as an organisation in the community and what they're doing. Their role as a good corporate citizen – what should you be doing, how you should be operating...' (LG1-1)

Other limitations of the Corporate Health Standard to date were associated with the way in which it had been implemented and the lack of support from the health sector. They commented that the health sector's failure to take on the support of this meant that the contract would be put out to tender and in the meantime there was no-one to support organisations working towards the Standard. In contrast, the interviewee noted how support from employers' organisations has helped implementation:

'the employers' organisations are all really supportive. We got endorsement from the HSE, the CBI, the NHS confederation...so we've got the endorsement from all the major organisations, employers' organisations that we need' (LG1-1)

Despite these limitations, Wales was seen to be leading the way with the Corporate Health Standard compared with other parts of the UK and one interviewee noted that it was probably more advanced than the Scottish equivalent as *'they haven't got such rigorous criteria and it isn't independently assessed'* (LG1-1). The perceived benefits for organisations included progressing their thinking around health improvement which helps with follow-on work. As the national level interviewee noted:

'When I move towards the work I'm doing on them being health promoting hospitals or whatever...that will be one element that will have already been covered, so I'm not starting from scratch. If they've got all those things in place in their organisations, they've already got somebody there whose leading on that, they've already got some sort of corporate group that's meeting. So that its relatively easy then to engage with them then on specific issues' (LG1-1)

Two local authority representatives did not comment on the Corporate Health Standard. However, the third interviewee noted the direct benefits within their own organisation. They felt that they were a role model for employee health and had recently been awarded the Gold Standard Award for Occupational Health. Such awards were seen as important as they established standards to aim for and provided incentives:

'there's no doubt that if one Local Authority has an award, the neighbouring authorities would say we want one as well. Let's find out what they are doing let's improve the service' (LG3-2)

Few other initiatives to tackle the health of the workforce were mentioned. One local authority interviewee mentioned a health walks scheme that they were aware of but had not taken part in directly. Another local government interviewee thought that a lot of work was being undertaken to improve the health of the workforce already. The Occupational Health Department held regular health fairs – where all employees could go along and get information on health and well being (this included, women's health, men's health and drugs and alcohol). This was seen as successful and well attended. They also provided on-going advice and health checks/screening for local authority employees.

Factors influencing activity

There was a general view that local government would like to be doing more to improve the health of the workforce but time, resources and competing priorities were put forward as the main barriers. This was the view from the national level:

'I think they would [like to do more] but it's a question of time and resources. And also the other side of it is, especially with the Health Service, and local government too to be fair, is that there are other competing priorities that are much higher up the scale...' (LG1-1)

To some extent it was felt that local authorities do not really understand the impact of having a healthier workforce and this lack of understanding acts a barrier to taking any further action. As the following quotation illustrates, provision of services was seen to be the key driver for local authorities and the links between a healthier workforce and provision of services was not being made:

'...I guess the prime driver is the provision of services to communities. Its not about...looking after your staff....Ultimately, looking after your staff is about providing your services cos if they're at home sick, they're not providing services...so some more appreciation of the benefits of achieving the standard or taking action to improving, or looking after the well-being of the staff' (LG2-1)

However, the interviews with local authority representatives seemed to indicate that there was an awareness of the importance of addressing workforce health at a local level, but there was an acknowledgement that they should be doing more. One interviewee felt they should be doing more to address the work life balance of employees by putting in place showers, on-site leisure facilities, crèches in order to 'ease the transition between work and home'. Overall, they recognised that addressing the health of the local authority staff would have a huge impact on employees and beyond. They also hoped it would inspire people to work for the council and the council would get the best out of them.

'We get the best from them in work and they get the best of it for themselves outside work' (LG3-1)

For one local level interviewee the distinction between the local community and the workforce was blurred and they recognised that addressing the health of the workforce was seen as part of addressing the needs of the local community. This interviewee was based in an area of deprivation and they recognised that the poor health of the community is reflected in the workforce which they saw as *'a microcosm of the wider community'*.

Another local level interviewee also recognised the importance of addressing workforce health and highlighted the issues of stress upon employees and the possible health and safety risks associated with particular occupational responsibilities.

'I sit on is the corporate government scrutiny committee, and there are regular reports that come in on the number of employees and so on, but within all that there are absences and sicknesses injuries in work, and its from that analysis of the documents that you are able to identify if certain jobs are potentially causing more damage or injuries to employees, whether that be stress or actual physical injuries' (LG3-3)

Therefore, the evidence from the interviews suggests that there was a fairly well-developed understanding of the importance of addressing employee health at the local level. However, the absence of appropriate mechanisms for improving workforce health was also put forward as a barrier to local authorities doing more. The intermediate interviewee noted that local authorities *'definitely'* wanted to do more but at the moment the Corporate Health Standard was the only vehicle available. Associated with this was the absence of leadership for workforce health improvement. The national level interviewee acknowledged that the national organisation probably needed to *'put it's house in order'* first and set a good example to the rest of the government sector. In one of the local authorities the interviewee cited quite extensive measures to address employee health. They explained how their pro-active Occupational Health Department together with incentives and goals provided by the Corporate Health Standard, provided them with the leadership and mechanisms to take things forward.

3.1.4 Actions to improve the health of local communities

Across all the interviews, there was a good deal of information provided about local government's contribution to improving the health of the local communities as these were regarded as their core sphere of concern. However given this core remit for local authorities it proved difficult to identify the most effective actions, particularly those that were seen to be beyond their mainstream activities. Several interviewees noted that one of the main contributions of local government to the health of local communities was the way in which they encouraged community participation. As the national interviewee noted, it is important to recognise the difference between consultation and engagement.

'there is recognition from some of them that actually if you can engage with them in an ongoing basis rather than just consult on a document, you're going to get people more involved' (LG1-1)

Similar issues about the importance of community engagement were also highlighted at an intermediate level:

'the way they engage communities in a discussion about the services that they need and the quality of those and then flowing from that how they improve their health...' (LG2-1)

Some innovative ways of engaging the public had already been put in place at a local level. For example, one interviewee referred to forums such as citizens panels, feel good days (invite people in, do some screening but also offer some practical stuff like home repairs) training,

standing forums. All this was seen to go some way towards reviving local democracy and was about more than just asking the local communities to respond to a strategy.

Factors influencing activity

One local level interviewee felt that one of the main barriers to local authorities doing more to tackle the health of the local communities related to communities' lack of awareness of what is available locally and apathy to engagement. The interviewee cited a number of community resources that were being under-utilised such as community buildings and sports provision. They felt that improvements would only really happen once communities realised they were missing out and started to demand things themselves. The interviewee referred to an example of a local community where this sort of bottom-up action was beginning to happen and they were starting to call local service providers to account. Overall, it was felt that there was a need to make communities more aware of what was on their doorstep - *'If they know they're missing out on something they're more likely to shout about it'*.

The voluntary sector was seen as playing a key role in enabling health improvement at a local community level. The voluntary sector was mentioned most extensively in one local level interview where the councillor had a background working in the voluntary sector which meant they were more in tune with some of the issues faced. They identified the important role played by the voluntary sector especially at the local level. Barriers to furthering the role played by the voluntary sector included them not being given *'the credence they deserve'* and the fact that they were embedded in short term planning and funding cycles which were not sustainable in the longer term.

3.1.5 Actions to improve the health of wider communities

The wider community was defined as other groups within the community, other than constituents, which included businesses, local services, people who visit or work in the area. Provision for tourists coming into the local area was also considered in this line of questioning. One local interviewee talked about how some of the local leisure services had been upgraded to meet the needs of tourists but how this led to other sectors of the community missing out. However, another local level interviewee felt that this was not an area of focus for local authority action.

When asked about wider social responsibility and the way in which corporate behaviour might influence the wider community it was noted that to some extent the local authorities did meet these criteria although there was still some way to go. For example, the national level interviewee noted that the local authorities were *'not always'* operating in a sustainable fashion but they were trying to encourage them towards this. They also noted that at a strategic level they were trying to develop a framework for sustainable development and they were trying to tie this in with health improvement. The intermediate level was also seen to have a role in encouraging local authorities to play more of a role in wider health improvement and they saw themselves as trying to maximise the health promoting role of local authorities and then promote them as health improvement agencies. At the local level it was felt that local authorities were signed up to the social responsible agenda. As one interviewee commented social responsibility is *'part of our role'* and they noted that at the end of every report to committee they have to produce an appraisal *'and one of the things we always look at is the environment, as every decision that we make has an impact on the environment'* (LG3-3).

Factors influencing activity

The factors influencing activity in this sphere echo what was presented in the previous sections. One additional factor highlighted was the variation in cultures between local authorities. For example, one interviewee noted that in their own local authority they felt there was a better culture than some other local authorities but even in their own case there was still some way to go with developing corporate social responsibility and associated actions.

It was noted (by the national level interviewee) that it was difficult to convince organisations to take on the wider corporate social responsibility or sustainable development role – as advocated by the latest version of the Corporate Health Standard. It was noted that some local authorities were doing this, but not all:

'They're going to find it quite hard to do I think...they still believe that sustainable development is just about the environment. Its just about waste...they don't see it in the sense of actually the whole impact they have on the community, including the workforce' (LG1-1)

3.1.6 Conclusion

Although there was recognition of the need for a broad range of organisations to take responsibility in health improvement, the local government sector saw a prominent role for itself to the extent that 'almost everything they do impacts on health'. The most significant area of contribution was perceived as improving health amongst the local community although interviewees experienced difficulties in pinpointing the 'most effective' actions in this sphere. Apart from some small scale actions, the Corporate Health Standard was seen as the main vehicle for addressing employee health although this was viewed by some as not pushing organisations far enough in terms of wider Corporate Social Responsibility (although this is set to change in the revised version of the Standard). In the future it was felt that support (particularly from the health sector) would help facilitate organisations to work towards more effective actions to address employee health. Also, raising awareness of the importance of addressing employee health needs to be a key action across the sector and within local authorities, as 'competing priorities' was seen as a main barrier to further action.

Improvements in the functioning of the sector as a whole would go some way to facilitating the role of local government in undertaking health improvement action. This includes more direct contact between the strategic policy level and local authorities with policy makers adopting a greater understanding of local level actions and local authorities playing a more pro-active role in influencing strategy development. This was one of the key issues behind the limited response to Health Challenge Wales at a local level. It was felt that engaging local authorities at an earlier stage of development would have fostered greater local ownership.

Better utilisation of existing mechanisms for joint working (such as the Policy Proofing process at strategic level and the Power of Well-Being at a local level) would be a key area to focus on. Also, further consideration should be given to the use of health terminology (which was perceived as a barrier to engaging non-health partners) and the pooling of financial budgets. Although these interviews have provided an insight into some of the potential issues facing the local government sector, further research to explore differences between local authorities as well as differences in perceptions and ways of working within local authorities, would help refine approaches to supporting the sector in health improvement.

3.2 The Education Sector

3.2.1 Perspectives on roles and responsibilities

Roles and responsibilities in society generally

Across all three levels the majority opinion on the question of responsibilities for health was that responsibility is shared between individuals and organisations. The perspective seemed basically to be that whilst individuals have ultimate responsibility for their own health organisations have an important role to play in facilitating health choices. The key organisations identified were the education and health services, although a role for the food industry was also suggested. The views of three head teachers deviated slightly from this apparent consensus. The head of one primary placed a much stronger emphasis on the responsibilities of statutory organisations, whilst the heads of two other primaries leaned more towards the idea of greater parental responsibility.

Roles for schools

With regard to the role of schools in promoting health and well being the most common suggestion, made by all of the interviewees was that schools should be '*educating for a healthy lifestyle*' through the curriculum. It was also suggested by several interviewees from all three levels that schools should be providing immediate opportunities for healthy living through providing healthy food and exercise. Thinking in broader terms the education directors at intermediate level stressed the relationship between a good education and health and well being and in two of the schools the importance of good pastoral care for staff and pupils was highlighted. Only one concern was raised in this section to question the extent of school responsibilities in the face of parental responsibilities. This was by a primary school head who commented;

'I don't think it's just us alone, I do believe that in some cases – and this again is very personal – I'm concerned that all the responsibility is coming to the schools when there should be responsibility at home... we did have a staff meeting about breakfasts, school breakfasts, and the staff came out with a very clear 'No' that breakfast at home was an important part of their – and I feel that, I really do feel that' (ED3-6)

3.2.2 Organisational relationships

With regard to how the education sector as a whole functions to promote health in schools there was a clear acceptance of responsibility at the higher levels, with all national and intermediate level interviewees recognising the importance of health promotion at their own strategic levels. As well as providing direction, guidance, training and support for schools, the national level interviewee and all three education directors also spoke of the importance of engaging and working collaboratively with other sectors such as social services, health services and voluntary agencies. More in depth discussions also took place in considerations of how these relationships should and do work in practice.

(a) Within sector relationships

In terms of how the different levels of the education sector work together to promote health all of the interviews seemed to suggest a preference for more reciprocal relationships. However, perhaps not surprisingly there were some contrasting perspectives on how far this could be seen

to be happening, with the most positive perspectives coming from above. For example, the interviewee from the Welsh Assembly explained;

'Whereas in the past local authorities were done upon by the Welsh Office, now they're fully engaged. We have partnership councils for instance . . . It not only works in a top-down way . . . but increasingly I will talk to my counterpart in the WLGA and say I think we've got an issue here and we agree it and then we work out a way of approaching it...' (ED1-1)

In support of this two of the Directors of Education considered that consultative arrangements were in place with education professionals and people at the local level. One of the Directors provided an example of 'The Better Schools Fund', as a new initiative from the Welsh Assembly government where it is important that 'cyclical' policy development occurs – *'listening to what local people are saying and translating that into policy development'*. Another Director similarly explained how the Local Education Authority analysed national objectives and applied them to the local setting with schools and other agencies to establish and respond to local targets *'increasingly on a partnership basis'*. The healthy schools initiative was held up as a good working example of this – with a good take up, *'indeed one that is increasingly stretching capacity'*, as schools felt able to respond to the strategy. However, whilst there were some examples of useful 'healthy' initiatives coming out of these relationships (such as healthy schools, eco-schools, improved school dinners, Dragon sports, water initiative, Prepare Plan and Assess (PPA), foundation phase, the curriculum,) there were also reported difficulties which suggested that the policy development process was not nearly as bottom-up as it might be.

'I think there's a far better understanding in planning now, in strategic planning. It's still top down and when sometimes it would be nice to be bottom-up because there are people out there who have very good things to say but it comes from the Welsh Assembly to the authorities to us. For example, in our school development plans we take on board initiatives that are authority initiatives via initiatives that are Welsh Assembly initiatives' (ED3-6)

There was also more overt criticism of government directives for the extra pressure that they put on schools without providing the right support levels, as well as tendencies for 'changing the goal posts'.

'I work in a school and I get bewildered sometimes by the speed in which the emphasis of what we're asked to do changes and I think politicians want to be clear about what they want from us...stop changing the goal posts...it is a very frustrating thing to happen-not easy to respond at a drop of hat, need to plan and train colleagues, look at timetable etc' (ED3-8)

The other main criticism of the relationship was of a lack of funding filtering through the two tiers. The following respondent described a desperate and unmet need for funds to carry out essential building works, as well as a view that Welsh schools lose out because of the Welsh Assembly:

'we always feel in Wales that we never get the full share in the education budget when we hear what's going on in England . . . Tony Blair will announce that x number of pounds is going to be set aside for this . . . but we never see that in Wales . . . it seems to get creamed off at the Welsh Assembly level and then doesn't seem to filter down to us in schools . . .' (ED3-7)

(b) Across sector relationships

Just as the need for more reciprocal relationships was recognised for organisations within the education sector, the many advantages that could be brought from improved cross-sector relationships was recognised by the majority of interviewees. At national level the interviewee

described the growing emphasis on joint working through cross cutting themes and funding sources for collaborative projects;

'I see no difficulty personally . . . in each budget – education, health, whatever – having top-sliced off their budget – just a sliver – and put into a central pot and saying this money is available for joint schemes meeting these criteria rather than simply saying well you continue to do whatever you do on education . . . – to force, let's be frank, to force people to think outside of their silos.' (ED1-1)

Health Challenge Wales was seen as a useful tool for encouraging this kind of strategic approach and the benefits of having different departments working close together with various official and unofficial working groups was also described. An implication of joined up working at a strategic level should be improved multi-agency working at the local level. There were certainly suggestions by the education directors that there was increased co-ordination between local service providers, as seen in *A Framework for Partnership*, the multi-agency *Young People's Partnership* and *Education Strategic Management Committee*, along with the additional work of the Healthy Schools Co-ordinator who work with various all Wales groups. Another Director commented:

'but we do work well together and we've got lots and lots of projects that are jointly run with health authorities locally but across the region as well – I understand we have a health officer which is funded jointly between ourselves and a couple of neighbouring authorities you know and health organisations and that's working out well because then that helps to translate policies into practice in schools and that's instrumental in the healthy living, healthy eating you know health-related issues in schools and really taking the agenda forward' (ED2-3)

However, it was also considered that whilst there was joined up working at the local authority this was not because of the example set by the Welsh Assembly, who was considered still to be dominated by 'silo working'. Instead it was suggested that:

'we are pushing the Assembly you know through national groups like ADU and you know people like that the ADSS we are pushing them the Assembly to become more joined up you know' (ED2-3)

Another school also described positive links with local businesses which had paid for a playground in the school. However, the majority of schools saw a big need for improvement in this area:

'I do think that could be much better developed. We do live in separate worlds, the Health Organisations and Education and at a more general level for the benefit of all children we probably don't work together as closely as we could. Sometimes it can be very difficult to get hold of someone from Health that you may need to speak to and information is not shared always very freely between education and health and that can be quite frustrating at times' (ED3-2)

Another head teacher felt that there is a major problem in the area not just with their school but other high schools in the area. They said that although they supported one of the most deprived areas in Wales the quality of support from both the health and social services is not good.

3.2.3 Actions to improve the health of employees

With regard to actions to improve the health of staff, no strategic moves were suggested to have been taken at Welsh Assembly level to specifically address the health of staff. However, at LEA level more direct action was certainly on the cards. All three Directors commented on the new

PPA scheme and the opportunity it presents to free up teacher time thereby helping to reduce stress. Two of the Directors commented on work being done by Occupational Health professionals for local authority staff. One Director described how a seconded occupational health professional was visiting staff in schools as part of a pilot scheme looking at ways of developing preventative health amongst school employees, whilst another described a growth in exercise referrals across the local authority, as a result of the work of the Occupational Health department. This local authority had also introduced a discounted scheme for staff in all of the local authority leisure centres.

The education directors were not able to provide much of an overview about what was going on in schools in the way of promoting staff health, although it was suggested that in schools which were adopting a whole school approach to health, staff health was probably also being influenced. From speaking directly with heads it did become apparent that in addition to this kind of osmosis effect, roughly half of the schools were taking small but specific actions aimed at staff health, whilst work life balance and the school ethos were also commonly identified to be important to staff health. Improving staff health via approaches to pupil health was mentioned in just under half of the schools. More healthy staff consumption was identified as a result of drinking water drives, accessing vegetable boxes and more healthy canteens. Staff involvement in sports clubs was also mentioned (by two heads) to have increased as a result of renewed focus on promoting exercise and the importance of leading by example was mentioned as a reason for supplying fruit in the staff room (by one head). In terms of actions aimed specifically at staff health roughly half of the schools were able to give examples of relatively small efforts that were being made. These activities included promoting local authority fitness packages (such as reduced membership to fitness facilities) weight loss/ fitness clubs/ lunch clubs for staff, promoting physical activity (such as installing a shower and five-a side competitions) and providing professional health advice and checks through Occupational Health visitors. The other key areas mentioned in relation to staff health were to do with work life balance and the school ethos. Half of the schools talked about the positive implications of the new PPA scheme which will enable teachers to spend 10% of their time away from the classroom to *'prepare, plan and assess.'* This was thought to be positive for health firstly because teachers will have less work to take home with them and secondly because they will have more time to engage in health promoting activities. Six heads mentioned this. Another head also described how the timing of the school day had recently been changed to start and finish earlier, providing staff with more opportunity to use the school gym facilities.

A positive and supportive school environment and ethos was also seen to be important for health and well-being, and half of the schools described ways in which they hoped to be improving the school culture. Suggestions included working to create more equitable management structures and relationships, increased socialising through training days, days out and sporting activities, and improved communication and access to counselling services. Overall, the majority of schools could be seen to be making some efforts at improving the health of staff, with only one school reporting doing *'nothing as yet'* (ED3-5). A majority also commented that they would like to do more in this area and specific examples given included having a dedicated on site counsellor for schools, more staff involvement as part of Healthy Schools, and the introduction of aerobics classes and screening services.

Factors influencing activity

Considerations of the key factors influencing the health promoting work of schools sheds an important light on the drivers, barriers and facilitators being experienced by schools and the apparent differences that exist between schools. Important factors here seemed to be management perspectives and resource issues. With regard to reasons fostering activity, a key theme coming across seemed to be the awareness and vision of either individual staff members or the staff team generally. For example the head of one of the more active schools explained

how they had been one of the first schools to pilot the PPA because the head *'basically thought it would be a good scheme and wanted to get in early'*, and their comments suggested a desire to improve working conditions. They talked a lot about social benefits and *'taking the pressure off'* and described how by requesting teacher plans to be in on Friday and giving teachers Thursday afternoon off to prepare their plans, they had purposefully arranged the new system to *'free up'* weekends (ED3-01). In other words in this school the personal commitment of the head came across as an important determining factor.

In one of the secondary schools, rather than just an individual lead, the driving force was seen to come from three key staff members who were pushing the health agenda, whilst in three other schools a more staff wide awareness was seen to be important. In one of these schools a growth in collective awareness on health issues was seen to have come about as a result of renewed focus on health generally and in education specifically. In another school the head described the general *'sporty'* ethos of the school as an important factor and another primary head spoke of a *'two way caring philosophy'* that promoted development which would benefit the staff. Another important factor reinforcing positive perspectives in this area was the positive feedback of benefits brought by some of the activities, in terms of both benefit to staff and benefits to the school. This included positive staff feedback (*'I've got my Sunday back'*), observable benefits to staff health (such as group of staff losing weight), and more socialising as a result of healthy activities, less absenteeism and increased take up of school lunches. Three of the schools also specifically commented on the link between good staff morale and improved performance, suggesting a win-win situation for schools here. However, whilst there were these positive perspectives on health promotion for staff, several of the interviewees also saw problems and limitations to the kind of actions they could take, stemming essentially from ideas about individual responsibility and rights. At national level it was explained:

'I wouldn't say, to be honest, that we have done anything that's really explicit for teachers. I suppose we take the view that teachers are of age, they must look after their own eating habits and so on. They must be covered by the wider health and wellbeing agenda as adults' (ED1-1)

This concern with the limits of interference was similarly discussed in three of the schools, although more from the point of view of not wanting to be seen to be pressurising or *'dictating'* to staff, rather than because they did not see it as their responsibility. Given these perceived barriers and the importance attached to positive staff feedback and morale, it is also not surprising that there were suggestions of the need to *'find out what staff want'* reflecting an apparent reluctance on the part of heads to take too much of a lead, and advocacy for a more participatory approach.

The flow of resources, guidance and statutory requirements from the governmental level down to school level was also frequently identified as important to health related activity for school staff. The PPA and Healthy Schools were two examples given of national initiatives likely to impact positively on staff health, but more commonly issues were raised with regard to funding and guidance. At Welsh Assembly level there was a concern that *'if you do it for teachers you have to do for other groups such as nurses'*, whilst the perceived problem of spending public money on public sector employees was similarly reflected on by an education director. Funding and guidance difficulties with the PPA, along with a lack of guidance for health promotion were highlighted as barriers by an education director and a quarter of schools especially given the need to prioritise pupils. Resource issues were similarly raised with regard to what would help schools to take more action, including suggestions of ring fenced, long term funding and specific training for key staff. Given the apparent concerns with competing priorities for funding it was also suggested by an education director that the benefits of improved staff health such as less absenteeism and better work, should be made clear as a way of justifying investment in these areas.

3.2.4 Actions to improve the health of pupils

With regard to actions taken to improve pupil health the national and intermediate level interviewees commented on the uptake of schemes, reporting a relatively big uptake on the drinking water initiative and a relatively low uptake of breakfast clubs. Two of the education directors also said that there had been a positive response to efforts to improve school dinners in their local authorities. However, they both also commented on the considerable variety that exists between schools in terms of their approaches and actions. All of the schools reported positive actions that they had taken to address pupil health, although there did seem to be considerable variation between schools. In terms of national programmes the majority of primary schools were participating in the Healthy Schools Scheme, roughly a quarter of schools had taken part in the drinking water initiative, half of the primaries mentioned that they were running breakfast clubs, and one primary mentioned the Dragon Sports Programme. In terms of practical activity, the key actions described by schools can be classified into the following areas; providing for health (food and exercise provision, health and pastoral care) and educating for health.

In terms of providing more healthy meals three of the primary schools offered a breakfast club. Roughly half of the schools had taken steps towards improving school dinners, often having restricted the sale of fried foods to one day a week, introducing salad boxes and pasta dishes in their place. In addition to school meals roughly half of the schools had also started to restrict unhealthy foods such as banning vending machines, fizzy drinks and 'reward cultures'; with half of the primaries having banned outright food such as sweets, crisps and fizzy drinks. Roughly half of the schools again had been actively promoting healthy snacking, for example through fruit or healthy food tuck shops, promoting water drinking or simply by replacing the usual chocolate bar and fizzy drink offered at homework club with a healthy snack. In terms of exercise just under half of the schools considered that they had made particular progress in this area, largely through increasing the number of activities on offer to pupils at lunch time and after school and in one primary by consciously incorporating more aerobic activities into PE time such as dance aerobics. Other suggestions on how schools were addressing the immediate health needs of pupils could be broadly categorised into the area of 'health and pastoral care'. In terms of health care, actions mentioned here ranged from the fairly standard visits of dentists and nurses, to more innovative projects such as the introduction of family 'drop-in' centres at the school, direct links with the local health centre such as visits from a community doctor, and confidential referrals by the school nurse at a secondary school. Another secondary head also described positively the weekly visits of an Information Bus provided by the Borough:

'that offers once a week free advice-fabulous, wonderful, they will also offer advice and counselling on contraception.... Good example of how the health authority, education and social services have worked together to provide service for young people' (ED3-8)

In terms of more general pastoral care, one primary school described the important contribution of the school council to the school environment and ethos and half of the secondary heads described the important role played by their counselling. A bullying project being run in conjunction with a Communities First partnership was also mentioned as a positive step.

With regard to providing health education the majority of schools mentioned the PSHE or life skills curriculum as an area where they were taking action to improve health, as indeed would be expected given that it is a statutory requirement. However there were examples given by a third of schools to suggest that they were going one step further by participating in particular projects. Examples included; a local authority project involving a peer counselling approach to drugs, a sex education programme being run in conjunction with a university, bi-annual 'health fairs' run by sixth form and 'Healthy School' days.

However, as well as specific subject lessons on health education, much of the literature calls for a 'whole school' approach to health. This would mean not only looking at provision and specific health education lessons, but also looking at ways that health could be addressed across the whole school; across the curriculum and the school environment. The importance of integrated and mainstreamed approaches to health is highlighted by St Leger (2004) who sees a settings approach as the most effective way to bring about health improvement in schools (St Leger, 2004). Encouragingly, there were indications given by roughly half of the schools of moves towards more coherent cross curricular approaches. Examples here included using the science curriculum, PE lessons and developing themed displays. The importance of educating families as a way of improving pupil health was also raised; one primary head described how they had sent advice out to parents on pupil lunch boxes, whilst another described the potential of the drop in centre to raise family awareness. There were also further examples given which suggested moves to incorporate health more centrally into the mainstream school agenda.

For example, one primary head described his efforts to extend health across the school:

'My task was to bring it together-been into fruit for long time, into schools council-giving them a say, bringing parents into the pack, now looking at healthy breakfast, healthy lunch, looking at teaching in the classrooms which supports role modelling the right way the nurse comes alongside us with the new parents, the dentists work here with us-health education as well as checking teeth. It's more broad now' (ED3-01)

This concern with continuity and increased participation around health was also suggested in a secondary school interview. This head described how the review of the national curriculum was

'providing opportunities to get involved with "essential 'enrichment' activities ...subjects can be used as vehicles can't they e.g. look at history of Wales and issues with mines, industry, illnesses associated with that, and is a rich scene of interest and enthusiasm and it's local to the kids, it's about their nation. But if you're rushing from the Tudors to the Stuarts you haven't got time to do that." Although this kind of approach was not yet being implemented in the classroom it was considered to be "work in progress.' (ED3-08)

Plans for the development of a cross-curricular approach were similarly mentioned in another secondary interview. Talking about the healthy canteen the interviewee explained:

'what we're trying to do with the next phase is to tie it in with the curriculum, so developing aspects via other areas e.g. obviously in Food tech but less obviously in languages looking at where food comes from, geography they've been looking at sustainability, eco-friendly, organic that kind of thing...' (ED3-09)

Factors influencing activity

The beliefs and perspectives of heads and key staff again came across as critical factors in shaping the health improvement agendas of schools. The majority of the heads when asked seemed to see their approaches to be fundamentally responsive to a perceived need to improve pupil health, along with recognition of the benefits that such actions could bring. Even one of the least active schools commented: *'we want healthy children because healthy children come to school on a regular basis and therefore will learn more and our job is made easier'* (ED3-5)

One of the more active secondary heads similarly explained:

'get sense of what's going on, and look around youngsters in school and see that some of them are malnourished, some of them are not on a balanced diet and that's the overriding thing you look at them at see the best way of moving forward' (ED3-8)

There were also examples given of work which was more directly responsive to specific needs such as mental health or the need to continue the good work being done at primary level. Most schools were also able to list observable benefits brought by the health promotion work, which in turn strengthened the health agenda. These included healthier eating and awareness (as suggested in good sales of healthy foods, good participation in activities), improved concentration and behaviour, 'fun' had by staff and pupils and improved community ethos and canteen revenue through pupils choosing to eat on site.

However, whilst all of the interviewees recognised the importance and the benefits of promoting pupil health, there were also notable differences in the perspectives of interviewees which seem likely to have an influence on school approaches. These variations related firstly to ideas about the place of the school in promoting the health of its pupils and secondly to the place of health in the school agenda. Whilst there seemed to be recognition across the board that schools could only do so much in the face of extra school influences, there was variation in terms of the extent to which schools thought they could and should go to improve pupil health. Limits to the impact of school actions were identified by a secondary school in terms of pupil choice and their ability to 'vote with their feet' (such as visiting the fish and chip shop at lunch time), and by three primary school heads in the context of competing parental influences such as unhealthy pack lunches, buying sweets, visiting McDonalds. However, whereas some schools saw parental roles and responsibilities as reasons not to undertake certain activities, other schools did not see this as an obstacle in itself. Discussions about breakfast clubs provided a good example of some of these contrasts. One primary head rejected the scheme on the basis that breakfast should be provided in the home, whilst another primary head explained their reasons for not adopting the scheme because:

'the very children we'd want to come to have breakfasts are the ones who come in late-so they're not going to come half an hour earlier to have breakfasts are they?' (ED3-5)

The head went onto explain:

'I think we're doing a fair amount yes and I think we have got to be careful cos I think it is the parents responsibility to ensure the children are healthy first of all, and I think if we take all the responsibility in 1 years we'll be sued for the fact that we haven't done this or we haven't done that-don't think we are responsible in those terms' (ED3-5)

By contrast in one of the most active primaries the head viewed the school's relationship with the home rather differently. This head instead seemed to take the view that if breakfast was not being provided in the home it should be provided in school, and if parental attitudes were stopping needy children from taking advantage of school breakfasts then the school had a duty to try to overcome these barriers, rather than just accepting them as fixed and unchangeable. It was explained:

'I know that we've led in certain things e.g. very keen to have breakfasts, and that's because I could see its advantages for us.... We want to have control over what we're doing to make sure children who don't get fed get fed, we need more flexibility to cater for needs' (ED3-1)

Whilst the head from this last school seemed to have a fairly pro-active, holistic and community based vision for their school, the head from the other less active primary made no such suggestions. In other words there seemed to be some difference in how heads viewed both the place and the potential of the school to improve pupil health in the face of other influences, which

would appear in turn to have an effect on the extent to which schools are prepared to take certain actions.

As well as ideas about the roles and responsibilities of schools in promoting health, there seemed to be some variation between schools in terms of how health fitted into the school agenda. The importance of health improvement being centrally linked with school improvement is highlighted by St Leger (2004), and was also suggested by an education director:

'Once you convince schools that this agenda is just about as much to do with school improvement than it is to do with social and cultural issues, then I think you're on a winner because schools will see there's something in it for them' (ED2-3)

This way of thinking seemed to be occurring more in some schools than others. Whereas some schools seemed to have a more 'laid back' awareness of health issues, which was seen to be responsive to general societal trends and influences such as the Jamie Oliver effect, other schools saw their health agenda as much more intrinsically linked with the direction, approach and philosophy of the school. For example, two schools described how the health agenda was a central part of its mission to become a 'community school', or a 'sustainable school'. The following points were raised by a head of a school which seemed to be taking some of the most comprehensive approaches to health improvement:

'I just feel privileged to be taking part in this because it is something that I really want to make sure before I hand this school over to somebody else I'd like to think that there was an ethos and a culture in the school and community where everybody was looking for the best of health and to grow up concerned for their health and welfare and the environment. That's all!' (ED3-6)

School activity therefore seems to be influenced not only by staff perspectives in the sense of where they see their responsibilities lying, but also with respect to how centrally health is tied into the general direction of the school. Where health improvement seemed to be intrinsically linked with school improvement schools tended to be more active. In line with this apparent trend one education director advocated the development of a clustered approach;

'I think once you've proven success in schools then they tend to jump on the bandwagon so that's why a cluster approach is good because you've got a group of schools that you can then share the best practice right across an authority and then that increases – it builds the momentum if you like. Particularly if you can prove it linked to behaviour and various things like that' (ED2-3)

Whilst the beliefs of key school leaders seem critically important in determining the boundaries of school action on health improvement and how health is incorporated into the school agenda, resource issues were also identified as important influences. Even more so than in the section on staff health, the flow of resources, guidance and statutory requirements from the governmental level down to school level was seen to be a critical determinant of activity in schools in terms of driving, facilitating and obstructing change. The majority of schools made some reference to national schemes as having provided encouragement and some kind of framework and sometimes funding for change. The Healthy Schools programme was the most commonly mentioned, although the Early Years Foundation Phase, the drinking water initiative and the breakfast club scheme were also identified. The 'freeing up' of the national curriculum was also seen positively in terms of allowing more space to address health issues. Two schools also described the positive contribution of the local authority in helping to address counselling needs and in providing training and support with providing healthy food. The benefits of information sharing and joint working between schools was also suggested by one secondary head who described the usefulness of the secondary heads association and their '*good weekly briefing news letter*' as well as by a primary head which positively described the '*clustered approach*' of the LEA and the good relationships and common goals that are forged between primary and

secondary schools in the area. A primary head also explained how they had taken up eco schools and dragon sports after hearing about the experiences of other schools and commented:

'I think that's great because it certainly isn't something we've been told oh you must do this which I appreciate but there is support there' (ED3-5)

As with barriers to improving staff health, difficulties with resources in terms of time, funding, training and competing pressures or priorities were mentioned by a majority of schools as factors undermining the health agenda. Of particular concern here was the short-termism of certain projects and the unsustainable implications of the bid culture in which schools operate, as noted by three heads. Adding to these resourcing difficulties, several schools had issues with the level of bureaucracy of certain government initiatives and the unnecessary pressure and tensions this caused in schools such as the paperwork for Healthy Schools, strict guidelines for breakfast clubs, strict approach of the Healthy Schools co-ordinator. The constant *'moving the goal posts'* through forever shifting government priorities and guidance papers was also identified to cause difficulties with planning and training. Suggestions of what would help not surprisingly reflected barriers already discussed; increased longer term funding, more staff training and so on. With regard to training a particular concern and need for guidance was mentioned by one primary head with regard to health education, due to the difficulties the school experienced teaching about drugs and smoking in an area where some of the pupils already smoke and certain parents are known to be on Heroin. The lessons here were thought to become too personal - *'so and so smokes/ mum's a druggie'* and guidance was needed on how to overcome these difficulties.

The desirability as well as the difficulties with cross-sector working generally have already been discussed in section one, but these issues were raised again in the more specific context of factors obstructing and facilitating health improving activity in schools. Two of the secondary schools highlighted a lack of co-operation between service providers, which they believed to stem from the different agendas of other agencies such as LEA catering. However, there were also several examples given of useful collective working between local organisations and bodies. The positive example of the multi-agency Community Bus has already been described and another secondary described how they have been working with a number of community organisation *'to develop this sustainable co-operative community'*. (ED3-9)

The importance of participatory processes for targeting needs and gathering support was similarly highlighted. For example, one school described the mental health work that was being done following an audit of pupils, whilst another secondary described the positive support given by parents following questionnaires sent home. Another school described the important commitment of the governors to the health agenda, and also explained how school involvement in the Children and Young People's partnership apparently facilitates better relationships with the LEA and government. Two primary schools also pointed to the role of school councils.

3.2.5 Actions to improve the health of local communities

In addition to staff and pupil health, schools are also thought to have considerable potential to influence the health of the local community. It has been suggested that schools may influence the health of parents and the local community through fulfilling an *'extended school function'*; by providing health related services and activities for the local community (DFES, 2002), as well as building links generally with the local community from the point of view of building social capital (Denman et al, 2002, Ford, 1999). Schools also have considerable influence on the health of wider populations, for example, through the education that they provide to pupils and their corporate behaviour such as recycling practices. Both of these spheres were explored in the interviews. With regard to activities aimed at improving the health of communities, a couple of the education directors pointed to the potential for community involvement through some of the

schemes already in place such as Healthy Schools week, the Children's Centre and other community initiatives as well as shared leisure facilities. Although they were not able to provide any detailed overview one education director did suggest a few examples of good work being done by schools in this area. For example, links with elderly through embroidery classes, Healthy Schools Week, links to local food co-ops, school meals being put on in the evening. It was also felt that through raising pupil awareness of health issues, schools would be generating greater awareness in the wider community. These types of contributions were also highlighted by schools, with the least active tending to point only to the 'knock on' effect and possibly shared leisure facilities. However, roughly half of the schools also described ways in which they were more actively engaging with parents and the community. Examples were given of providing information and services such as sending healthy eating information and questionnaires out to parents, supporting wider parent needs such as literacy support, running events such as healthy eating days, sports and activities days for parents to attend, running weight loss/ PE sessions for the wider community/ activity clubs for parents to join in.

Examples were also given of schools contributing positively to the lives of the people in the community such as work with elderly, cleaning up local spaces, and it was also pointed out that by catering properly for pupil needs, especially mental health, the community would by implication benefit. There were also further examples given of more general efforts to develop better school and community relationships by 'opening doors', holding meetings, dances, clubs, working with other community organisations. One education director and a third of schools (most already active in this area) also offered examples of community oriented work planned for the future. Examples included; exemplifying good practice, developing a model of care for minority ethnic/ traveller families, better guidance on nutrition for parents, developing work with voluntary organisations, employing a dedicated on site health professional or community liaison officer, a move towards 'Children's Centres', and the co-location of important community services at schools. If implemented much of these suggestions could be important to community health in terms of both improving the services on offer to the local community, as well as helping to strengthen the community more generally.

Factors influencing activity

As with the previous two sections, management perspectives again emerged as a key driver for promoting health in the community. Whereas a couple of the schools quite clearly had a very limited view of the role of the school in community, seeing its sole purpose to be educating pupils, other schools embraced the idea of school and community links and participation much more strongly, seeing a central role for the school in the community and some responsibility to the health of the community. It was the schools which have been adopting the most comprehensive and holistic approach to health that seemed to lean towards such a perspective. For example, one primary head explained;

'I think the centre of the community could become..... in the new school we have built community facilities-got own kitchen in there, own toilets, and two rooms for them to use, IT suite has double access-its about opening the doors up and saying we're doing certain things come and join us including trying to impact on the community and its broader health, I'm not going to say what they're eating...but then if they see the posters around and the work we're doing it might (impact on eating)' (ED3-1)

The philosophy of schools as 'sustainable school' and as 'community school' also seem to have encouraged schools to look at the broader picture. For example, the philosophy of the 'community school' was described to be 'changing students' attitudes to learning whether it's through sport or other cultural activities' and by encouraging parents to be involved through joining in the activities with the students. These were described as:

'small wins but it's going down the right pathway of getting parents working alongside their children, engaging in their learning, engaging in healthier lifestyles, all at the same time' (ED3-10)

In terms of what has helped and hindered this kind of community approach, much of the suggestions again came back to a question of resources. Plans or desires for increased activity clubs, community liaison officers, health professionals, community facilities, were recognised by a majority of schools to be dependent on funding being available for schools to take on these extra activities in the face of competing priorities. A particular need for long term, ring fenced funding was also highlighted by two schools as a way of *'taking the pressure off bids'* and another school highlighted the need for *'people at strategic level to put those changes into place'*, with respect to the planned co-location of services at schools. Relationships with local organisations and the communities themselves were not surprisingly also identified as important factors in this area. On the subject of agencies, there were calls for improved co-ordination between local agencies. However, positive examples were also given of the strong lead of Communities First partnerships, useful suggestions from the community police officer, and the positive role of the Children and Young Peoples Partnership.

With regard to the local communities themselves one secondary school described general difficulties with *'insular communities'*, whilst a primary school expressed concerns over preaching to parents through sending letters home. Another primary head described a lack of communication and a reticence of parents as factors causing difficulties for the planned Mothers and Toddlers Group. However, this school also described their own need to find the *'right person'* and overcome this inertia, suggesting that building good links with local communities was seen as dependent on both the efforts of schools and the local people. Where this was starting to happen this was seen as a real help. For example, one primary described how opening the school up for public meetings and classes really helped bring local people into the school, whilst another active primary described how they were inundated with requests and suggestions from community groups.

A final observation here is that working with the community seemed a relatively new area for schools requiring considerable extra guidance, co-ordination and support to facilitate the development of effective relationships. Given that work in this area does seem fairly new and largely dependent on management attitudes, sharing good practice and providing evidence of positive links between community work and school improvement will also be important if such approaches are to develop across schools.

3.2.6 Actions to improve the health of wider communities

A final area to be explored briefly in the interviews was concerned with activities and issues relating to the health improvement of the wider population. Due to the length of some of the interviews some schools were not able to answer questions in this last section, and generally schools did not have as much to say here. From the discussions that did take place two main areas emerged in connection with environmental and citizenship issues, although generally the interviewees only responded when asked directly about associations with the terms *'environmentally friendly'* or *'socially responsible'*.

In terms of environmental action all three education directors reported to be promoting *'eco-schools'* which was considered to be popular amongst schools. One of the education directors also considered that sustainable development was addressed through the curriculum and reported to be working towards policies around the ecological environment. The majority of schools that answered reported to have been participating in recycling as well as educating on the importance of recycling, with over half of the primary schools participating in *'Eco-Schools'*. With

regard to citizenship issues, the importance of participation was highlighted by two education directors, who pointed to the positive contribution to be made by the Children and Young People's Partnership and the role of school councils in encouraging responsibility and awareness in pupils. Two primary schools also mentioned the role of school councils in encouraging responsibility and participation, a couple talked about 'global citizenship', supporting charities and educating about poverty, whilst another pointed out that just by providing a good education they were fulfilling a socially responsible role.

Factors influencing activity

Due to limited time and limited discussion in this last section, there was not much consideration of factors influencing activity in these areas, although some limited observations can be made. Firstly Eco-Schools as a national initiative seemed to be viewed positively as a scheme which encouraged schools to take up environmental activity, although one primary reported that there was also '*a little bit too much work*' involved. The importance of having a lead and commitment from individual staff was also highlighted by one primary head who described the contribution of the Geography teacher. The same head also described clear benefits brought by the scheme evident in the raised awareness of children with regards to ecology and the environment, as seen in 'knock-on' effects such as encouraging children walking to school. In other words, from these brief insights, staff perspectives and commitments along with national guidance, direction and resources again seem to be important influences on work in this sphere.

3.2.7 Conclusion

Across all interviews there was strong acceptance of a role for schools in improving pupil health. To a lesser degree there also appeared to be some acceptance of roles in improving the health of staff and communities. Participation in health promoting schemes was widely reported across schools, and all schools were taking at least some positive actions in terms of both providing for health (such as the provision of food, exercise and pastoral care), as well as educating for health (such as PHSE, through the curriculum). With regard to staff health only one school reported to be doing '*nothing as yet*'. To varying degrees all other schools were taking actions through impacting on staff health via pupil health (such as improved consumption in canteen, participation in sports clubs), through specific actions for staff (such as weight loss clubs, health advice), and through work life balance and the school ethos (such as freeing up teacher time, social activities). With regard to community health roughly half of the schools were making notable efforts to engage with parents and the community (through providing information, running clubs for the community, encouraging community work, building stronger links with the local community.)

National schemes and directives were mentioned positively as factors encouraging health promoting activity (including the PPA, and Healthy Schools scheme), whilst issues with funding and guidance were mentioned across the board in terms of limitations and facilitators for action. Local collectivity provided another potentially important stream of resources for schools and was mentioned frequently in relation to the desirability of improved service co-ordination and greater participation by staff, students, parents and the local community. However, whilst there were these common areas and common influences emerging there were also considerable differences between schools, with some schools pursuing a much more holistic approach to health than others. One suggested reason for these differences was the different local circumstances of schools and the difficulties experienced by schools in deprived areas. However, some of the most active schools in this study were from more deprived Communities First areas and in this study the overwhelming factor coming across to explain apparent differences did seem to be the perspectives of heads. However, it should also be considered that differential resource levels will likely influence teacher perceptions of the potential of a school to make a difference, as indeed

was suggested in the most negative interview where the interviewee repeatedly mentioned the unacceptable physical condition of the school and the severe lack of funding that they were experiencing (ED3-7). It should also be noted that the most active schools were selected because they responded to a survey questionnaire or were chosen because they had good practice and in this sense probably are not typical.

There were also several general implications with regard to how schools might be encouraged and enabled to take more action to promote health. Given the apparent importance of school perspectives on health, along with an expressed dislike by some schools of being dictated to, a useful development might be for greater information and good practice sharing between schools and the development of evidence bases on the impact of interventions and approaches. This kind of approach might therefore help to spread positive perspectives on the potential of schools to influence pupil and community health and the relevance of improving local health to overall school improvement. However, as well as promoting positive perspectives and good practice, the interviews also strongly suggested that ensuring adequate resources in terms of funding and guidance will be critical to enable effective implementation of health promoting approaches, particularly in the face of otherwise competing demands on resources.

3.3 The Health Sector

3.3.1 Perspectives on roles and responsibilities.

Roles and responsibilities in society generally

There was overall agreement amongst respondents about the need for a collective approach to health improvement. As one intermediate interviewee commented *'everybody has a responsibility for improving health, from the Assembly Government down'* (HS2-2). Another intermediate level interviewee commented on how responsibility was seen to be shared at all levels – individuals, local and national organisations. However, within this collective approach to addressing health improvement, some organisations were perceived as having more prominence over others. For example, two interviewees highlighted a key role for local authorities particularly with regard to addressing the wider determinants of health. One summed up this role as follows:

'In terms of actually delivering health improvement, local government is hugely important. I think they have control over most of the main levers' (HS1-2)

Another interviewee saw local authorities having *'an even bigger impact on health than the NHS does'* (HS2-3). Organisations were viewed as playing different roles and able to contribute different types of input into health improvement action. One interviewee noted that some like local government have great breadth and depth to their roles so can contribute a great deal (although this needs to be drawn out). Secondly they are large employers in their own right and will have responsibility for them. They in turn have families, *'so there's a chain'*. Contrasted with this is the media who are also employers but their main role is communication, so it needs to be harnessed to provide the right information for the public. Interviewees agreed that individuals should take some responsibility for their health. However, there was recognition across the sector that individual responsibility was placed within a framework of public sector support.

'people lack the skills and the confidence and the environment, the home circumstances etc, to take responsibility for their life because they haven't got the income, the confidence and so on' (HS1-1)

It was also felt that certain individuals needed to be supported by organisations and institutions, more than others, so support was needed for groups like the elderly that are more vulnerable than

others. In describing this framework of support, local level interviewees referred to the situation in their own communities where some people were very dependent, needed a lot of support and tended not to take responsibility for their own health. However, despite this acknowledgement of the need for structural support for individuals it was noted that this would only be effective if individuals were receptive to help and support.

'if they don't want to listen...A lot of it is patients taking responsibility for themselves as well or being encouraged to do that' (HS3-5)

Roles for the health sector

For those working in public health, their main contribution to health improvement was to provide organisations and individuals with access to specialist public health experts, such as smoking cessation experts.

'Our main role is providing all those organisations I've listed above - and the public - with access to specialist public health input. A lot of people do public health but we are there to support, advise, occasionally direct/manage...provide that specialist resource, the health information and intelligence, the evidence behind things, advice on evaluation...so our role in a nutshell is specialist public health expertise' (HS1-2)

One intermediate level interviewee working in public health noted an important role in terms of addressing structural influences on health and health inequalities. It was also important for public health organisations to take responsibility in *'getting the right messages across'* about healthy living (HS2-2). Looking towards the future, the emphasis was on understanding local level needs with local level organisations adopting a more pro-active approach:

'move away just from dealing with people when they have a problem to try and anticipate what sorts of problems they might have...and that in a sense is what the local health social care and well being strategies should be doing...is that moving up-stream and getting a grip on some of the determinants of health' (HS1-1)

It was also recognised that those working in health care services could be making a significant contribution to health improvement at a number of levels: improving the health of the workforce; behaving responsibly as well as directly undertaking some preventative action:

'A lot of what the NHS currently deals with is the consequences of failure to act earlier...the NHS can do what it can. It can do what it can to improve the health of its own workforce, it can do what it can to behave in a responsible manner, set an example, be a role model and there are some preventative activities that come into the remit of the NHS like screening, immunisation' (HS1-2)

Although the health service had the potential to engage in preventive work this had not as yet been fully realised because of the focus on treatment and care. It was felt that in the future, there would be an increasing role for the health services sector to be more concerned with health improvement:

'If I was to look to the future that all the organisations that I mentioned earlier have to be a bit more assertive. No a bit more pro-active should I say, at keeping people well in the community and not just be seen as an NHS that treats people when they fall over' (HS2-4)

They also commented on how the Designed for Life Strategy is likely to have an impact in moving services towards a more pro-active role – *'but we've got so much catching up to do unfortunately'* (HS3-1), and they commented on how the current situation mainly functions as a reactive service.

Integral to an increasing role for the health care services in the future, was a specific role for health professionals. One intermediate interviewee noted that in the future we will be more likely to see health professionals interacting with the public and taking more of a prominent role in health improvement.

'no matter what the government does nationally, no matter what the region may be saying, they're not the ones sitting down with 170 odd thousand citizens' (HS2-2)

However, within the current situation it was noted that the health care services lack the capacity to take on a wider health improvement role and that greater involvement from the health care sector had to be accompanied by greater resource:

'We just do not have the capacity to take that on and I don't think any [health care service] has. You can make a difference at the margins by the way I expressed it earlier, when patients come in, but it's very difficult to take it on' (HS2-4)

3.3.2 Organisational relationships

(a) Within sector relationships

Ultimately the main drivers for health were seen to originate in Whitehall (HS2-1) and were related to national economic, fiscal and educational policies which provided *'the underlying climate for health'*. This situation was thought likely to continue for some time as devolution was still at an early stage. These non-health drivers behind health policy were also noted by another interviewee. They perceived that national economic policies such as taxation on tobacco had the major influence on health - encouraging or discouraging behaviour through fiscal measures. There was need however to be consistent in health related policies so that advertising and availability of unhealthy products reflected health policy and health messages. These mixed messages from government created confusion but at the end of the day it was recognised that a short term financial imperative for government may outweigh long term savings:

'An obvious example is the promotion of tobacco in formula one racing...at the end of the day which comes first the health of the citizens or Gordon's (Brown) back pocket' (HS2-2)

As well as these wider policy drivers, health care professionals were also perceived to have a role in influencing policy discourse. The interviewee felt they played a key role in lobbying and driving through change.

'the calls for a ban on smoking illustrate this, health professionals have been calling for this for a long time...they have prodded the conscience of government' (HS2-2)

At the local level Health Social Care and Well Being Strategies were named as a key policy driver in terms of trying to bind together health promotion, prevention and treatment. Local level strategies were also seen to be important drivers. For example, one interviewee described how their own health promotion strategy provided the impetus for much of their work on health improvement. One of the advantages of this was that:

'It retains focus when agendas keep changing all the time, although we change and adapt you've still got an overarching direction so it helps you to keep on track. It also helps you to monitor your progress' (HS3-2)

Health Challenge Wales was seen as one way in which central government demonstrated its commitment to addressing health improvement. One interviewee documented how the drive for Health Challenge Wales came from within Wales and the Cabinet asking for more proposals to improve health in Wales. This was seen as:

'important in its own right, as what we have here is a government who while faced with the pressures of waiting lists and so on have actually decided to stick with the health improvement agenda' (HC1-3)

Health Challenge Wales was put forward as something which was not owned by the Welsh Assembly Government. Instead it was something that should help establish a level playing field for the Assembly and all other organisations and individuals - *'this is as much of a challenge for the Assembly to respond as other organisations'* (HS1-3). Interviewees commented on the way that Health Challenge Wales had given a profile to the health improvement work that is already being done. *'I very much see it as a way of making clear what we do that is intended to improve health'* (HS1-2). They went on to note that it has enabled issues to be put on the health agenda that might otherwise have been overlooked.

'It hasn't actually made any difference to what we do per se. I think it's sometimes made it easier to demonstrate that and to give it a profile because a lot of the time when people talk about improving people's health...smoking etc would have been wrapped up in the usual health promotion initiatives... And I think really Health Challenge Wales is a potentially good antidote to people just thinking about waiting lists' (HS1-2)

Health Challenge Wales was also hailed as a useful mechanism for breaking down the barriers between the health sector and traditionally hard to reach sectors like business:

'...good for people like us because there are things that we'd like to talk to the business sector about...but this potentially gives us an arena in which to do it because you can say I'd like to come and talk to you about Health Challenge Wales...it gives you an opening in through the door' (HS1-2)

Some organisations at a regional and local level documented considerable activity that had been undertaken in response to the Challenge. One interviewee in the health services (HS2-2) said that they were *'massively involved'* in Health Challenge Wales, with many individuals in the organisation co-ordinating events such as sponsored swimming and running events. Another commented that Health Challenge Wales had been *'instrumental in making individuals and organisations more aware of their own roles'* (HS3-3). It was acknowledged that some organisations within the health sector still had some way to go towards fully embracing the Health Challenge Wales concept. Generally it was felt that local public health organisations were further ahead than the local health care organisations. The main reason for this was that public health organisations were seen to be closer to local authorities and had health promotion people in place:

'They are closer to the GPs, and to the community and so on, so likely that they will be closer to the point of impact than [health services] which generally just broadly see people who are ill' (HS2-3)

Three interviewees working in health services at a local level said that they had not taken up the Challenge. One had heard of it but not responded as they considered the actions part of their work anyway. Another interviewee (HS3-1) said they had seen lots of things coming through and although they felt it was the right thing to do, *'health services were not necessarily tied into it.'* It was felt that it was another arm of the Welsh Assembly rather than coming out of the Health Service Division. Although it was recognised that it was important to educate and change people's behaviour, health services were *'not engaged in that agenda, we are unfortunately dealing with*

treatment, we haven't turned around.' This was felt to be particularly the case for acute services. The third local level interviewee who had not responded to the Challenge had not heard about it prior to the interview. Along with reticence in responding to the Challenge there was also some concern voiced at local level about how the concept could raise expectations about the role of the health sector. Their main concern was about the lack of capacity to deal with the independent sector becoming more involved:

'could either get them doing it but doing it badly or if you're lucky they might do it well but if they haven't got the support it's actually a governance issue in my view because you've got no control over whether it's best practice or not' (HS3-2)

They felt that it was positive that organisations wanted to jump on the Health Challenge Wales 'bandwagon' but they felt there was just not the capacity to support that. They noted that they could provide limited support to organisations such as providing guidance on smoking cessation but there was no further capacity to address wider organisational issues beyond that. In terms of relationships within the sector one national level interviewee commented on the leadership role for the Welsh Assembly Government in taking forward health improvement. They saw the government taking a lead to provide a strong sense of direction and set the priorities; make sure things are being addressed in a whole systems way; and identify the sorts of things that are already working (good practice):

'Our job is primarily to set the strategic context for health and social care. Not particularly to organise the service and not to set the individual policy areas, but to set that overall context' (HS1-1)

At the intermediate level, interviewees noted an important role for the national level organisations in terms of providing overall leadership and direction to help on matters where local level organisations could not act alone. The ban on smoking in public places was put forward as one example of where this strategic direction was needed:

'...what would make a very real difference is government direction on a smoking ban because as much as we try to eliminate smoking and indeed this particular Trust is completely no smoking from next April. It is quite difficult to police those if you do not have specific government back up so there are very specific policies that the Welsh Assembly Government would need to bring in to enable things like that to happen' (HS2-4)

A specific role for intermediate organisations was also identified. As a regional organisation, they were seen as having a unique position, influencing the development of national strategy and the implementation of policy and practice at the local level. At a national level they were able to advise ministers and drive forward policy development, whilst at a local level they were able to provide specialist advice and support to public health teams. The main reason why this approach worked was structural and peculiar to Wales, with a common organisation for public health and Public Health Directors splitting their time between policy development and implementation. This gave them a unique insight into the realities at each level.

The view of the functioning of the sector from local level organisations was mixed. One interviewee commented on the positive communication across the sector with regular meetings to up-date on what is going on while another felt that intra-sector relations worked well, with national policies flowing down in a way which enabled good local decision making and local tailoring of policies to meet need. Another interviewee acknowledged that the sector worked well together when they had to respond to a particular problem. However, they noted more problems when the sector attempted to work together pro-actively. They noted that in the past there was excellent working together but that was threatened by new organisational restructuring. Although they noted that there had been some more recent improvement, *'what we're still not doing is sharing areas of expertise.'* Another local level interviewee also described the challenges presented by intra-

sector relationships. They felt this was because the centre and regions *'have no idea how to implement strategy, so I suppose we're the deliverers of their policies.'* More advice and guidance from regions, particularly in terms of outcome measurements, would facilitate this. The different priorities between organisations in the health sector were raised as a potential threat to intra-sector working. One interviewee from an intermediate level public health organisation saw the threat of the existing culture of the health care services which emphasises treatment over prevention and the need for immediate returns for investments. The bottom line being that *'they need to deal with people who are sick.'* Variations in local level expertise were also put forward as something that needs to be taken into account in terms of relationships within the sector. Local teams vary considerably in terms of levels of staff that are experienced and knowledgeable so this results in some teams making greater in-roads into some areas of health improvement than others.

(b) Across sector relationships

Although there was recognition of the health sector playing a significant and increasing role in health improvement, it was also acknowledged that they could not tackle this agenda alone and that partnership working, particularly with the local government sector was integral to the way forward:

'There's a lot of preventative work done by the NHS...but a lot of stuff is shared, a shared agenda with local government and then there's a lot that local government can do within its own powers to improve the health of the population, as indeed can central government...regulation etc...a lot of it resides with local government' (HS1-2)

Positive steps towards effective joint working between the health sector and other sectors were associated with recent strategy developments such as Designed for Life which had encouraged the development of relationships between the health care services, the local authority, and the voluntary sector. Another interviewee also talked about positive engagement with various agencies locally, such as housing, social services, health, specialist agencies, and mental health services and how they worked together to achieve good community care, which they felt is improving. Ensuring representation on all key local partnerships was cited as one effective way in which the health sector could foster effective cross-sector linkages. One interviewee described how they endeavoured to be part of all strategic partnerships in the local area especially the issues based ones around community safety, substance misuse, strategic commissioning groups and advisory planning groups.

'So try where we can to be involved in the strategic partnerships which means right from the start you're getting health put onto the agenda' (HS3-2)

However, despite good headway being made with partnership working there were concerns that there was still a long way to go with some of these relationships and links with some sectors (such as the business sector) were still very limited. Concerns were also raised regarding capacity and the fact that although the sector had quite a large workforce, they were mainly dedicated to implementing programmes.

3.3.3 Actions to improve the health of employees

National level interviewees offered limited commentary on approaches to tackling employee health within the health sector and the only strategic driver to tackle staff health was the Corporate Health Standard (mentioned mostly by national and intermediate level interviewees and one local level interviewee). However, this ignorance was not accompanied with a disregard for

approaches to improve employee health. Rather an acknowledgement that there would be things happening at a local level that they were simply not aware of:

'There's not been an overall strategically directed programme, a few initiatives; I think a lot will be happening at local level' (HS1-2)

Employee health was a sphere they would only become involved in if things got out of hand. This was balanced with the view that the remit for employees' health was mainly confined to adhering to health and safety regulations. These interviewees described organisational statutory responsibilities to protect the health of the workforce and population such as the handling of radioactive substances and incineration. Then there are the Health and Safety issues at departmental level which deal with such issues as Repetitive Strain Injury (RSI) and computer screen regulation. Despite this lack of strategic impetus for tackling employee health there were a number of actions being taken at a local level. This included vaccinations for staff who were working in close proximity to patients, informal discussions about lifestyle related behaviour, staff walking sessions, health checks, and the dissemination of leaflets on healthy lifestyles. Reference to local level policy frameworks for supporting these measures was minimal although one interviewee did comment on the implementation of a family friendly policy which was viewed as being particularly effective. They explained that as about 90% of his workforce were female adoption of flexible working hours through the family friendly policy, had led to improved quality of life for employees with children. A reduction in the sickness rate to about 2% had also been noted although they also mentioned this had always been quite low. This interviewee also noted that there seemed to be more team spirit as a result and felt that the health strategies put in place through adoption of the Corporate Health Standard had also resulted in employees taking the message into their home life as well. Statutory and mandatory training programmes on issues such as health and safety awareness were also mentioned as well as training on management skills which were seen to help senior staff manage more junior members. For example, training covered knowing how to manage people properly, how to deal with sickness and absence and how to deal with performance management.

One of the main areas of concern for staff health was levels of stress amongst the workforce. This was seen to be one of the main challenges facing health sector employees and something which was seen to be on the increase due to overloads on wards and the need to deal with more acute, complex health needs and an ageing population. This had led to the development of sickness targets and monitoring of absences and return to work interviews which, for long term cases, are *'managed to the minutiae.'* In terms of action to address stress one interviewee described the very good occupational health service that was in place where staff were also offered self referral stress counselling sessions, smoking cessation clinics (*'very well received'*), exercise classes and weight loss sessions. This was coupled with good communication between employer and employee was highlighted with Union representation at board level, so that management could keep in touch with what was happening on the ground. A happy, healthy workforce was seen to be one of the main benefits of this action and this was particularly important as staff had to give out health advice and this was more effective if they themselves were healthy.

'a healthy workforce which is a happy workforce as our staff could be our patients if you're not careful' (HS3-1)

These sorts of measures to alleviate stress were mirrored in other local level settings. For example, one local level interviewee working in the health care services talked about clinical supervision from managers in relation to reducing workload stress. They also noted how support was available at the base clinic from colleagues, for offloading in times of stress and whom they would sometimes ask advice and support in relation to work matters with clients. This interviewee also mentioned the introduction of flexible working hours that enabled staff to work the same hours but in a different format and of the availability of job share and part time posts. Overall, action to alleviate staff stress was seen to be working effectively. However, one interviewee

commented on persistent levels of stress throughout the organisation and attributed this to the need for an organisational overhaul in the way staff are managed and valued.

'But unless there's an inclusive approach to change management you start to get devaluing of staff...when we have change management at a local level we have a procedure, we meet with the staff, we let them know what the changes are, we let them know what the future is, we ask them to input what they feel would work well etc, its an inclusive approach' (HS3-2)

They felt that much of the current stress had been caused by the way in which organisational change had been *'imposed'* from above.

'If you just impose change with little consultation and inclusion it causes a great deal of stress in the workforce and I think that has come about' (HS3-2)

Overall, interviewees at all levels felt that they could be doing more for employee health. As one noted:

'Got a pretty sensitised workforce!...whether we're terribly good at taking our own medicine' (HS1-2)

In addition it was felt that addressing employee health could have positive ripple effects for a wider sphere of the population. This was seen as important as staff could engage in diffusion practices through professional and social networks.

'I've always taken the view that all our staff were ambassador for appropriate health care – to pass on good practice and to encourage others to seek information and advice". "We employ going on for 4000 staff, they've all got families, we've got around 10,000 staff out of a 170,000 population, if they can spread the message about health you're going to have an impact' (HS2-2)

Given the overall *'health promoting'* remit of the health sector it was felt that there was considerable room for improvement in terms of health promotion and the workforce.

Factors influencing activity

The organisational complexities of the health sector were noted as one of the main barriers to overcome in terms of taking a more strategic, pro-active approach to addressing employee health. The fact that it is an all-Wales organisation working out of many different sites was an issue although it was noted that *'communication structures are getting much more robust now'* (HS1-2). The resources available for doing this line of work were seen to be limited in their current form with staff at a local level not really sure about the priorities regarding this sphere of work. Local health budgets are generally driven by meeting patient needs and although it was felt that work could be done for staff if they were also classed as patients there was not perceived to be much scope for action beyond this. Even where frameworks were in place for tackling staff health, resource limitations (time) were still viewed as a hindrance. For example, one interviewee referred to the level of bureaucracy and paper work that accompanied the implementation of the Corporate Health Standard. Some local level organisations had effective mechanisms already in place through which to communicate with staff and deal with issues arising. One interviewee described the open and honest relationship they had with staff within their organisation and how they met everyone as a group on a monthly basis and also held one-to-one briefings with all individuals. When asked what had encouraged this sort of set up, the interviewee referred to *'personalities and a good team'* which was very experienced in dealing with organisational change. They also noted that:

'It's about having no hidden agendas from the staff and making them feel that they're party to decision-making' (HS3-2)

Despite some effective actions being taken at a local level it was suggested that improvements to the way the health sector functioned as a whole would enable this action to be better supported. In particular one interviewee described the scope for improvement in the way in which staff were managed as a way of addressing stress levels.

'I think there's an assumption that because people are very professional and very good at their professional role that they can manage staff and that is a wrong assumption. I think there are staff who are managing great teams of staff with them having no training and also no experience, just because they are very senior in their professional role' (HS3-2)

They also related to the perceived lack of awareness of this poor management at a senior level and the fact that this inhibited better support for staff and the avoidance of stress related problems

'I think there's also an assumption that management just happens and it doesn't. Management is a very skilled thing to undertake and if there's no acknowledgement of that again at senior level then there's no acknowledgement of the time then that takes at a local level to support, supervise staff making sure they're as stress free as possible and can do their jobs as well as possible. So for me it's about having people who are very experienced managers managing staff. And those who aren't experienced, supporting them to get the training required so that they can then undertake their job better' (HS3-2)

So ensuring appropriate management training is in place, together with support for this at a senior level was seen as ways of tackling this issue. The interviewee also put forward the idea of short term secondments to provide peer support to colleagues throughout the health sector as a means of providing more support to less experienced teams. It was also felt that other mechanisms within the sector could be used as exemplary good practice. Effective strategies were seen as those that were well resourced, and had well trained staff with clear roles and lines of responsibility. A good example of this was provided by the development of Infection Control Teams to tackle hospital acquired infections.

Recognition of the benefits of improvements to staff health was seen as a main driver to implementing these sorts of actions and overcoming some of the associated barriers. For example, despite the financial cost to the organisation (in money and staff time) it was felt that these costs should be balanced against the more positive staff morale that ensued. Failure to recognize the benefits of improvements to staff health were seen to confound poor levels of staff morale which were already apparent in some local organizations. The constant pressure to meet targets, personnel being frequently *'pulled up'* when things go wrong together with the removal of things like contributions to Christmas decorations were all sent to contribute to a disheartening climate for staff and the failure to tackle staff health in any other sense contributed to this low level of morale.

3.3.4 Actions to improve the health of local communities

In responding to this section there was a distinction between health care service interviewees (who tended to focus on patients as the main communities served) and public health interviewees (who spoke more about local communities as their main sphere of influence). Some specific actions were referred to by local level interviewees working in health care services. These included providing smoking cessation helpline numbers, making referrals to exercise schemes, providing patient health checks. Although it was noted that there was a limited amount being done directly in terms of health education mainly because they had a limited amount of time with each

patient. For those based in public health this was a difficult section to comment on as *'the very nature of their work focuses on improving the health of people they serve'* (HS2-1) and *'that is what we are here for'* (HS3-3). The most effective actions taken to improve the health of local communities included reference to Healthy Living Centres where the interviewee described a whole raft of community development initiatives from smoking cessation to play.

'They're also involved in coming up with solutions on how they would resolve those issues alongside any organisations that could help them. So there's a real sense of not being done to and that's really important for not creating dependency in communities. Practically wise, its also helped to attract additional resources to those communities, albeit project funding, temporary funding but nevertheless if you can have ongoing temporary funding in communities you can actually sustain quite a bit. And one thing we always say is it's not the project we want to sustain it's the skills and capacity that people achieve while the project is there is what's sustainable' (HS3-2)

Within this framework the main role of the health sector was to make sure health is on the agenda. Previously there use to be an emphasis on the environment and social regeneration, there was less emphasis on health and their aim is to consider health in its broadest sense so they also have environment programmes, social cohesion programmes, social capital programmes, its not just about the traditional health issues. Interviewees working at a local level also discussed the range of partnership working they were engaged in as a means of promoting health in the local community. For example, one interviewee mentioned a current drive by their organisation to seek funding for more essential services in the local area. Although most examples of community based health improvement related to actions by public health organizations there was also some activity by the health care services. For example, one interviewee described the provision of community based services which included a drive to reduce dental decay in young children due to parents' prolonged bottle feeding with juice. They also detailed how parents are advised to seek dental care for their children and teach them how to drink from a cup at an early stage.

'Advising parents this has been successful, a lot of people have never seen a dentist so we advise them to get one. Pushing it from eight months has that helped promote the policy around dental care, I am sure it has' (HS3-4)

Factors influencing activity

The very large and fast moving political agenda was cited as a main barrier to doing more health improvement work at the community level. Associated with this was the need to re-engage with clinicians within the policy context. It was noted that this group was previously involved in priority setting but this had been sidelined in recent years.

'...so that rather vital link was lost, it's being re-established now. We're trying to work through the professional advisory structure, the Welsh Medical Committee and it's Executive have agreed that they're going to facilitate me contacting all the Chairs of the Specialist Advisory groups and getting that contact with clinicians set up again....so that we can properly contribute to the health and social care domain' (HS1-2)

To be effective it was crucial that the health sector and the rest of the public sector worked together at a strategic level facilitated by Health and Well Being Strategies. The development of joint posts also contributed to effective collaborations. For example, one interviewee felt that there was more working together with social services and more integrated care of children, due to a new health visitor post based in the local social services department for looked after children. They also talked about a planned strategy to link up various agencies' computer networks so that

all information was available to relevant professionals from agencies, such as health, and social services. However, there was scope for improvement in cross-sector relationship as difficulties were identified in relation to the statutory responsibilities of partners. In particular, the division between local authorities and their responsibilities for housing and education and the local public health organisations where the health impact of such factors were felt. The challenge was to develop policy and organise funding in 'a joined up way' across sectors. Another interviewee described partnership working as 'an extreme challenge' as those working within teams are employed within a range of organisations with different terms and conditions and working practices, so that:

'we are having to create new operational guidelines, we are having to create new interface documents because it's never been done before' (HS3-1)

In addition it was felt that more could be done to harness the potential of the voluntary sector in contributing to health improvement. One idea would be to provide retirement fellowships for health sector employees to contribute their skills and experiences through voluntary agencies. This was seen as particularly important given an ageing population. Appropriate engagement with local communities was also seen as an important feature of partnership working. Having a sustained level of commitment to a community was viewed as a more effective approach and made it easier to work with the same communities in the future. In some quarters of the health sector it was perceived that this approach to community engagement was open to threat from changing organisational cultures. Currently, organisations felt they had a hands-on role in active community engagement but they were concerned about the strategic drive for the organisation to take on more of an advisory role. They felt that if forced to adopt this advisory approach at a local level it would have a detrimental effect not just on the communities concerned but also on the health sector staff whose job satisfaction was related to this hands-on approach. Overall, then the approachability of health sector employees was seen to be a key way of making effective in-roads to community health improvement. As one interviewee noted:

'That's why people feel they can come here; they tend to come here for all sorts of different problems. We never turn anyone away if we don't know what they want or who they want to speak to we can sort it out for them... We build a relationship first, we don't say you are doing this wrong, but gently tackle problems one at a time you can't quantify that can you?' (HS3-4)

Difficulties in implementation also related to resources, 'finance and the availability of appropriate staff' (HS2-2). Due to financial imperatives it was not possible to employ dedicated health education staff. Instead everyone's remit had been expanded to include it, which meant the service was often stretched or the issue not prioritised. It was felt that ring-fenced funding for initiatives at a local level would incentivise local level managers to take measures.

Another local level interviewee felt that there was a considerable lack of financial and practical resources which prevented a lot of essential work from being done. They said that the money has to be in initially, rather than trying to tackle health promotion in a half-hearted way and whilst this would be expensive initially, it is essential to counterbalance health promotion and acute services, and reduce the need for reactive health interventions. It was felt that the current funding culture and structure favoured health treatment over prevention. Resource imperatives meant that short term returns take precedence over longer term investments – the challenge is demonstrating the value of not just avoiding hospital admissions but improving capacity and independence when the pressure is to 'count bums on beds' (HS3-1).

3.3.5 Actions to improve the health of wider communities

One way in which the health sector was seen to contribute to health improvement amongst wider communities was through strategy development work which often involved consideration of health

improvement beyond their immediate client base or catchment area. For example, one interviewee based in a regional office emphasised their role in the development of national strategies aimed at the wider population. Similarly, another interviewee felt that their intermediate level organisation could contribute to national level debates and the development of all-Wales strategies through the consultation process. This interviewee also commented on the way in which their organisation could lobby government for social and legal change and in this way was seen to be demonstrating social responsibility. Similar views were also expressed by local level interviewees. One commented on the way in which their organisation made contributions to pan-Wales policies such as smoke free public places and the National Service Framework for children, young people and maternity services in Wales. They were also involved with the Society of Health Education and Health Promotion Specialists (SHEPs) to improve the health promotion workforce across Wales and more generally they tried to influence and support other local organisations like themselves across Wales. Outside Wales the interviewee noted that staff members were expected to disseminate their work through UK and international conferences and staff were also involved in teaching a Masters course in public health at an English University (links established through staff who had studied on this course). Overall, the interviewee felt that they *'reach out a little bit but probably not as much as they'd like.'*

Another local level interviewee also talked about the way in which they influenced health policy developments within one region in Wales through advisory input to committees that served the whole of the region. They recognised that there would, therefore, be some likely influence on the wider population via strategies implemented at a regional committee level. In particular they commented on the effective work that had been done around needle exchange schemes and this was an issue that had been fully debated across several counties in Wales. They also described other health topics that had recently been the subject of discussion including out of hours services, flu campaigns, and a model of substance abuse detoxification, MMR vaccinations and more diagnostic work by GP practices.

Another way in which organisations in the health sector were seen to be contributing to health improvement in the wider population was through their environmental policies. One intermediate level interviewee explained how their organisation had a statutory obligation to not go *'dumping waste over the back wall'* and the organisation tried to ensure that individuals have the necessary information, training, equipment, and support and monitoring to facilitate this approach. An environmentally friendly approach was also embedded in some work at a local level. One interviewee felt that as an organisation they were doing a lot on this front. There was a regular task group that met to consider the management of waste and recycling, this was thought to be particularly important to reduce increased energy costs. Other organisations had considered measures to become more environmentally friendly but the organisational set up at multiple sites across Wales sometimes necessitated travelling long distances. Although there was an increasing use of video and telephone conferencing this was driven by the staff's attempt to use their time efficiently rather than any green principles. Within the health care services reference was also made to protecting the health of hospital patients and visitors by introducing restrictions on visiting hours to reduce cross infection. Finally, one local level interviewee described the way in which their organisation reached beyond the immediate client group through multi-agency initiatives that can be accessed by the wider population in the local area – not just patients but the wider general public. They referred to one specific initiative which provided play and learning facilities for young children and also parent and children activities such as a 'Read with Me' scheme.

Factors influencing activity

A number of the barriers to undertaking more work in improving health amongst the wider community follows the barriers outlined in the previous sections. Financial constraints were mentioned in relation to lack of action on the environmental front. One organisation had

considered doing some sort of recycling of disposable instruments but found that it would be a costly venture and there was no funding to accompany this. Limited budgets and accountability as a constraint on activity was also mentioned by another interviewee who felt that despite opportunities and organisational enthusiasm to impact on the wider population the existence of budgetary statutory responsibilities meant that individuals were *'very wary of spending money on things that don't directly impact on their areas of work'* (HS2-2).

The same interviewee also raised the issue of prioritisation in their work and the way in which *'economies of scale'* arguments meant that could not spread themselves too thinly across too broad a range of communities. They associated work to address the wider population as linking with multiple partners and they felt that this could create unnecessary complexity in working practices and could also result in *'too many communities served'*. In other words *'communities that are too small to have a maximum impact, or economies of scale.'*

3.3.6 Conclusion

An awareness of the significant contribution that the health sector play in health improvement was balanced with an acknowledgement of the role of other sectors, notably the local government sector and its influence over the wider determinants of health. Within the health sector, public health organisations were seen to be currently leading the way on the health improvement agenda although it was felt that health care services could have an increasing role in the future. Although not driven forward at a strategic level, there was also significant actions being taken to provide advisory input to the health improvement agenda and in this way interviewees felt they were making contributions to improving the health of the wider community.

In terms of addressing employee health the main area of concern was levels of stress within the sector. Strategies to counter this were noted including flexible working, counselling and links with occupational health. However, it was also felt that there needed to be an organisational investment in tackling the underlying causes of stress which some associated with poor staff management structures.

Having the organisational capacity to deliver health improvement action was a main theme throughout the interviews and a key concern at a local level. This related to finding dedicated time and resources to better respond to addressing employee health as well as being able to support interest from outside the sector as prompted by policy developments such as Health Challenge Wales. As well as capacity issues, cross-sector working was identified as another area for improvement. In particular, it was felt that national and intermediate levels needed to have a greater appreciation of issues around policy implementation at a local level and the important contribution made by organisations adopting a participatory approach to community health improvement. Also, better sharing of good practice across the sector together with peer support mechanisms could provide a useful means of overcoming variations in local level expertise.

Although the interviews provided an insight into some of the differences between public health organisations and health care services, a greater insight into how the different parts of the sector fit together might be identified through an in-depth organisational mapping process. This might also be used to identify effective cross-sector mechanisms which could be applied to health improvement. Future research in this area should also include perceptions and experiences from different levels within health sector organisations with health care professionals being a key group to include.

3.4 The Business Sector

3.4.1 Perspectives on roles and responsibilities.

Roles and responsibilities in society generally

It should be noted that interviewees at national and intermediate level answered many questions from a personal point of view, as they felt that their professional role did not include consideration of health-related issues. All interviewees at national and intermediate level and the majority at local level thought that individuals should take responsibility for their own health, particularly by adopting a good diet and taking exercise, as a lack of responsibility incurred costs to others in terms of the demands on health services and society in general. Certain groups however, were seen to require more support from society. Schools had an obligation to educate children about healthy eating and exercise at a stage when they are more receptive to health messages because as they get older *'they don't want to be told what to do'* (BS2-1). Parents were seen to have a similar role in *'setting good habits'* (BS3-7) for their children. The elderly were another group who were seen to require particular support as they were felt to be less receptive to health messages and needed good access to the health service for support and advice. A slightly different view was presented at the local level. Although two interviewees mentioned that responsibility should be widely shared *'I should think as many people as possible'* (BS3-3), the majority thought that national government had a significant role in educating individuals or regulating businesses.

'The Department of Health should make sure that people are aware of things they could be doing to improve their health' (BS3-2)

For example, one interviewee thought that the government could introduce fines for businesses who did not adopt health-improvement measures, whilst another suggested that the government had responsibility *'in terms of what they allow'* (BS3-7).

Roles for businesses

With one exception, this organisational role of educating and encouraging the individual was perceived as rather more limited in the case of businesses, which were unlikely to take on any voluntary responsibility for health and well-being. Their role was primarily to comply with legislation to ensure their products do not harm customers; and to provide a safe working environment by fulfilling their statutory duty to employees. At national level, the interviewee was aware of health as one of the Assembly's strategic priorities and was conscious that one of the drivers of health is economic well-being; and that being in work is actually beneficial to health. However, *'health is a by-product and not a main driver'* (BS1-1). If the evidence was different and people's health was slightly adversely affected by being employed, it was doubtful that departmental practice would change. The department's contribution to policy on improving conditions in areas of material deprivation was probably its main role in improving health. Improving health and well-being was not a central role of this organisation:

'We don't have a remit to promote healthy living as such - we promote it as a fact that it's an Assembly policy' (BS2-1)

The main role of business organisations such as the CBI was to represent their members and they did not have an obvious remit to promote health. One interviewee never raised health-related topics with client companies and emphasised that the views expressed were personal. All national and intermediate interviewees thought businesses had a role as employers to fulfil a legal duty – the employer *'needs to ensure the working environment is healthy or doesn't cause harm*

to health' (BS2-1). One interviewee was able to make the distinction between health and safety and health promotion:

'Perhaps in a call centre where you've got very little activity where you're just sitting down – should employers provide facilities to allow people to exercise properly? That's a moot argument as to whether that's within an employer's duty or not. But that would be promoting health and is not strictly then related to insurance or health and safety because it's not that you're providing an unsafe environment, it's just that you could actually do something to promote health more so that's more in the health-promotion area I think' (BS2-1)

Doing something to promote health 'more' was an idea which had little meaning for most other interviewees. The health of employees was considered to be germane to maintaining a capable workforce:

'Health promotion is quite key there so that you don't have sickness absence. They [business organisations] would I think see themselves as assisting in trying to provide best-practice examples of health promotion and trying to spread that amongst the membership base' (BS2-1)

One intermediate level interviewee also connected any role of business in health improvement as relating to employees, although this was not an issue covered by this interviewee's professional experience: *'I have no knowledge of what they [companies] do and do not do for their employees.'* They talked about health and safety issues affecting a relative who worked in a factory using hazardous materials. The interviewee also discussed business compliance with EU and UK health and safety legislation; and with regulations imposed by countries to which goods are exported. This interviewee was asked if businesses accepted any voluntary, as opposed to legal, responsibility for improving health:

'Well if you want to keep your staff and you want to keep them fit and healthy, I think you should be doing it voluntarily but if you're doing things to FDA standards or to EU . . . standards, it's got to be to the higher standard and they've got to comply' (BS2-2)

At local level, one interviewee said larger companies were beginning to see the benefits of taking employees' health seriously and thought smaller companies would follow suit when they realised they could save money by promoting health. This interviewee thought that in theory, health should be high on the agenda of business because savings could be made through increased productivity and reduction in sick leave. However, in practice it is not – because of the cost. Businesses were thought to have more limited responsibility for improving customers' health and their role was seen as making it possible for people to look after their own health. For example, by providing information about food content:

'I think where you have a danger is where perhaps you have something like McDonalds where it's not clear that what you're eating is 90% fat or whatever the particular figure is when it should be made very clear that that's exactly what people are eating' (BS2-1)

However, at local level one interviewee thought businesses had a more important role in tackling health issues, such as the rise in obesity. They said that food retailers and manufacturers had a responsibility to educate people so that they could make informed decisions themselves; but over and above this educational role, they had a responsibility to adapt the conditions within which those decisions were made. However this view was exceptional. Other interviewees at local level did not distinguish health improvement carried out as part of the main function of the business from 'doing something more'. Interviewees talked about catering and health care businesses and how they achieved improvements in customers' health by delivering services. However these businesses did nothing more to promote health than other restaurants or nursing homes. A dentist also referred to the role of their practice in educating patients about dental hygiene, the dental effects of smoking, and so on. As dentists have a professional responsibility to educate

patients, this appears to be no more than a function expected of any dental practice and does not demonstrate any exceptional commitment to health promotion. One intermediate level interviewee mentioned some concern among businesses regarding EU directives about recycling, but did not think that many companies would respond of their own accord to social and environmental concerns.

Interviewees were also asked whether labels such as 'socially responsible', 'environmentally friendly' and 'health promoting' can be associated with the business sector. Responses to this line of questioning provided a further insight into interviewees' perceptions of the role of business in health improvement. Most interviewees tended to take a neutral view, thinking they were not applicable or had limited relevance to businesses.

'I don't think you can say that any of those society-improving aspects is really within their purview other than . . . by creating wealth they make things better for society by giving the resources for people to actually do things which will make them healthy . . .' (BS2-1)

In terms of 'socially responsible' at national and intermediate level, a distinction was made between businesses and business organisations. Organisations and the people in them were thought to be less 'socially irresponsible' than businesses themselves. However, *'businesses survive by being nasty to each other'* (BS1-1). Businesses had to compete and that was the meaning of competition. This view was less negative at intermediate level: *'I wouldn't say necessarily socially irresponsible'* (BS2-1). The claim of businesses to be 'environmentally friendly' appears to rest on compliance with the law. 'Health-promoting' seems to be the least applicable description and most interviewees did not respond to this. Asking about these phrases emphasised the difficulties in other parts of the interviews in talking to business people about health. This could be because the descriptions arise out of a way of thinking which is different from the business philosophy. In answer to other questions, two interviewees used the words 'open and honest' to describe their dealings with consumers and local communities. These are businesses which appear to have acted more to improve health than those of other interviewees and perhaps 'open and honest' is a more acceptable expression of how they would like to be perceived.

'Is a company socially responsible, is an individual socially responsible? It's preference there – I just don't like the term. . . responsibility for [the] product resides with the company to make sure that once they use it or put it inside someone it does the job it's supposed to do . . . So they're responsible there. But as far as thinking that everyone that's employed by them should be healthy, happy, wise, eating x y and z . . . are they to be Big Brother?' (BS2-2)

At local level the distinction was between small and large businesses. One view here was that social responsibility was a 'trendy' idea but that in five years' time it would be taken for granted and accepted as just part of what big companies do. In the case of a small dental practice, although the interviewee felt that the advice and education provided to patients during consultations was by its nature socially responsible, this does not constitute exceptional action which would distinguish the practice from its peers. In terms of environmentally friendly; there was agreement at national and intermediate level that this description did not have a *'natural connection'* (BS1-1) to businesses. The law, and its effective enforcement, was thought to play a role. Companies working with toxic products might not be environmentally friendly because of the nature of their work. However for the most part, the way they dispose of waste is environmentally friendly - because of environmental monitoring and the ability to trace pollution back to the source. At local level there was a view that one business did no harm to the environment, while in another, *'I don't think we are particularly environmentally friendly'* (BS3-4).

Overall none of these descriptions was felt to be particularly apt for businesses at national, intermediate or local level. Interviewees said nothing which would indicate that businesses seek to be described in any of these ways and there was some feeling that the phrases were over-

simplified and hackneyed. When talking about 'social responsibility', distinctions were made between businesses and business organisations; large and small businesses; and responsibility for products and responsibility for people. Business organisations were felt to be more responsible than businesses; large businesses were more responsible than small businesses; and responsibility for products was accepted while responsibility for people was related to unwelcome interference.

3.4.2 Organisational relationships

(a) Within sector relationships

Welsh Assembly policy was thought to influence businesses in many sectors within Wales through the Economic Development Strategy. Due to the correlation between being out of work and unskilled with other indices of deprivation, the area where policy is likely to have most impact on health is at this strategic level, by influencing the quality and availability of jobs. EU State Aid Rules were a constraint on this but the Assembly is increasingly independent of Whitehall and the European Union. Other policies thought likely to have an impact in the business sector were EU environment regulations, many of which were justified on grounds of human health; and policies from the Health and Education divisions within the Assembly. At local level, too, education policies were mentioned generally as having an impact on health and well-being. At intermediate level it was not thought that Welsh, or even UK, policy had much effect on one business sector. Regulations from abroad had most influence:

'Any new directive that comes in from the EU or the FDA or even if Japan brings in something new that's outside of what's happening in the EU or the UK – it depends where you actually sell to. So they could actually make a complete change that helps their companies and not you and you've got to go and look into this and find out what on earth is happening . . . We don't actually have a remit from the UK government to make any changes in that respect – I know we're in charge of health but not for products for health because that's global. We have not got the legislature to do that' (BS2-2)

Regulations on Health and Safety and safe disposal of hazardous waste would have come from the EU first of all and reached businesses via Whitehall rather than the Welsh Assembly. At both national and intermediate level, it was thought that businesses tend to act independently and the influence of Assembly policies is small. The Assembly and business organisations had different roles which appeared to prevent the organisations from responding to Assembly policies; and the Assembly from responding to business concerns:

'I think essentially there's a split of responsibilities – the Assembly sets particular policies and business organisations aren't plugged into that as such because all they're doing is primarily representing their members' views to the Assembly which may then be included within policy but there's no lever which the business representative organisations or the Assembly Government can work on each other to change things' (BS2-1)

However, it was felt that if the Assembly could help businesses to save money, businesses might respond more effectively:

'And where the Assembly's policies are coming in, they can identify and perhaps guide people to ways in which they can minimise – obviously help to improve the health of the workforce and also minimise – the premiums that they possibly have to pay' (BS2-1)

At local level one interviewee thought that there should be more collaboration between government and businesses to raise awareness of the benefits of a healthier workforce and to

highlight the cost of sick days. It was thought that development of occupational health services at local level was more likely to be of greater benefit than anything done at a national level. However, smaller businesses were unlikely to provide occupational health services. There was also a view that schools and businesses could facilitate more exercise for pupils and employees. One interviewee said that schools had a duty to provide two periods of physical exercise a week; but they did not always do so. Larger businesses might provide such facilities, but the interviewee did not know of any in Wales. At local level, one interviewee suggested that national government could offer financial support to businesses who allowed their employees to take time off to get fit. It seems unlikely from this evidence that Health Challenge Wales will act as a lever for businesses to undertake action to improve health since it lays no legal obligation on businesses to do so. The lack of any perceived connection between health improvement and the business sector probably accounts for there being very little awareness of HCW at any level. Health Challenge Wales had not influenced Assembly policy affecting the business sector. It might possibly have influenced general thinking but nothing specific except for some form of support and assistance to businesses via the Welsh Development Agency - but this was *'only a mini project'*. The effect of Health Challenge Wales on business representative organisations appeared to be similarly small:

'I think certainly at an organisational level there is a background awareness but not a full-scale engagement with that because it's not really their role.' (BS2-1)

One intermediate level interviewee emphasised that it was not something discussed with client companies - *'It's not something I've asked them or that has ever arisen in conversation'* (BS2-2). Health issues were relatively unimportant in a business context. In their own organisation, there had probably been a mention of Health Challenge Wales *'about three years ago, when it first came up'*. However, since then, nothing had followed. The view that businesses were unaware of Health Challenge Wales was supported by evidence from interviewees at local level. Only two seemed to have heard of it, and neither recalled it immediately. One, after prompting, said they had heard of a *'walking one'* but was not sure what it was (BS3-2). A second remembered after the interview having received a Health Challenge Wales booklet and showed it to the interviewer. It was unused – possible reasons for this were thought to be the format (black-and-white photocopied booklet) and lack of prior information about Health Challenge Wales and how it might help the interviewee's dental practice. One interviewee who had not heard of Health Challenge Wales was based in the company's UK headquarters in England. The company's regional shareholder teams take on local health initiatives so this might be something engaged with at a regional level in Wales. Most interviewees at local level appeared to have a general awareness of various drives by government, health services and doctors but these were felt to be piecemeal and needed more coordination:

'How can we all work together to make sure Joe Bloggs actually sits up and takes notice?' (BS3-2)

There was a view that there was less joined-up working in Wales than in other parts of the UK. One food retail company worked closely with government health initiatives. When developing policy and products they incorporated guidance and direction from the Food Standards Agency, such as on salt intake. This was voluntary action arising from the core principles of the company. Other interviewees' awareness of policies likely to affect health was minimal. For example, one interviewee could not think of any policies and said the business was short of time. Health and safety issues were discussed by three other interviewees at local level and one was aware that the company was not allowed to discriminate against people on grounds of mental health. Two interviewees involved in businesses delivering health care said that compulsory social services guidelines for nursing homes and research-based policy formulated by the British Dental Health Foundation had influenced their practice; but they did not mention any policies at Assembly or Whitehall level. One of these described working with GPs and sometimes other health services to ensure nursing-home residents were taking the correct medication. However this interviewee thought the relationship between health services and elderly people did not always work well

when the latter were living at home – on admission to the nursing home, people were often taking too much or too many prescribed medicines. Other local interviewees did not appear to have developed relationships with other organisations at government or intermediate level. A branch manager working for a confectionery company said they had no contact with organisations such as trade unions or chambers of commerce.

(b) Across sector relationships

Within the Assembly, shared responsibility takes the form of corporate policies and departments work together mainly to improve conditions in areas of material deprivation. The Heads of the Valleys Programme was *'multi-faceted, looking at joined-up working across portfolios'* (BS1-1). However, the interviewee thought they *'could do better'* because there was still a *'silo mentality'*. The responsibility of different ministers for activities in different departments was thought to be a barrier to more joined-up work. The perception of a lack of teamwork extended to business organisations:

'I think it's very compartmentalised – each organisation sees its own requirements for services. There is some joint work in the sense that certain initiatives will be signed up to and agreed upon but in reality and in terms of day-to-day working I don't think you see a great deal of joined-up working' (BS2-1)

They thought that on the whole businesses at local level did not work together. However there was scope for businesses to collaborate with unions to improve workforce health because businesses would not want to be known as bad employers – they wanted to attract a good-quality workforce and build a good reputation. Another interviewee thought there was scope for collaboration between businesses to provide facilities for the workforce. If another company linked up with them, both businesses' employees could use the gym; they could give the other company a reduction for corporate membership and also give their own employees an hour off once a week to encourage them to use their free membership more. However, this interviewee was not aware of any collaboration on a day-to-day level to provide facilities for employees, nor of any joint action on recycling and other environmental issues. Another department in their organisation was responsible for advising on the latter. Across sector relationships were also mentioned in terms of balancing preventive and secondary health care. They said the increased importance of local government's role in preventive health had not worked out very well because this had coincided with longer waiting lists for elective surgery. Spending a larger proportion of a limited health budget on promoting health had meant there was less to spend on treatment:

'They needed longer to show that there was a real cost benefit. People want instant results - they want waiting lists down and to be able to get to see a consultant or a GP as soon as possible. It didn't work that way' (BS2-2)

There were some instances of inter-sectoral relationships which appeared to work well. One company had worked with a hyperactive children's support group to gain an understanding of what they considered to be causes of concern. As a result the company had removed monosodium glutamate and other unnecessary additives from foods in their range. Building relationships with organisations and support groups was an important driving force for the company to promote health. The company's regional shareholder groups organised events in local communities, e.g. road shows; and work in schools to teach children about diet and health and Fair Trade. The company was a leading supporter of Fair Trade; they did everything they could to support the welfare of the growers and to ensure they receive a fair price. They made lasting relationships so that even if the growers had a bad harvest they could guarantee and rely on the support of the company and the continuation of that relationship. Another large manufacturing company had *'very strong community interaction'* (BS3-3). The business had an

education programme in schools which fitted into the curriculum and was intended to encourage children to become scientists. Topics included 'how the body works' and material responded to contemporary concerns such as the link between nutrition and Type 2 diabetes. Another interviewee thought that doctors' and dentists' professional organisations worked together well to share information and knowledge which could then be used to educate patients and professionals.

3.4.3 Actions to improve the health of employees

Asking interviewees at Assembly and intermediate levels about action to improve health of employees met with similar difficulties to those encountered in asking about business roles and responsibilities for health and well-being. Firstly, it was not seen as part of their remit to ask about action to improve health: '*... most of these matters would come under HR*' (BS1-1). There was also a view that this was intrusive:

'... it's not a question that I ask. On an individual level I'm more than happy with health promotion and doing it myself. And I do that to my family. But it's not something I would push down somebody's throat of a company' (BS2-2)

One intermediate level organisation provided a counselling service for its employees; but this intermediate-level interviewee could not comment on any action by the business sector in general. Secondly, the idea of companies taking a voluntary role in improving health was unfamiliar: it was thought most businesses would take action to reduce work-related illness as part of compliance with health and safety law:

'Lots of businesses will be looking at their health anyway – there's a huge drive because of insurance issues which means that individual businesses are keen to reduce the premiums that they have to pay. There's certainly a much high profile on health and safety and illness issues primarily driven by insurance premiums. . . . I think you'll find that's the most significant driver for individual businesses' (BS2-1)

This view was supported by three interviewees from the local level, who said they improved employees' health by maintaining hygiene in restaurant, dental-practice and nursing-home settings and ensuring staff took a full lunch break. One intermediate interviewee thought that any action outside the legal framework would be limited:

'There are some businesses who will provide subsidised membership of gyms and things like that which would be seen to be to try to help individuals have a healthy lifestyle – you'll probably find it's quite limited – mainly the larger businesses rather than the smaller businesses' (BS2-1)

This view was supported by two local interviewees who were not aware of any action taken by their businesses. Other interviewees mentioned areas where it was not clear to what extent action lay inside or outside the legal framework, such as varying staff workload and giving staff frequent breaks to minimise stress. However there were two companies – one large, one small – which provided their employees with free access to a gym. (N.B. The smaller company's gym was part of a health club for customers and not provided specifically for employees; the larger company's gym was outside Wales, and part of the UK headquarters of a business with branches in Wales.) Three interviewees said their businesses had acted outside the legal framework; and ways in which they assisted employees were quite varied. One was a small business and two were large businesses. As well as use of a gym, they said the company had a flexible working approach and provided private health care. Different organisations visited the site to talk to staff; and employees were encouraged to join in bike rides and hikes organised by their sports and

social club. One interviewee's gym was part of employees' free membership of the health club run as part of the business; the company also provided private health care and had a no-smoking policy. Another company had a Green Travel Plan; a counselling service; annual staff medicals; and provided healthy food options in one of the staff restaurants. Another business interviewees' *'very rough guess'* was that 25% of businesses would be pleased to do more to improve employees' health; 25% would do something *'if it didn't affect their bottom line very much and if it seemed to be helping individuals'* but that *'very roughly 50% would not be that bothered'* (BS2-1). The national level interviewee thought that asking if businesses would like to do more to improve employees' health was like asking *'whether you're in favour of motherhood'* (BS1-1).

Evidence at local level did not entirely support these views. Some interviewees agreed with the response that *'there's always more you'd like to do'* (BS3-3). Another interviewee noted that there was quite a good environment for staff already. Two local level interviewees thought the company management would be open to suggestions about further actions. These were the companies already taking a range of actions to improve employees' health. Certainly these comments about management's 'open' approach were non-specific and could be interpreted as an automatic assent to something obviously beneficial. However, in the context of what the companies already do to improve employees' health, they seem to imply that in these businesses corporate culture may be a stronger determinant of action than the 'bottom line'. This influence was acknowledged at intermediate level:

'There is an element of individual bosses who have a particular desire so your individual attitude would have an impact.' (BS2-1)

Evidence from two other interviewees whose companies did not take any action tends to support this proposition. Neither said that their companies would like to do more. One interviewee thought that staff would regard action to improve their health as intrusive. Another argued that it would not cost the company a great deal to provide free gym membership and private health care for employees, suggesting that cost was the main obstacle to taking action.

Factors influencing activity

Cost was considered a barrier in one business which did not take action. For example, one interviewee thought the most important barrier was the way in which dentists are paid per patient treated. This meant that time was money and therefore it was difficult to make time for health improvement in the daily schedule. This supported another interviewee's view that:

'It's very difficult particularly for small businesses because of the time involved. Time is precious and getting people to do something which is promoting their health but which is taking an hour or two of their working day won't go down particularly well' (BS2-1)

Cost was also a barrier for one interviewee's small business which was already taking action to improve employees' health but still having to look carefully at ways of reducing staff costs. This did not seem to be an issue in another larger company, where there did not seem to be any barriers to more action. Legal issues were also mentioned as a barrier: one business had abandoned plans to provide a sports ground because if it was not maintained properly and someone was injured, the company would be liable. A green transport plan had not worked well in one organisation because of poor public transport services and heavy traffic which discouraged employees from cycling to work. The only other barrier mentioned was the possibility of resistance by staff to any measures taken to improve their health.

Remarks by one interviewee about sickness absence suggested that when employers act outside the legal framework, the major driver may be a desire to reduce the costs of sickness absence.

One interviewee said the business benefit of giving staff free membership of the health club and

private health care should have been less sick leave but there was not much sick leave anyway. They thought this was not because of the benefits of exercise - some staff could not find the time to use the gym - but because the Managing Director's generosity and encouragement, even when the company had not been well off financially, had evoked a strong loyalty and 'team spirit' amongst staff. For example, someone who had broken an arm was 'signed off' for six weeks but returned to work after two weeks with the help of another employee giving lifts to and from work.

This suggests that an extra effect of action may be a reduction in stress resulting from employees' perception that they are valued. Thus health improvement may be achieved not only through providing direct opportunities for behavioural change such as exercise facilities; or counselling services intended to help employees to cope with stress; but also by affecting the emotional quality of the work environment. Both types of sickness absence may be reduced – staff who are not suffering from work-related stress are less likely to take time off unnecessarily; and employees also have less risk of suffering 'genuine' physical illnesses such as cardiovascular disease. One interviewee acknowledged the importance of keeping staff happy, because this enabled a happy working environment, and cited the business's management of sickness absence as something which improved the health of employees. These remarks may have referred to good morale or 'team spirit' reducing the likelihood that staff would take time off when they were not sick.

One business did not pay employees who were off sick and it is plausible that those who were unwell were deterred from taking time off. Possibly 'sickness presence' was a problem because this interviewee also talked about staff illness as a threat to hygiene - the importance of keeping staff away from the restaurant when they complained of sickness. Action to improve employees' health in this business took the form of the manager's personal care for individuals who appeared frequently unwell. They talked to their employees about whether they were getting enough sleep or eating properly; and might advise them to take vitamins or see their GP. Staff sickness also seemed to be perceived as a threat to hygiene in one business, where managers were all aware of the importance of communication about staff illness - sick employees might spread infection if they handled confectionery products. Another interviewee also said that staff who were unwell were encouraged to stay away from work at the dental practice; but measures were also taken to protect staff against infection from patients.

3.4.4 Actions to improve the health of customers

At national and intermediate level, there was no evidence of any strategy for encouraging businesses to improve the health of customers. It did not seem appropriate to ask the national level interviewee this question in the context of other material in the interview. One intermediate interviewee was asked, but was not able to comment and the other said that there was a greater awareness of customer health but this did not necessarily lead to effective action:

'There is a greater awareness and this is probably down to the fact that they're trying to reduce the likelihood of being sued. But if you take Macdonald's as an example – they're in theory trying to introduce healthier food into some of their product lines but whether they are actually helping is a moot point. I think there is certainly more consideration by businesses of at least the public perception of them' (BS2-1)

This view was supported at local level by one interviewee who said their confectionery company had produced some health-related information promoting *'the idea that people should have some things in moderation'* such as *'did you know's'* about the benefits of chocolate (BS3-1). This interviewee acknowledged that this was probably more to do with marketing than health consciousness. Staff were trained so they could advise on the content of products for diabetics but some customers had said their GPs had told them they might as well eat normal chocolate in

moderation. One interviewee seemed to think the idea that business organisations would have policies relating to health improvement of customers was somewhat absurd; but added that ostensibly some businesses at local level might:

'I think in theory lots of businesses do . . . You only have to look at some breakfast cereals or whatever or Benecol or anything like that or anybody who's selling bicycles . . . There's always a health marketing spin on it' (BS2-1)

However, apart from one interviewee all other local level interviewees did not seem to be especially aware of a 'marketing spin' or of how their businesses might be perceived as having an impact on customers' health. The position of two interviewees was slightly different because they worked for businesses running a health club and a dental practice whose main purpose was to improve the health of customers. With these, the focus of questions was on actions which were not expected as a normal part of running the business, that is, which might distinguish them from other health clubs or dental practices as being more interested in promoting health. There was little evidence that businesses had given much thought to improving customers' health. Actions mentioned were: no smoking policies; responsibility for products; training for some technical products and advice, education and information given to patients during consultations; and providing healthy options within the restaurant menu. One company had taken action to improve customers' health in a number of ways. For example, by reducing salt and fat in food products across their entire range; removing unnecessary additives; educating and informing customers in local branches and on a website; and labelling products clearly to classify their nutritional value, and including details of salt content; and advice on dental hygiene on high-sugar products.

Factors influencing activity

One interviewee felt that the 'philosophical base' of businesses was an important influence on their views and practice in relation to health improvement:

'I think it's partly the ethos as to why they're there in the first place . . . Individual businesses when they start off they tend to be there as an individual who wants to make a living for themselves, wants to make something grow primarily to generate wealth for themselves . . . They grow into businesses that are trying to deliver value to their shareholders. That's their philosophical base if you like – providing value to shareholders. Then other effects on customers . . . are more to do with how do we make sure we fit in and continue doing our business in a way that makes sure we can continue providing value to our shareholders. . . . it's the reason the business was set up in the first place. That's the key really.' (BS2-1)

The main factor influencing one business' actions were the principles at the core of the business and this was an influence which predated the recent interest in health-related issues. The company is owned by consumers and tries to act in consumers' best interests. They thought good relationships with the government, support groups and suppliers had helped; as had the company's regional shareholder teams. The company had benefited in terms of better understanding of what communication works; what consumers need; and their levels of understanding of health. Consumers perceived the company as trustworthy and responsible and this was also beneficial. They also said although it took time to reformulate products, this disadvantage was outweighed by the benefits gained. Another interviewee said the high cost of organic food and lack of time to grow more was a barrier to further action and added:

'The place I've got is really not my sort of place. I would like a health place, to serve only healthy food. I would like to be able to buy organic food, yes. I grow tomatoes, cucumbers, and take some down to the restaurant . . .' (BS3-5)

Overall, the evidence suggests that some businesses do not appear to accept any voluntary responsibility for improving customers' health. However most businesses are aware of customers' concerns about health and take steps to reassure them. It is difficult to see how the company selling confectionery could promote customers' health without acting directly against its own interests. This dilemma was spelt out by one interviewee:

'The problem is that businesses live by selling as much of their particular product as they possibly can. Therefore if somebody wants to buy something with lots of fat in or that's extremely sweet because they like it and want to eat lots of it, that's all well and good for the company, that helps them along' (BS2-1)

Therefore it is important to distinguish 'health marketing spin' from communication which helps individuals understand more about the effect of products on their health. The values of the business were the main driver for action. Time taken to reformulate products was considered a minor disadvantage.

3.4.5 Actions to improve the health of the wider community

At national and intermediate levels there was little expectation that businesses would act altruistically. As one interviewee noted some businesses would help the community if they could afford it but not if it hurt their profits - *'the bottom line of business is to stay in business and make a profit.'* With the exception of the more pro-active company noted above (BS3-7), the paucity of actions to improve the health of the wider community tended to support this view. One interviewee felt that their company was aware of environmental issues. They recycled and saved energy as far as possible – the latter for financial as well as environmental reasons. The company also supported The Children's Society at a UK level – branch managers had previously been free to support local charities but this practice had been discontinued. Another interviewee said it was *'impractical'* for such a small practice to undertake any action to improve health on a wide scale and that any effects would be limited to the immediate community:

'Ripple effects really as our practice reacts with the local community. If anything is passed on beyond that, that's it really. We are not set up to do that' (BS3-4)

One company was a member of the Parks Association which had given them a David Bellamy Award for being a 'green park'; they retained and maintained hedges at their caravan park. Another company had installed a technically advanced recycling facility which was the only one of its kind in the world. The company had also carried out two projects in the last year for local charities for deprived and disabled children which were 'project managed' in the same way as their own manufacturing projects. The interviewee was asked about recent problems with a local community group concerned about the possibility of pollution from the factory. The company had responded by being *'as open and honest as possible'*. Concerned individuals and groups had been invited to the factory and shown around. The company had collaborated with the Assembly to carry out epidemiological and other studies investigating claims of environmental danger caused by the factory. *'Outside experts'* had also been consulted to provide evidence on environmental pollution. Another local level interviewee said the business used degradable packaging and had a policy on pesticides. Its regional consumer groups worked at local level to bring understanding and awareness of issues such as fair trade. The company was a leading supporter of Fair Trade and had strong policies to ensure everything was done to support the welfare of growers.

Factors influencing activity

At national level it was noted that businesses recognised that action improved reputations but on the other hand there was the threat of competition and companies who spent too many resources on improving health and helping the community could find it difficult to survive. One intermediate level interviewee identified legislation as a major influence on activity:

'They've thought greatly about recycling laws because they've had directives from the EU about what they can and cannot recycle and how much they've got to increase and how to re-use various things. And that has caused quite a lot of concern within those companies' (BS2-2)

Another intermediate level interviewee made a distinction between social enterprises and other companies. They said social enterprises had a completely different ethos and organisational structure, thought to arise from the fundamental principles underlying the formation of the business. This interviewee thought that all the big retailers would say they ensure that their suppliers conformed to ethical standards regarding human rights and so on. However, they added that:

'... it's difficult to police... effectively and I think... a reasonable amount of stuff imported from China or certain parts of the Far East will actually have been produced in circumstances that we would consider here totally unacceptable' (BS2-1)

Ethos was confirmed as the main driver for action by another business and an additional driver was consumer opinion – people want to know where their food has come from and more open food labelling was a response to this. The only disadvantage for this business was that products or ranges which did not conform to the company's standards had to be discontinued, such as products containing certain additives. This decreased the range but it was felt that the values of the business were more important. They went on to note that the company would find it easier to take more action if other food retailers adopted their policies on banning advertising to children of products high in fat, salt and sugar; and banning merchandising sweets at checkouts.

Another company felt they were 'not atypical' in taking action. This interviewee believed most large companies would have a similar approach. However the law still seems to be an important driver - this time from a pre-emptive point of view. They said the company tried to anticipate more stringent legislative requirements and this was why they had installed the recycling facility. The company had an '*absolute priority*' for complying with health and safety law and internal censure following a breach would be more severe than from outside the company. This was a business using substances commonly perceived to be very dangerous and the interviewee admitted that few people would choose to live next to the factory. Thus the company's policy of being 'open and honest' with local people and of collaboration with government could be construed as a reaction to local protest; their charity work might be an answer to 'how can we make the environment for our business better' and to improve their reputation. However, the business also had a long-standing programme of education in schools to encourage children to become scientists, suggesting a more sustained and positive approach to building relationships with the general public. There appeared to be no incentive for one business to preserve hedges and the business had to pay for assessment by the Parks Association. It was thought that this action did not bring in any extra business. The company had considered recycling paper and glass from the bars but this would have added to the cost of rubbish removal and they had decided not to go ahead; but '*next year legislation will make us do it*'.

The interviews suggest that action to improve the health of the wider community may be closely associated with the quality of communication between a business and the people affected by its activities. The interviewees from businesses which had taken little or no action, did not mention any process of communication. In fact, one company had restricted communication with local

communities by deciding that branch managers should no longer have the power to respond to local charitable appeals. However another company which was more pro-active in this sphere was involved in a continuous process of communication with consumers through its regional groups, and in building long-term relationships with its suppliers. This communication was part of upholding the core values of the company. For one business communication with local communities appeared to have been an important factor in dealing with unfavourable public opinion. The company's projects for local charities may have been necessary steps in defusing protests against a business which has been perceived as a threat to the local environment. The discrete nature of the projects, which are unrelated to the main business of the company, is quite different from the integrated approach demonstrated by the more pro-active business. Overall, the main drivers for business action to improve the health of the wider community are a business ethos that their activities should improve or not cause harm to the wider community; consumer/public opinion; and legislation. The actions mentioned during interviews were related to recycling; charitable causes; the 'green' environment; and international business relationships.

3.4.6 Conclusion

There was a strong feeling at national and intermediate levels that it was not the role of business to concern itself with health, particularly in relation to customers and the wider community. There was no evidence that interviewees at any level thought that businesses would identify, or wish to be identified with the phrases 'socially responsible', 'environmentally friendly' or 'health-promoting'. Responsibility for the health of employees arises mainly from the need to comply with Health and Safety laws and other regulations. Action beyond this threatened the profits. If businesses are to take more responsibility for improving health, legislation appears to be the most effective facilitator.

Awareness of and views on health initiatives, including Health Challenge Wales, were largely negative. There appears a real need to improve communication within the sector. Companies who had taken voluntary action to improve health appeared to have a particular corporate culture and had developed relationships with customers and the wider community. To facilitate such cultures at national, intermediate and local levels presents a particular challenge. Developing a deeper understanding of how such cultures develop over time and issues of business sustainability are crucial. In addition there appears to be a real need to be important in achieving this and the language used to encourage businesses to take on a more health-promoting role should be carefully considered. Extending access to occupational health services might also have a role.

3.5 The Voluntary and Community Sector

3.5.1 Perspectives on roles and responsibilities.

Roles and responsibilities in society generally

Respondents across all levels agreed that while the individual held some responsibility for health improvement, organisations also played a role and this was more pertinent for individuals with the highest levels of need such as those living in areas of disadvantage. For example:

'Well I think it is joint definitely. It is too easy to say that it is individual's role, because individuals are limited in their choices and they need to be able to access the choices that they want to make' (VC2-1)

Another local level respondent gave a similar comment about health starting with the individual but broadening out to encompass a wide range of players:

'I guess it starts with the people themselves. That's where I start at. For all of us our health is our initial concern. And then, talking from a working point of view, health is covered by so many ...you can start with your GPs and your doctors, you can go to your other health professionals...anyone really who deals with people. Anyone who deals with housing, with finances, with offering health information and that's the way we work right across the board' (VC3-3)

Roles for voluntary and community organisations

Overall, all interviewees recognised the importance of the voluntary and community sector in addressing health improvement. One national level interviewee representing voluntary organisations talked about how the sector's role had changed in recent years. Historically the sector had always played a role in education and campaigning trying to raise awareness of specific health related issues, and it was noted that that role continues. However, now their role had broadened out into a more active role in health promotion. For example, they mentioned the health promotion grant scheme specifically for the voluntary sector. Added to this is a direct service provision role for the voluntary sector. It was noted that this mirrors the national picture for voluntary organisations, that is, they really tend to *'fill the gaps, they're not the main providers'*. This was exemplified by reference to the hospice movement which is almost exclusively voluntary sector led *'and that sort of grew up because the state wasn't providing that particular function.'* Other examples of direct service provision include the area of assisted living and after care and also in terms of things like housing where the voluntary sector is very involved as a provider of supported housing and also provides life skills especially for people with disabilities. The interviewee compared the situation in Wales with that in England where there is a push to promote the voluntary sector's role in direct service provision. In Wales this is not the case and instead the respondent noted that the Welsh Assembly Government is:

'keen to maintain this role of the voluntary sector working in partnership with local government and health in a sort of complimentary way, not sort of taking jobs away from public sector' (VC1-3)

Another national level interviewee representing community organisations commented on the latent health improvement role played by the sector indicating that much of what goes on at a community level has indirect health benefits for local people. For example, they referred to the way in which youth workers are often subconsciously contributing to health improvement:

'sometimes its done but its not classed as being health. For example, if a youth worker sets up a football match...its not always seen as a health role' (VC1-2)

This theme was also echoed by a local level interviewee who talked about how health filtered into everything they do at a community level with all projects adopting a 'holistic approach' to health. For example, their health and environment worker was also working on developing a multi-use games area, and working with local sports clubs and next phase is to draw down funding for a sports development worker. Adopting an all round approach to health was also reflected in the comments from both local level voluntary sector interviewees. One identified their main role as working with people to *'make small changes which might affect their health'* (VC3-3).

Two national level interviewees and two local level interviewees spoke specifically about the role of the Communities First programme. In terms of health improvement, there is a commitment at all levels for health improvement to be a priority for Communities First Partnerships. Communities First have six key work areas of which health is one and the national level interviewees agreed

that this needs to be addressed if these area of disadvantage are to improve. One national level interviewee also referred to a recent report by the People and Work Unit (2005) which showed that the Communities First Partnerships wanted to address health issues. However, there was an important recognition at the national level that the main role of Communities First was to act as a 'catalyst' to draw in other sources of support and funding. So although Communities First funding supports the infrastructure specific projects are funded by other policy areas.

3.5.2 Organisational relationships

(a) Within sector relationships

National level interviewees agreed that their main role was to raise the profile of the voluntary and community sector and trying to encourage other sectors at national level of the important role that the voluntary and community sector plays. As one interviewee commented their main role was in:

'...persuading people of the important role that the voluntary sectors play, sometimes in service delivery itself...ultimately raising the profile and flagging up the important role that community and voluntary sectors can play across the whole range of policy delivery' (VC1-1)

Another interviewee commented that this role also extended to ensuring that these other sections are dealing with the voluntary and community sector appropriately and following relevant principles and codes. The importance of raising the profile of the voluntary and community sector was also identified by the intermediate level respondent. They felt that their main role in health improvement was to 'keep well being on the agenda' particularly in light of the pressures from competing issues such as hospital waiting lists. There were limited comments on the relationships with intermediate organisations. However, one national level interviewee did comment on what they felt was a limited role for these types of organisations and felt that the needs of local communities should be heard first hand. Another national level interviewee provided a useful example of where local level organisations in the voluntary sector have an opportunity to feed directly into the strategic level. They noted that the Welsh Assembly hold twice yearly ministerial meetings with voluntary sector representatives. Depending on what issues are to be raised they field a team of people from relevant organisations who are expert in particular issues on the agenda. They noted that this is a mechanism in place across the Welsh Assembly Government and provides a useful means for getting local level issues on ministerial agendas. However, another interviewee provided an example of where there was a missed opportunity for the local to feed into the strategic because of what they described as a 'lack of understanding' at a strategic level of how things work at a local level. They referred to a specific example where local residents were invited to present at a Welsh Assembly Government event but ended up not attending because their community workers were not allowed to accompany them. This respondent felt that this highlighted the lack of understanding by the Welsh Assembly of the real issues and concerns facing the community in question.

'...it turned into a bit of a nasty one because the food co-op just basically refused to go because they couldn't have their support workers go with them. They were meant to be giving a presentation at this event and they were so thrilled about doing this presentation...but the Assembly just did not understand. So I think there are barriers with the Assembly... there is a lack of understanding' (VC3-1)

Voluntary sector interviewees identified the mechanisms for joint working within their own organisations which can be different to those of the statutory and community sectors. They do not necessarily look to the Assembly for their main guidance and policies. Instead some local level voluntary organisations look towards their own national level headquarters. For example, one

respondent talked about the way in which information is filtered from the top-down through monthly team meetings and the appointment of a manager with a specific remit for well being meant that these issues are given particular priority. Overall, they reported that the existing structure worked well in terms of top-down and bottom-up information flows. In particular they talked about one manager, with specific responsibilities for health and well-being who channelled information down to the local level.

'He's extremely good. He will send through all the new information that is coming through, he deals with all the leaflet drops. Internally as a group we meet together once a quarter for a general staff meeting, breaking down into our team groups we meet together once a month. It's quite structured but it is a very supportive structure. Everything is filtered through. I've been here now for the best part of 12 years and it's been worked out so that what comes from the top is filtered through to the bottom' (VC3-3)

When asked about strategies for bottom-up working there was an equally positive response about the structures in place:

'We have monthly supervision and the team meetings and there is always a particular spot for information sharing at all the general meetings. Working across the board with older people, things come up that help in one area and would be of great benefit in another and there is a great concentration on sharing information' (VC3-3)

However, it seems that the situation does vary between different voluntary organisations. For example, another voluntary sector respondent commented on the role of their national umbrella organisation in terms of lobbying parliament but local level organisations worked autonomously with guidelines and codes of good practice left to the responsibility of local groups to interpret at local level with all the groups working differently. There are also differences in the structural organisation of the independent voluntary sector with some organised coterminously with local authorities and others cutting across statutory boundaries. All this has implications for the way in which others within the voluntary and community sector work with the independent voluntary sector. As the intermediate level respondent noted:

'the structures are so different. It is quite complicated. I can see that for the statutory sector that that can be quite difficult. Say where you are covering things governance issues and where it all fits in and the accountability and the structures are do different' (VC2-1)

In terms of policy influences one key policy cited by a national level interviewee was 'Making the Connections' which sets out the vision for the future of public services in Wales. In terms of policies likely to have an impact in the future, this respondent referred to the Strategic Action Plan for the Voluntary Sector which will set out a vision for the voluntary sector over the next five to ten years. This is currently being drafted but will include health and well being as a key strand. Reference was also made to Health Social Care and Well Being Strategies and the Wanless Local Action Plans emerging from the Wanless Review. However, they described these policies as 'hospital driven' with an 'emphasis on the organisation of services' with a neglect of issues around social care. The respondent was looking forward to this being addressed in the forthcoming policy document – 'Designed for Care'. At national level there was recognition by one interviewee that the driving forces and policies emanating from central government do not always have direct relevance for organisations at local level. Instead the most important thing for local level organisations is how this policy is translated on the ground:

'What we've got to remember is that at the national level we've got all these policy streams, all of these big strategies. At a local level it's translated very differently. It doesn't matter where it's come from in the Assembly, how it's titled, it's how people look at it on the ground. Especially for Communities First areas where we're trying to make things more realistic for people. If Partnerships talk about big policies and everything it's not actually a reality for people but if we talk

about having a walking weekend...that's where the difficulty lies in attributing what's happening on the ground...' (VC1-2)

This point was reinforced by comments from a local level interviewee. They noted that government level policies had little relevance for the way in which they worked at a community level.

'I have to say that at the level that I'm working I can be informed by them but I wouldn't say that my community understands that and I feel that I should respond for my community. They have participated in events and in consultations but I'm not sure they really understand what they participated in and what the strategies mean for them, I wouldn't say they were that informed...I think they would think they are things which are out there...but they're not really relevant to us' (VC3-1)

The respondent went onto note that the main problem stemmed from the fact that the local area did not have a local strategy and although there was an intention to develop an area forum this had not progressed. This was also echoed by another local level interviewee who commented on how their work is driven from a bottom-up perspective by the specific needs of the community - *'at the end of the day we work for our community'* (VC3-2). In light of these comments there was limited reference to national policy drivers by local level interviewees. One voluntary organisation referenced guidelines and policies from within their organisation at a national level, one referred to the impact of policies around dental health in steering their work in this field and another talked about the impact of the Communities First programme as a means of supporting health and well-being of disadvantaged groups. Reference to Health Challenge Wales varied across the sector.

Two national level interviewees commented that they were aware of joint working in relation to Health Challenge Wales at the Welsh Assembly level, between health departments and their own. However, one interviewee went onto note that these Assembly departments had always worked on things jointly so this was not a new departure. Neither of these interviewees was able to cite examples of Health Challenge Wales related activity at a local level. The intermediate level interviewee was aware of Health Challenge Wales but was sceptical about its influence and questioned whether it would *'really tackle the big issues'*. They commented that they felt the first phase of the Challenge had focussed too much on physical activity neglecting what they saw as *'real challenges'* such as mental health issues and that they were looking to see more action on this area in the next phase of the concept. Three out of six local level respondents had heard of Health Challenge Wales. One respondent who was based at a Healthy Living Centre had heard of it and described how it had encouraged them to take forward an initiative to encourage school students to increase their physical activity. They talked about this initiative being planned after they received the promotional documents on HCW and this prompted them to think about *'how can we promote Health Challenge Wales?'* Another local level interviewee had responded to Health Challenge Wales by handing out packs at various events and talked about how it gave their organisation a *'bit more focus and motivation'* (VC3-6).

(b) Across sector relationships

Interviewees identified a number of mechanisms to drive forward inter-sectoral relationships at the strategic and local level. One national level interviewee referred to the Policy Proofing Process which is designed to encourage more joint working across the Welsh Assembly. This includes a regular policy forum which aims to ensure that they connect with colleagues in other policy areas – so that they're aware of other priorities and vice versa – so that they can make those connections as early on as possible. In terms of how well this works in practice, the respondent commented that *'don't think we're there yet, but getting there'* (VC1-1). Another interviewee cited an example of a mechanism to encourage more inter-sectoral working at a local level between the

voluntary sector and local authorities. They described the compact that each local authority has with the voluntary sector which is meant to replicate the support provided by the Welsh Assembly at a local level.

'You have a partnership framework and a local code setting out how LA funding will work for the voluntary sector and most Local Authorities also have a joint liaison committee – actually get together with the voluntary sector in their area on a formal basis and the liaison officer's role is to work closely with the voluntary sector and the CVC – in some Local Authorities there will be a local network of health orgs – all voluntary orgs in Cardiff etc who are working in the health and social care field – they will meet together on a regular basis and increasingly seeing these orgs working together in partnership' (VC1-3)

Relationships at the local level between different sectors were cited as working well. For example, one interviewee noted that their organisation worked very closely with other agencies to provide a package of care and that interagency working, was very good in their area. However, there were a number of concerns raised about inter-sectoral working at the local level. One local level interviewee commented on the different agendas of their own community organisation and that of the health sector:

'If we want them to do something and they say its 54th on the list and we say actually its 3rd on our lists... We're aware that they have funding available from government to work in Communities First areas but it's as if they've drawn up their own agenda and we're having problems tapping into that because it doesn't meet our needs when we want them' (VC3-2).

These difficulties in working relationships between the voluntary and community sector and health sector were further exacerbated by the perceived reluctance of the health sector to work with voluntary organisations, not recognising them as having a role in health improvement when compared to health care professionals such as nurses.

'We don't work alongside district nurses or health visitors. They seem to see themselves as the professionals and we are not looked on as professionals. We do try and get them involved (particularly 2 nurse practitioners on the estate) in for example the needle exchange but they didn't seem to see that as in their area of work. Which is why we've got the harm reduction team and Response... On health promotion days the nurses get involved doing blood pressure and cholesterol checks but that's the only thing...I overheard there was going to be a meeting of health professionals a week on Thursday, so I said 'am I to come to that? (the nurse practitioner said) Oh no it's just for health professionals' (VC3-5)

This interviewee also went on to comment about the difficulties in establishing relations for health improvement with the business sector, despite attempts to engage with them:

'There are three light industry estates in [the local area]. I thought when we are doing health promotion days it would be a good idea to go into the factories. Because people are working in the daytimes so may be couldn't get out to the health promotion days. I thought the factories would be really pleased to get us as a healthy living team to come along –I wrote them a very nice letter explaining who we were, explaining how we would arrange the health promotion day and I thought the employees would think oh what good employers to be organising ...I sent the letter to every owner/manager –no cost (to them) only a room, and the employees would be away from their work stations for about 15 minutes...(for health tests and advice) ...all but 2 said no or didn't reply. I was quite disappointed and it showed employers to be irresponsible. They just didn't want to know' (VC3-5)

3.5.3 Actions to improve the health of employees and volunteers

At national level there was generally limited awareness about any actions being taken to address the health of employees or volunteers, but there was an acknowledgement that there *'may be some examples out there'* (VC1-2). To a limited extent there does seem to be some support provided at a national level for community and voluntary organisations in terms of dealing with staff issues. For example, interviewees highlighted a mechanism to try and curb the burden on the extra work created by Criminal Records Bureau (CRB) checks. They have set up a special unit which provides a free service for the voluntary sector and helps them prepare their CRB checks. But other than this, interviewees were not able to comment on any other support provided for voluntary and community organisation regarding staffing issues that particularly related to health although there was some recognition of the limitations of the voluntary sector in providing favourable conditions for employees and volunteers, mainly because of their financial situations.

'So all the frills you get in terms of terms and conditions that you get in some sectors are not there in the voluntary sector' (VC1-3)

However, the intermediate level respondent noted how times are changing for the voluntary and community sector with staff conditions becoming more of an issue for the sector as part of being more accountable to funders.

'If they do want to get funding, they do want to get support from the statutory sector they have got to up their own internal policies' (VC2-1)

This drive towards formalising employee policies was balanced with the acknowledgement of the difficulties of enforcing formal conditions for volunteers while at the same time making volunteering accessible and appealing. Thus, moves to formalise induction training for example, might deter some people from volunteering:

'You are trying to recruit and retain volunteers is so difficult. People can't dip in and do a couple of hours and go home. They've got to do the training... I mean they are relevant but people think 'oh I don't' want to be involved in all that'. So it is trying to draw that line that you are still accessible, so are still seen as a safe organisation if you like, you are not part of the statutory organisation but you are complying with legislation' (VC2-1)

At a local level, there was some evidence of specific actions taken, but in general most actions were undertaken on an informal, ad hoc basis, mostly resulting from the wider work they do on health improvement for local communities. All apart from one organisation were able to comment on measures taken to address staff health. The one that did not describe any measures noted that the group was at too early a stage of development, and they were the only real member of staff in post. Two local level interviewees commented that addressing staff and volunteer health was not something they did pro-actively but they talked about a less salient approach through all the community based work they do. As one commented

'Don't push things down people's throats-don't want to alienate them-leave things around, word of mouth-'drip, drip, drip' approach. Try and lead by example. Think that by doing this kind of activity they take it on board themselves' (VC3-2)

Another interviewee talked about the awareness raising activities that were part of health based information days where staff and volunteers are provided with information to pass onto the client group. Addressing staff health was viewed as an important area to address as this has implications for how they are perceived and responded to by the rest of the community. One respondent summed up the difficulties of staff being seen to be undertaking unhealthy activities (such as smoking) and the poor role model this portrays to the rest of the community.

'That's a major major problem improving the health of the work force. I feel how can we go out and preach to residents when we have got staff who they see outside the building, smoking...and the community café which doesn't provide healthy food - chips and burgers which is what the residents want... The cafe caters for the community and the staff go there to eat...The staff order chips and burgers' (VC3-5)

Some respondents mentioned simple practical measures that organisations were taking to improve staff health. For example, one talked about how a number of measures had been taken to encourage healthier eating on the premises, including always having fruit in the office, having a fridge so that staff could always bring in fresh food and supplying pates and cutlery so that staff could always have a proper meal. However, one of the most effective actions they had put in place to improve staff health was the no smoking policy. One interviewee talked about the personal benefits of the no smoking policy which meant she had cut down her smoking from twenty cigarettes to about three a day. The second interviewee said that it had lead to a cleaner working environment for others. Another organisation was also looking forward to implementing a no-smoking policy

'The staff all smoke outside the building...We are going to extend our no-smoking policy so staff have to go completely away from the building (and introduce it to all organisations on the estate...Some of the staff have tried to quit although many have failed. Is not so much of a problem here in the centre, but smoking is a big problem in the partnership where "there are lots of smokers' (VC3-5)

In addition to specific actions being taken to improve the health of staff and volunteers, respondents also commented on the general caring ethos of their organisations and how this contributed to providing a holistic supportive environment.

'I have found over the years found the organisation to be really marvellous. If somebody has a health problem ... they are marvellous at actually helping. There is a lot of good nature and a lot of care because people are giving their time up, either as staff or volunteers' (VC3-3)

In one organisation, they had developed a whole series of measures to ensure the health and safety of staff when undertaking their work. This included weekly staff meetings to share problems and they noted that support was always available on a daily basis. Overall, there was a feeling that the voluntary and community sector could be doing more to focus on the health and well-being of staff and volunteers. As one interviewee noted, *'I've realised that it is not as much of a focus as it should be' (VC3-6)*. This interviewee also went onto list a number of changes that they would like to see being put in place which included *'smoking cessation programmes'*, *'more work around diet'* and something to address *'issues around working hours and working culture.'*

Factors influencing activity

Not having dedicated time to set up procedures and strategies to tackle staff health was seen as a key barrier by one respondent. They talked about the need for dedicated time to assess the current situation and outline steps to make improvements. Having a dedicated person to deal with these issues was also seen as a potential facilitator:

'It is about having the time to see what you do already. You know to do a proper little scoping exercise: what have we got, we do we need to do. It is just having time out to do that. Everyone is so busy... Yes, I suppose it is having a dedicated person to look at those issues. I don't know of any organisation that would have that' (VC2-1)

Limited staffing in the voluntary and community sector also manifested itself as problematic in other respects and made it difficult to practically implement some of the measures. For example, the measures to enhance the health and safety of volunteers conducting home visits (as noted in the earlier section) was hampered by the organisation's small staff base, which meant that joint visits were not always feasible. The way in which individuals perceive health and their willingness to take on board health improvement advice was viewed as a limiting factor on the role that organisations could play in tackling employee health. Two local level organisations who seemed to be less active in this sphere than the rest, commented on the way in which there was a limit to what they as an organisations could do in this sphere. One respondent commented on staff perceptions as the biggest barrier to overcome. The fact that staff did not see their behaviour as problematic meant it was difficult to persuade them otherwise. They felt that this change in perceptions was a huge task that needed governmental action.

'They don't see it (unhealthy behaviours) as a problem. They don't think they are going to die or get chest problems. They don't think their mobility will be affected even though they can't run up the stairs or down the road. They live life for today I think...If we cant make an impact with them with the work we are doing , what is the government going to do? Are they going to tax cigarettes right out of the roof so people won't buy them. Because if they wont take responsibility for their own health somebody will have to do something. Tax the chocolate?- I don't know what the answer is but obesity and smoking on this estate is just dreadful...I really worry for the children' (VC3-5)

Another interviewee commented on how *'it's down to staff'* and how the co-ordinators could try and lead by example, but they can't *'push things down people's throats'* as this might alienate staff (VC3-2). A similar point was raised in another interview where the interviewee noted that in some cases, volunteers are recruited on the basis of their ability to work with difficult groups and this might mean that they are drawn from sections of the population that have poor health cultures. Consequently, this makes health improvement action with these volunteers an even greater task.

'I think also particularly for grassroots workers... it is quite a stressful job and I think that also we try to recruit within our target group, so that there are going to be certain cultures around health to do with drinking and smoking. So I think that that is quite hard to address because it is quite ingrained' (VC3-6)

3.5.4 Actions to improve the health of local communities

Under this section, interviewees were asked about actions to address their main communities served. In the case of community groups this was usually defined as local areas where they were based. For voluntary groups this was usually defined as a particular section of the population which formed their core client group. All organisations at the local level reported on some actions being taken at the community level although the response varied in terms of the type of actions taken. Organisations talked about providing for health improvement through the provision of activities related to improving behaviours such as diet and physical exercise. Educating for health improvement was also discussed in terms of raising awareness of health related issues. Further to these examples, organisations also talked about providing opportunities for socialisation and improved levels of confidence, thus contributing to health improvement in a more holistic way.

One interviewee referred to a whole series of activities that the community group facilitated which were focussed on improving levels of physical activity. This included yoga and dance fitness classes, swimming lessons, and gardening activities. In another voluntary group they talked about the *'Moving More Often'* classes that the organisation was facilitating for people in residential and nursing homes to encourage them to be more mobile. Food co-ops were cited by two

interviewees as an effective mechanism to improve the health of the local community. They both talked about the way in which the establishment of the food co-op led to a series of other health related projects. In this way the co-op was seen as an anchor point for setting up other nutrition related projects and for securing funding. In one community the food co-op group had accessed funding for projects related to young people's health and they had run several sessions on healthy eating, smoking cessation and physical activity. They had also linked with the local primary school to prepare healthy hampers for each class in the run up to Christmas, as a healthy substitute for selection boxes. The respondent also related to a summer time event where they took young people to an orchard to pick fruit which they then used to make smoothies. They were keen to repeat and add to these activities in the future and this included taking the children to a farmer's market where they want to introduce them to different kinds of food. In another community the interviewee talked about similar activities stemming from the work of the food co-op. Co-op volunteers were running fruit tasting sessions as a result of a survey they did which showed that local children had a limited awareness of the range of fruits available. They also add recipe cards to the bags of fruit and vegetables sold through the co-op.

A number of activities that community groups were involved in were focussed on raising awareness of general or specific health issues. For example, one group were involved in raising awareness of domestic violence in the local community and another group was trying to make inroads to raising awareness about general health issues amongst older men. This latter group had tried to go into working men's clubs to raise awareness but as the respondent noted

'it is one of the groups that is quite difficult to get into because you are trying to take health messages into a place where they are smoking, drinking and eating pies'

However, in general terms, voluntary and community organisations saw themselves as having an 'awareness and enlightenment role', bringing local communities' attention to health improvement issues and suggesting ways in which they can overcome their difficulties of resource limitations. One interviewee summed up this role as follows:

'if on tight budget, if you live in area where there is no doctor's surgery, there is no dental surgery etc-its how do you get out of that rut-our role is to find paths and to interact with people who can then follow our lead' (VC3-2)

One of the main health benefits of activities led by voluntary and community organisations was in terms of mental health. As one interviewee summed up:

'it is to do with raising self esteem, self confidence and making people feel that they have got a positive future. So taking actions to work towards people fulfilling that future that they want' (VC3-6)

One local interviewee talked about how the people in the local community led extremely isolated lives and this together with high benefit dependency meant there were limited opportunities for them to socialise. Their involvement in community activities gave them a chance to break through these barriers of isolation and take up opportunities for socialisation. Respondents talked about specific examples of local residents gaining in confidence having taken part in activities, which encouraged ongoing involvement. For example, participants of a parenting group were reported to gain a lot from the sessions and decided that they wanted to progress to do training in child minding and First Aid. Another local respondent also talked about specific examples of local residents gaining in confidence after becoming involved in community activities. One young boy who had been the editor of the community newsletter had progressed to university to do a degree in community development. In another case local mothers had progressed to attending Welsh lessons having started learning it in the mother and toddler group. The respondent noted that although this sort of progress was sometimes slow finding the first step on the ladder was an important part of giving people confidence.

Factors influencing activity

One of the key drivers for the voluntary and community sector undertaking further health improvement activity at a community level was their approach to community engagement as a way of making successful in-roads. The importance of appropriate community engagement was highlighted as a driver at national level. The interviewee noted that individual members of communities often lack confidence and are *'intimidated by people in suits'* and *'all of the public sector have got to learn these lessons about how to engage with people in communities'* (VC1-1). They went on to exemplify the best approach to finding out about local community needs and advocated an informal, non-intimidating approach rather than *'holding a formal meeting'* and this was coupled with avoiding raising expectations with communities as this could lead to disillusionment. This need for appropriate community engagement was also echoed in discussions with representatives of local level organisations. One in particular commented on how the local authority seemed isolated from the communities and therefore did not really understand its needs. Another representative from a community organisation also alluded to this issue and referred to the way in which outside organisations *'parachute in'*, take what they want and then leave the community disillusioned. This means it is more difficult for others to follow and try and regain local residents' trust. In this particular community, this followed the legacy of a series of disappointments following the closure of the mines in the 1980s. Effective community engagement was also seen to encompass appropriate approaches for the target group in question. For example, one interviewee referred to the importance of working with young people in a way that they will understand and respond to.

'I think the key barrier is ... targeting the message in the right way so that it isn't so alien to the young people's culture that ... it is completely indigestible to them... So it is really looking at how you can do it in a sense a subtle, graduated way, so that you don't disengage them (laughs) before you've even engaged them. And again to do with nutrition and diet. It is a matter of acknowledging what their diet is like at the moment so, you are not suddenly going to get them eating avocados and olives, you know what I mean? It is a matter of looking at what is familiar and unthreatening and, as I say damage limitation so it is trying to encourage them not to eat certain foods that are really unhealthy' (VC3-6)

As well as developing an approach which the target group can relate to, it was also seen to be important for the target group itself to be involved in taking ownership of the action or initiative so that they have greater ownership of it. The interviewee who worked with young people referred to one particular programme where the *'education seems to come from within the group.'* Another aspect of appropriate community engagement was the importance of making an assessment of the history of community engagement in an area. The intermediate level interviewee noted that some communities were pushing ahead with health improvement activities more than others because they had a long history of community development work. They referred to one community which had a community base and a team of people already in place before the Communities First initiative started. This contrasted with another area that was starting from scratch. However, another respondent pointed out that although having a history of community engagement made it easier to take forward subsequent activities, this usually led to targeting the same *'usual suspects'* with the result that *'the people who were excluded are still excluded'* (VC3-1). Therefore, community approaches needed to be adapted in order to address the less engaged.

Overall, it was felt that the voluntary and community sector was well placed to make effective in-roads to communities. At one level, the sector was seen to enjoy good links with local communities, especially when compared with other sectors. This included having:

'good access to local communities and are used to working in quite a participative way so that when messages and education around health is being delivered through the voluntary sector I think maybe those messages are more palatable and it can feel less like a nanny state because those links to the community are already there...' (VC3-6)

At another level, they were seen to have a particular head start in tackling health improvement given their links and relationship of trust with the most at risk members of the community:

'Also it is working with the people who are most likely to be maybe making negative choices around their health. So they are quite well placed to be promoting healthy living within that. I'm thinking ...of stuff that is done at a local authority level ...like social services or whatever, you know people can feel quite judged by social services and can also think that there's a risk, that there will be consequences if they don't do certain things. You know, what's going to happen to their children and things like that. I think with the voluntary sector it can be a sort of positive and trusting relationship' (VC3-6)

Related to the issue of appropriate community engagement was the importance of responding to local level needs. There was agreement between respondents across all levels that local needs were a main driver in determining which actions took place at a local level. For example, one community organisation noted that no-one took up the free swimming offered by the local authority and from this they *'cottoned on that people couldn't swim'* (VC3-5). Therefore they set about providing swimming lessons which taught 200 people many of whom now take up the local authority's free swimming provision. Local need as a factor shaping action at a local level was also acknowledged at the national level – *'very much down to local circumstances'* (VC1-2).

However, one problem in identifying the most pressing local needs was the misleading information sometimes presented by government statistics overlooking issues at a very local level. One interviewee referred to considerable problems associated with alcohol abuse and cigarette smoking amongst young people in the local area. However, because the statistics do not identify the area as being problematic in these issues, the providers tend to overlook them. They also experience high levels of drug use and although the police are aware of the problem the fact that it doesn't translate into hard statistics means it's *'really difficult to get anyone to show any interest.'* Although the sector seemed well placed to contribute to health improvement in terms of its effective approach to community engagement, it seemed less well placed in terms of access to resources to undertake this work. One national level interviewee saw capacity issues as ultimately limiting the potential role for the voluntary sector to a gap-filling role.

'the voluntary sector may have the skills to get into an area of provision but capacity has always been the issues because typically most voluntary organisations are very small and even the larger ones tend to rely on a hand to mouth grant chasing exercise – resources wise they are not very secure so that tends to militate against taking on long term contracts for administering public services...so the sector is best when it's playing a complimentary role, filling the gaps, small scale work, usually at the local level, but capacity is the problem' (VC1-3)

Capacity was another issue in terms of the levels of support available to voluntary and community organisations. Their main concern was that they should be moving on to do specific Communities First related work, but this would mean that there would be no-one providing community development support which they felt was still very much needed given the infancy of community engagement in this particular community. As well as capacity issues, general resources available for the voluntary and community sector was seen as a hindrance to their ongoing work, with the political agenda favouring *'innovation rather than sustainability'*:

'They are reluctant to or don't award grants to the same organisation for the same project, so sustainability is always an issue. And then for groups who have never had anything this is their chance to get some funding. So it's innovation against sustainability' (VC2-1)

The lack of appropriate community buildings and spaces was also seen as a barrier to undertaking more community based health improvement activities. One interviewee commented on how they had finally got the lease on a small terraced house from which to base their activities but given the proximity to elderly neighbours this was not really suitable for community activities. Relationships with other sectors were discussed in an earlier section above but here it is referenced in the specific context of a driver for activity to improve community health. A number of local level interviewees talked about community based activities which involved linking with other partners and how this had facilitated some activities. For example, one interviewee talked about their links with the local district nurse and a national chemist retailer to provide information about skin protection for the elderly. In another case a respondent talked about the community group's links with the housing department at the local authority in order to address poor local housing standards which they recognised as having a detrimental effect on health. This group had also made links with local dog's homes in order to arrange for their clients to do walking activities. This respondent also referred to the links with health services provision for ensuring their clients are registered with a GP and made sure that all children's immunisations were up-to-date.

3.5.5 Actions to improve the health of wider communities

In this section, interviewees were asked to comment on any action beyond their immediate community or client group. At national level the issues were the same as the previous sections, that is, there was limited awareness of specific activities at local level. At the local level itself, two of the interviewees (based at community organisations) were unable to comment extensively on this sphere given their focus on their immediate communities. Overall, this was the sphere where the voluntary and community sector exerted the least amount of influence with mostly ad hoc, informal activities discussed. One local level organisation commented on the development of networks between neighbouring communities and described how local people were beginning to buy fruit and vegetables from the co-op for other people in these neighbouring communities. So word of mouth had helped spread the message. Two interviewees talked about the way in which their voluntary organisations helped provide support and awareness raising activities for people outside their main client group. One talked about the way in which they also worked with the families of their clients and they saw this as benefiting their clients indirectly.

'If you can come alongside older people in whichever situation that they are in and help any difficulties or problems that they are having then you are going to take the stress off the family. I mean quite often when relatives come in, they come in because they are either at the end of their tether or tired out. And if you can actually step in then in some way, big or small and help deal with that situation with the older person for them. Even just simply just getting Mum's house insulated so it is a worry off somebody's neck, that helps' (VC3-3)

They also referred to a specific initiative around 'Care in the Sun' where they invited their clients to bring their children along with them. In another case, an interviewee talked about the way in which they were trying to raise awareness of health-related issues to the wider local population, beyond their main client group. So they were going into school to raise awareness and also into workplaces. Another local level interviewee talked about the way in which the work of the community organisation and its initiatives were disseminated across Wales and beyond through papers presented at academic conferences. In addition many local authority areas (particularly in Wales) invited members of the organisation to talk to them and share their experiences and they

also receive lots of visitors from other local authorities and voluntary and community agencies interested in the work being carried out by the centre.

Factors influencing activity

The main issue in terms of a barrier to doing more to tackle health amongst the wider population is that fact that voluntary and community sector is so focused on the needs of its immediate client group whether that's the local community or a specific group in the population. Even those organizations who were managing to do some work in the wider population noted that capacity and resources were a barrier to doing more. This is coupled with difficulties of getting issues onto other agendas.

'Again, time constraints and not having a volunteer to put in straight away can hinder it (partnership working). And sometimes not everybody's agenda is the same. There are times when you can go along and think well that would work there, but it is not in everybody else's agenda and then you have to badger away until you can get it raised up the agenda' (VC3-3)

Another barrier to further work was the stereotyped images associated with some volunteers. This particular interviewee worked with young people as their main client group and they identified the difficulties of trying to forge links between this group and the wider community:

'Yes I think probably a lot of young people have quite troubled relationships with their local community and so turning that around is quite difficult, because they are seen as a collective so it only takes one young person to upset things for the whole group to be labelled. So I think that that is quite a challenge. And it is not a group that has been seen by the local community as maybe taking responsibility for that community and having a leadership role. So that is quite a challenge, changing those perceptions and forging that role for the young people and giving them the confidence to take on that role. And for them feeling that they want to make that investment for that community' (VC3-6)

3.5.6 Conclusion

From the interviews conducted it can be concluded that the sector sees itself playing a significant role in health improvement particularly at the community level, where the voluntary and community sector is often more accessible than other sectors working at a local level. This role includes some direct health service provision, education and campaigning, as well as more general community engagement activities which were seen to have benefits for socialisation and self-esteem. Specific voluntary and community initiatives (such as Communities First) were viewed as potential mechanisms for driving forward health improvement at the community level. Less action had been taken to improve the health of employees and volunteers and there was limited work to address health improvement amongst wider populations. Dedicated resources (staff and time) were key requirements for a more pro-active approach in these areas.

In terms of supporting the sector in adopting a more effective role in health improvement a number of suggestions emerged from the interviews. This included forging better links within the sector so that strategic drivers become more aware of local level situations and the variation in organisational structures and ways of working across the sector. Further work also needs to be undertaken in raising the profile of the sector and highlighting its contribution to health improvement amongst the independent and statutory sectors, while being mindful of the different and often competing agendas. Although considerable in-roads seem to have been made in terms

of community engagement there is further scope for working with more disengaged sections of the population.

Alongside these implications for policy, there are also additional implications for further research. Exploring how other sectors perceive the role of the voluntary and community sector would enhance understanding of how inter-sectoral relations could be developed. Also, unpacking the array of perceptions and experiences across the sector, looking in more detail at each of the different organisation types would be helpful in understanding specific issues for each group. In this way, support could be better tailored to the needs of different organisations within the voluntary and community sector.

3.6 The Media Sector

3.6.1 Perspectives on roles and responsibilities.

Roles and responsibilities in society generally

The majority of interviewees across all levels recognised responsibility to be shared between individuals and key statutory organisations (particularly the health service and education), whilst a couple of respondents also saw a role for employers and voluntary agencies. The need for the government to take a lead on more preventative health work was also specifically identified by the national level interviewee and one journalist who provided the most elaborated account of shared responsibilities for health.

'I actually think everybody from the individual all the way up through up to governmental and non governmental organisations have a role for looking after people's health. I think the ultimate responsibility lies with the individual because it's your body you've got to look after it really and the NHS in a sense is primarily there to pick up the pieces but it's also there to educate people so they know they've got the skills and the knowledge to look after their own health and to improve their own health and then the government has overall responsibility for the NHS for setting policy and funding. It also has a policy direction then to set out to the NHS to schools to education but then it goes across that through environment through housing through policing. I mean every part of society has an element in health because health just kind of transcends all the borders' (Med3-1)

Roles for media organisations

With regard to the role of the media in promoting health, all of the respondents recognised the influence that the sector can have through reporting on health issues. For example,

'I think that the media does have a role to inform and to keep people aware of what's going on out there and how they can improve there own health and well being.... And I think we should also be aware of studies and scientific research if the media are actually aware of what's actually going on then when things are being discovered we can be in a position to go with that then and publish it' (Med3-3)

The national level interviewee also commented on the potential of the media to put forward health messages, although like all of the other interviewees it was recognised that this was not the primary business of the sector. The other respondents were also quite clear that the key role of the media was as a 'neutral informer', to 'report on issues within the health community as they arise' (Med2-1) and to provide as much information as possible for people to make informed

choices. In other words they were not there to propagate government messages, rather to provide the public with 'all sides of a story.'

'When they elect the politicians we're there to keep tabs on them but we have got a role to help people make the best of their lives as well so I think we've got a very key, informative role you know we're there to put across the arguments on all sides of every single debate and we're there to feed the information down to the individual who may not necessarily have access to it...so they can make up their own minds on it, because we're not there to force people into one particular point of view or another, we're there to make sure people can make up their minds with the fullest information available.....' (Med3-1)

3.6.2 Organisational relationships

All of the respondents were clear that there was no direct relationship between media organisations, the government or any other organisations. However, a high degree of mutual (but not necessarily shared) interest between government and the media was also recognised, in terms of the potential of the media to influence behaviour (national view), as well as the role of the media in 'keeping a check' on government activities by keeping the public well informed (the majority view of media organisations). For example the national level respondent considered that part of their work is to target the public via the media. They were conscious of the need to use the media and would always think of how to approach the media at the start of a new campaign. To put across public health messages the government would normally buy advertising space, but they also explained how they largely do re-active media work, meaning that after issuing a press release they wait for journalists to get in touch with them rather than actively discussing issues with the media. There were also examples given of health campaigns which have involved collaboration with the media organisations. For example, the BBC's 'Big Fat Problem', and 'Keep Well This Winter' which was targeted at the local media. They also described how there were some examples of their Health Challenge Wales work already being used. For example, Argos ran a four page supplement of text taken directly from Health Challenge Wales.

The journalist perspective, however, seemed clear that the function of the media was not to put across government health messages but to keep the public informed of all issues that they considered important to public health. This means that whilst sometimes government messages might be positively reinforced by the media, at other times government policies or recommendations would be criticised or challenged by media reporting.

'It is to be a watch dog as ever to look at say how the health service is performing, to look at how individual bits of the health services perhaps even down to the level of how individual GPs are performing....and I think it has a duty to report on developments....I mean we should be reporting on these things. We should be doing our duty to making people better citizens and all the rest of it just as we would in any other area of public life' (Med2-1)

In view of this relationship it is not that surprising that no policies were identified that might impact directly on how the media approached health and well being issues, although a few of the interviewees shed some light on the process of reporting on government health policies; namely that it must be considered newsworthy.

'just because the government is saying bring out a public health message as far as the journalist is concerned I think there is a judgement as to whether that is newsworthy or not and if so how newsworthy it is and so on' (Med2-1)

These thoughts were similarly echoed in considerations of Health Challenge Wales. The majority of journalists had heard of the initiative, but none reported to have done much reporting on it, possibly because it lacked newsworthiness;

'You need to make a decision about what's in the public interest when you report it. And that's the overriding factor not that it's simply Health Challenge Wales you know is the public going to be interested in this, is this a new initiative, is it a new drive, is it going to make a difference to their lives, that's what we need to ask' (Med3-1)

Another journalist remembered doing something generally on Health Challenge Wales when it first came out – but nothing since. They commented that they have never received any inquiries about it and reflected:

'Maybe the Assembly hasn't pushed it particularly well from a publicity point of view, both in terms of getting over news coverage of it and in terms of encouraging people to try and take it up. I certainly haven't seen a lot of stuff anyway...I often wonder where AMs, etc, mention it in speeches, I'm sure a lot of the people don't know what it is!...it's a difficult concept to sell...' (Med3-4)

In other words the relationship between journalists and the government seems to be driven by a need to generate the right kind of journalistic interest on the part of the government, and on the part of journalists the need to provide neutral, unbiased information to the public on the health issues which they deem to be most newsworthy. This has clear implications for the government in terms of making its new approaches and messages as 'newsworthy' and media friendly as possible. With regard to relationships with other organisations, the media's independent position is again relevant, with suggestions given of *'keeping a check on GPs'* (Med2-1). However in local level organisations concessions were also made to the idea of supporting and publicising local causes.

3.6.3 Actions to improve the health of employees

With regard to what actions media organisations have been taking to improve the health of their employees the overwhelming impression was not much. The higher level respondents reflected on changes in the media industry as a whole and suggested that the working culture of journalists has become healthier. For example, it was no longer acceptable to drink a lot at lunch time, or smoke at work and more attention is paid to the personal safety and stress of journalists. However, they were not able to offer any specific examples or overview of any pro-active health promoting steps being taken by media employers. This impression matched up fairly well with the responses from journalists who, speaking from their experiences as employees (except for one chief editor), were unable to offer many significant examples of pro-active action. Standard health and safety measures like screen breaks were mentioned, although the legal obligations here were also acknowledged. Several journalists also commented that their canteens had become 'fair trade' or just generally healthier, although it was also pointed out that these were contracted out and therefore not directly influenced by the media organisation itself. Overall, the general impression seemed to be that approaches at best are *'fairly neutral, the opportunities are there but we're not actively pushed'* (Med3-2), and in other cases are even less pro-active; *'what tends to happen is stuff goes on until the machinery or the person breaks and then something happens'* (Med3-4). As well as a recognition that not much was being done to improve health, there were also suggestions of a need to address stress.

'This tends to be an industry where we tend to flog ourselves for better or worse, we're our own worst enemies for that, but that's down to us being a rare breed' (Med3-4)

To sum up then it seems that whilst media cultures may have become slightly healthier, employee health can not be said to feature significantly on the agenda of any of the media organisations interviewed.

Factors influencing activity

From discussions about possible influences on workforce health and health promotion it also became apparent that a more health promoting approach by media employers will be more likely if links are made between health improvement and productivity, or if the bottom-up demands coming from staff are such that employers cannot ignore them. The 'type' of company also seems likely to have some influence on approaches. Across all three levels suggestions were made along the lines that *'chasing news'* (Med1-1) and making a profit is the top priority, which dominates over everything else:

'Will sound cynical, but if didn't impact on their profits then no, if its going to make a difference to their profits then yes maybe it would, private companies, shareholders you know, bane of our lives. Part of(big newspaper company), I don't think to be honest they really care. Just health and safety so they can't sue' (Med3-1)

It follows that the one incentive that might exist for employers was if they saw a connection between health and productivity such as through a fall in absenteeism.

'Perhaps it would take a spate of health problems among employees I think if employees are off sick due to ill health issues that are related to lifestyle then I think that might spur them into action.....they would think about it then because it would affect their productivity' (Med3-3)

The editor interviewed also acknowledged that their special budget to pay for extra staff during busy holiday periods and their general concern with stress issues reflected awareness *'that if staff were pushed too hard he wouldn't get the best out of them anyway'* (Med3-5). Whilst this reasoning suggests that increased management awareness of a positive link between productivity and health may promote action, another apparent vehicle for change seems likely to be the type of bottom-up demands and expectations which play a role in shaping workplace cultures and decisions. The healthier working culture described by the national level interviewee was thought primarily to reflect changing attitudes in society generally, whilst the increased safety or stress consciousness described by the intermediate level interviewee was similarly thought to reflect an increased awareness of risks and duties, in conjunction with the impact of a general 'feminisation' of the profession. One of the journalists interviewed also considered that the improvements in the canteen had emerged because of demand from a *'fairly informed workforce'* (Med3-2), whilst another thought that the move towards *'fair trade'* products reflected the wishes of canteen staff following Live8.

In addition to these quite general influences which will be acting on most businesses, another important factor to come out of the interviews seemed to be the size and type of company. The journalists who seemed most pessimistic about their employer's approach to employee health also mentioned the large, corporate nature of their company as a likely barrier, in the sense not only that management decision making was far removed from the employees on the ground, but also due to its loyalty to shareholders. In contrast, the one company that reported to be looking at stress, was self described as a *'family business'* with a caring philosophy, suggesting that where there is more local ownership, a higher degree of what has been termed *'moral management'* may be more likely to occur. This type of incentive is not necessarily linked to productivity or changing expectations, but instead is associated with the personal beliefs of the management (e.g. See Grit, 2004).

3.6.4 Actions to improve the health of consumers

From the literature and the interviews three main areas emerged with regard to how media organisations can influence the health of their consumers. These were through their advertising and publicity function, through running their own campaigns and through their reporting of health issues. Several examples were given of health promoting actions in the area of advertising and publicity. It was described how a few years ago an editor of a local paper banned the promotion of a bakery chain's pasties and asked them to promote healthy sandwiches instead (Med1-1). The editor of another paper described how they publicise Marie Curie breast cancer awareness and provide free coverage for local charitable events and promote voluntary groups that could be of assistance to their readers' health. Another local paper also described how they cover a lot of health activities in the local community:

'I think we probably should be highlighting what those separate organisations are doing to health and well being you know if there running particular schemes on a local level we're only a local paper and say the council want to run healthy food schemes in schools I think we should play our part in publicising that as an issue and to get peoples awareness of it as well' (Med3-3)

Only one organisation was highlighted by the national level interviewee for their health awareness campaigns although the interviewee also reported to be aware of local newspapers using prizes to encourage responses to health campaigns. The only journalist interviewed who described these kinds of campaigns was from the same organisation. They explained:

'...is quite good now and again at a sort of cross media approach to things-a website, programmes and news items-basically challenging people to change their lifestyle, certainly looking at diet and fitness alongside that, general tips on healthy living....In terms of coverage one of our reporters here was signed up to see how much weight he could lose and he was shown to be exercising and so on.' He also cited the example of work place awards (discussed later in 'wider community'), and annual campaigns e.g. binge drinking' (Med3-2)

In terms of addressing health issues through reporting, all the interviewees (except for the local paper journalist) were able to suggest ways in which their activities might contribute positively to the health improvement of readers and viewers. The Welsh Assembly respondent and the lecturer in journalism both gave examples of positive actions that they were taking in terms of reporting on health. The Welsh Assembly respondent described how they were working on a 'Media Tool Kit' to encourage journalists to run health promotion messages by being user friendly, by presenting the messages in simple, usable form, and also by suggesting the use of case studies, as these are considered to be effective in getting across messages and attracting readers and advertisers. The lecturer in journalism also provided examples of how they try to bring home to trainee journalists the need to adopt a balanced approach to reporting on health stories, by encouraging consideration of the consequences of their reporting. For example, it was explained how the MMR case was used as case study of how reporting can *'both skew the debate and set the whole tone of the debate at the same time'* (Med2-2). Using the example of bird flu it was explained:

'so part of the education one tries to give young journalists is to keep a sense of proportion about these things and not to get carried away with the notion oh my god this is going to be the biggest national disaster ever you know sometimes it might be but very rarely are you justified in saying that...' (Med2-2)

The two key ways in which journalists thought that they contributed positively was at one level by providing their consumers with information on topical issues so that they could make informed

decisions, as well as at another level by providing more direct health tips. The widely perceived role of journalists as neutral and balanced providers of information has already been discussed in section one and this position was re-iterated by the majority of journalists. However, the following account in particular provided an insight into the perceived importance of this approach to public health.

'It's not my role to tell people how to live their lives and again it's trying to adopt this neutral stance e.g. school meals and childhood obesity, we take the approach that there is a general consensus among researchers and politicians that there is a problem...part of that is diet and exercise and you can inform like that but you know you can point to the benefits but it has to be balanced you can't be saying all these kids are fat you should do something about it has to be about people then choosing how they want to respond, it's more about being a carrier of information, it's not for us to decide how people should live their lives' (Med3-2)

As well as aiming to provide a balanced and informative coverage of health issues there were also examples of more direct health tips and messages being incorporated and put forward by media organisations. The national level interviewee described examples of a 'good booklet for young people on health issues' produced by a newspaper company in conjunction with the Health Promotion Department at the Welsh Assembly, in addition to health supplements produced by a couple of local papers. Another newspaper described how they run a column on medical matters written by a local GP where readers are invited to write in with any health problems, as well as running articles on healthy eating, for example. Another paper described positively their weekly health supplement in terms of providing practical and useful advice:

'that's really a huge broader look at health so you do get a lot of health improvement articles within that you know we'll do diet plans or exercise plans we'll do features about how doing the housework can help you add up to the total of exercise it's very much a healthy lifestyle message within that you know it's telling people what a health diet is telling them what the new super foods are telling them there's a healthy alternative to curry...so there's a big health improvement agenda within that, in addition we also have regular columns from the minister so he'll put his health challenge Wales in probably every 2 months, doctors do a regular column, ministers do a regular column' (Med3-1)

Factors influencing activity

With regard to factors influencing approaches to the health of consumers there seemed to be two driving forces at work in dictating media approaches generally, which in turn then inform how they approach health issues. These underlying principles seemed to come back to the need to make money and the need to fulfil journalistic objectives through their self defined roles as 'neutral informers'. The following revelations provide insights into the points of compatibility and tension between the media and health, with implications for how health might be more effectively promoted in the media. There was explicit recognition across all three levels that the underlying goal of media organisations was to sell stories or attract viewers. Related to this the priority need for newsworthiness was mentioned across the board. For example it was explained;

'Generally as far as we would look at it it's about something to add that would bring on the quality of our paper and sell it' (Med3-3)

In other words, the kind of stories or features that organisations run, are to a large degree driven by what is considered newsworthy by editors or journalists. The following insights highlight how this principle can both limit and provide opportunities for health improvement coverage in the media, with some clear implications for how these opportunities might be advanced.

In terms of tensions between business principles and positive health coverage, the Welsh Assembly interviewee described a tendency for health coverage to pick up on scare stories or faults in health service (such as MMR, waiting lists), as this makes better news. They also explained that in the case of local newspapers there were difficulties with parochialism as local newspapers were often only interested in local stories and unwilling to cover general messages or stories. From an interview with a journalist from a local newspaper this also seemed to be the case. They specifically explained how they would have liked to have picked up on the school lunch story, as they thought that this might have provided opportunities for positive health coverage, but they felt that this would not be acceptable as it would be considered too much like 'old news' (Med3-3). Another journalist also commented on how restrictive word counts limit opportunities to provide health tips and messages. In other words a general implication of the need for newsworthiness is that potentially useful health coverage will often lose out to more sellable stories. This matches up with the findings of an analysis by the King's Fund of health-related coverage which found that coverage was dominated by stories around the themes of 'NHS in crisis' and health 'scares', which they defined as 'risks to public health that were widely reported but which often involved little empirical impact on rates of illness and premature death.' Conversely, the important themes of preventative health measures and serious public health risks such as smoking and alcohol received very little news coverage (Kings Fund, 2003).

However, there were also suggestions of how making money can be compatible with useful health coverage. The chief editor of one paper described how their papers would use a topic such as Breast Cancer Awareness and canvas firms to advertise around it. This enables the company to promote something that is topical whilst also drawing in useful revenue. Through providing free advertising space to voluntary groups, the editor felt that they were also not only providing a service to readers, but were also presenting an ethos of caring for the community, creating a good public image. A local paper also described how coverage of local healthy events is a good direct selling point for the paper, as well as also being useful to its reputation.

'obviously being a newspaper we tend to do things that we would consider worthy of being a story and worthy of a place in the paper, and obviously we are thinking of ourselves as well, so for example if a school is promoting healthy eating initiative or a walk to school initiative we would probably look to do something on that because if we can get pictures of kids then their parents will buy the paper so we look at it from that point of view but if a local community group is taking some sort of action to promote healthy living and it's interesting or different and it's something that's worthy of a place in the paper then yeah we'd definitely look at that. And I think pictures are quite important as far as we're concerned if we can get interesting pictures you know...' (Med3-3)

They also described how although they had not run any such campaigns in recent times, they would potentially cover a health issue not simply from point of immediate sales but because *'it'll reflect well on the paper and will also benefit the community.'* Another journalist, talking about their weekly health supplement, explained how the readership benefits from broadened health coverage, whilst the paper benefits through increased selling points. The journalist considered that whilst the supplement was in a sense responding to demand and giving people something extra that they want, it also enabled them to set their own agenda giving the paper more breadth and authority, for example, by adding 'seriousness' by having worthy contributors (such as medical professionals or health ministers), and pursuing interesting subjects. This idea of health advice and information as providing 'added value' to the paper, by providing 'a service to the reader' was similarly suggested by another journalist talking about their 'fact files'. They explained how they had received positive feedback on these, with reports of people *'cutting them out and sticking them on their fridges'* (Med3-4). So whilst the priorities of selling stories can sometimes obstruct positive health coverage, there are opportunities for the two to go hand in hand. There were several suggestions that there is increasing demand for coverage of health issues, in turn providing business incentives and greater scope for media organisations to improve their reputations, improve sales and sell more advertising space through focusing on health issues. There were also suggestions that journalists can take some kind of lead in their coverage to get

across messages and ideas that they think are important. Given this combination of bottom-up and top-down influences on media output there are strong implications for finding ways of presenting health messages in more sellable forms. The proposed Welsh Assembly 'Tool Kit' in this respect has the potential to be a positive development by highlighting more innovative and attractive ways of promoting health. A more pro-active governmental approach to the media was also identified as desirable by the national level interviewee, and although this was considered difficult due to limited resources, such an approach might help to add newsworthiness to any campaigns or messages that the government is hoping to promote. This also ties in with the Kings Fund report on media and health which suggested that there needs to be '*a better understanding among public health protagonists about how news is constructed and the imperatives and constraints under which different news outlets operate*' and following on from this a '*more skilful presentation of health issues by experts and policy makers for news and features outlets, with attention to the need for accessible language, and for sound and pictures for radio and television.*' (Kings Fund 2003: 6-7)

As well as the need for health coverage to be newsworthy, the other underlying principle from the journalists' perspective seemed to be that their reporting should be as neutral as possible. There seemed to be a clear consensus that the role of the journalist was not to propagate government messages or to tell their consumers how to live their lives. Again this principle seems to create both tensions and points of compatibility with positive health coverage. There seemed to be two areas of difficulty with this 'neutral' perspective; firstly that it often did not result in 'neutral' reporting, and secondly it sometimes means putting across messages or arguments that are 'anti-health', and can cause confusion. With regard to the first point the national level interviewee acknowledged that it was in the nature of the job for a journalist to be critical of public services and policies but he also felt that this was often over exaggerated (Med1-1). As well as exaggeration undermining the supposedly neutral stance, the lecturer in journalism also considered that there were problems caused by a lack of medical or scientific understanding amongst journalists, stemming from the fact that most journalists are Arts graduates, coupled with a keen desire by journalists to report on priority topics like MMR and E-coli. They cited the MMR example of confusion which '*was almost entirely down to the media exaggerating the importance of some fairly eccentric research...*' (Med2-1). There were also examples given with regard to the second point; that by presenting both sides of a story, confusion and the propagation of messages which can undermine public health will be somewhat inevitable. The MMR case was again cited by a journalist who explained how a newspaper would have been compelled to put across conflicting views, which mostly likely would have caused confusion and may have had negative implications for public health.

However, whilst there will be these inevitable tensions, examples have also already been given where health stories have been covered in such a way that positive messages come attached. The following explanation provides a good example of when and how such opportunities can be created:

'There's always been a tension between straight news gathering and a need to maybe inform in a positive way. I think you can do bh within the context of the same sort of issue...take for instance, we weren't involved in it particularly, but the E-coli thing is the obvious contemporary one. And what we would probably do with that is as a straight news story because it has very high news value in terms of ticking all the basic journalistic boxes. But there's also an opportunity there to get a message out without compromising your own journalistic principles, is a desire to inform. Putting plenty of fact files in about it and as long as those are verified...there's absolutely no harm and no conflict...how to avoid this, what to do, who to contact...stuff like that can go hand in hand with any sort of health story really where there might be an issue where people need to know about something. They can work together quite well' (Med3-4)

In other words whilst the nature of journalistic reporting can sometimes result in negative or confusing health messages going out to consumers, it also provides scope and opportunity for

positive and useful information to be delivered without compromising journalistic principles. Given the need for journalists to provide balanced accounts, however, there are also some implications for how statutory bodies might improve their communications with the media, not only from the point of view of creating greater newsworthiness but also for providing clear messages and statements that could better support the government 'case' in media reporting. One broadcasting journalist, talking about the case of MRSA as an example of a media health scare, commented:

'I think that the government could help themselves by putting out clear messages... I know that it's sometimes difficult to find clarity within an organisation like the NHS because on the one hand you get people telling you what a problem it is and on the other people not dismissing it but saying it's nothing to worry about.' He went on to talk about Health Trusts explaining "some trusts are more co-operative with the media than others and you know the more cooperative people are with us the more cooperative we can be with them in terms of getting the messages across' (Med3-2)

There was also recognition of a government communication problem and a lack of focused and clear messages being sent out by the national level interviewee. Again plans to look at putting out more user friendly messages in the Media Tool Kit may help here, as would more actively discussing issues with the media, as opposed to the re-active approach already described.

However, whilst there were these common themes and principles emerging from all of the interviews, which highlight the key forces at work in determining approaches to consumer health, there were also some differences. These differences seem likely to be influenced by the individual perspectives of editors or journalists, and the type of organisation. Although consumer demand will vary from one organisation to another, thereby influencing output, there will also be internal drivers influencing the output of each organisation. The above discussion of newsworthiness highlighted how there is also some scope for journalists to lead their own agenda. These individual influences were also acknowledged by the Welsh Assembly interviewee who considered that approaches would be influenced by different levels of public spiritedness amongst editors, and in particular the importance that individual reporters attach to public health. This type of public spiritedness did seem to be evident in the only editor that we spoke to who, talking about their promotion of voluntary groups and charitable events, explained *'we don't have to do it, but we do it because we think it is right.'* They also talked about the potential power of newspaper editors particularly in the tabloid press, in comparison with the way their company operates now:

'You don't think that way, you try to help the community that's the way (name) newspapers handles itself' (Med3-5)

As well as the personal philosophies of editors or journalists the type of organisation was also thought to be important. Differences were identified between the kind of approaches that local and national papers could best adopt; with local papers better placed to run local campaigns and national papers more likely to cover broader health stories and messages. The public service function of one organisation was also thought to be responsible for it having one of the most constructive approaches to health. The journalist from this organisation similarly explained:

'you have roles and responsibilities as a journalist particularly as a public sector broadcaster. If you're working for a private company you may be able to take more of an editorial line, certainly in newspapers, people are part reporter part columnist, but from my perspective it is one of the key objectives, you know it's written in our guidelines to be fair, balanced and impartial' (Med3-2)

The public service remit and public funding was also seen to be a key factor in why this organisation could run promotions and campaigns, and would be more likely to work collaboratively with government departments.

3.6.5 Actions to improve the health of wider communities

For the purposes of media organisations the wider population was understood to be any population impacted by the activities, corporate behaviour or reporting of media organisations, that is, not just their consumers. Where there was confusion about what this meant interviewees were asked about corporate social responsibility, environmental policies and socially responsible reporting. This section will be split into general corporate social responsibility, socially responsible reporting and factors influencing activities in this area. Interviewees were not able to provide much information about CSR policies due to their positions as journalists in much bigger organisations. Whilst most interviewees thought that their companies would have such a policy they were not able to provide any details about it. This was similarly true of considerations of environmental policies, although one journalist described some limited positive environmental actions that they thought were in place or being considered at their headquarters in London. They also noted that locally there have been some action on car sharing, but this was at an informal level through people taking the initiative themselves. One journalist also gave the example of how their (externally contracted) canteen had made moves to become fair-trade. Two interviewees were also able to give specific examples of actions that were likely to impact positively on the wider population. These included the promotion of local voluntary groups and planned 'Work Place Awards' which would be on offer to companies who are taking actions to promote the health of their work force. Taking up the causes of local groups or communities is also one area in which local papers in particular are well placed to improve the health of wider populations. The example already given of the local paper covering healthy local events is therefore also relevant here, and another couple of examples were also given by another paper such as saving a local playing field and supporting a Miners' campaign for compensation.

With regard to reporting and its potential impact on the health of the wider population, three key ways of impacting were identified in the literature. The first two areas relate to explicit reporting on public services and groups of people, and the third area is concerned with the impact of media discourse more generally. With regard to reporting on public services a report by the King's Fund highlighted how media reporting on public services is highly influential in affecting the priorities and decisions of policy makers. The same research found that public health experts and policy-makers felt that the media neglected issues that were important to public health, while often giving prominence to 'scare stories' and health service issues, due largely to their greater newsworthiness. In support of this an analysis of health-related coverage in broadcasting and print media found that the coverage was dominated by stories around the themes of 'NHS in crisis' and health 'scares'. (King's Fund, 2003). A similar opinion was echoed by the Welsh Assembly interviewee who felt that journalists often over exaggerated problems with the NHS when space could be more constructively given to more important public health stories. In the journalist interviews however little consideration was given to this idea of exaggerated criticism and its potential impact on public health. Indeed, only one journalist showed awareness of how the 'watchdog' role of journalists could negatively impact on public health by damaging organisations through over exaggeration. This journalist explained:

'the media in a wider context can be guilty of sometimes bashing the NHS e.g. MRSA. They're reporting a very genuine and you know worrying phenomenon but not doing it responsibly and giving the impression that this is happening in every ward in every possible, so I think that has then an effect on the staff, an effect on morale.' It was felt that his own organisation tried to avoid falling into this trap by always trying 'to be neutral' (Med3-2)

With regard to the impact of reporting on groups of people, the negative construction of marginalised and vulnerable groups has obvious negative implications for health and well being. Several studies have also revealed that the ways in which mental illness is framed in media discourse significantly impacts upon societal attitudes and the stigma surrounding mental illness, whilst users of mental health services have also indicated how adverse media coverage prevents

them coming forward with problems (Mind, 1999, cf King's Fund, 2004). Several interviewees provided examples of how they thought they had a responsible approach to their work in this context. The lecturer in journalism considered that ethical issues formed an important part of the post graduate course, which came up regularly across the course as well as specifically in a course called 'reporter and the reported.' The interviewee later elaborated on their approach explaining;

'I think we do as teachers of journalism have the responsibility to make students aware of how easily it is to fall into stereotyping, clichés, all things like this, and that they should always be conscious when writing about mental health or other health issues that you're actually writing about people and you should do nothing to exacerbate prejudice and should do everything in one's power I suppose to lessen it' (Med2-1)

There was recognition by several interviewees that the media has earned a bad reputation for irresponsible reporting, which they recognised could have negative implications for health, but all those journalists who discussed these issues considered that in their own organisations care was taken to avoid this kind of negative reporting.

'I think it's something that perhaps consciousness, you know approaches to issues like mental health have got a lot more sensitive in recent years. I think they probably were fairly sensitive in broadcast news but that sensitivity has spread I don't think stand up comics make jokes in the way they used to, so I think generally we are rather better. I'm sure there is still a long way to go and you know whenever I meet a representative of a pressure group for some particular e.g. epilepsy, and the way she felt they were stigmatised and people were afraid of them I think that's true but I pressed her to give some example and actually she should give examples from print but not from broadcasting...' (Med2-1)

The third area identified in the literature related to the impact of media discourse generally. In an article on the framing of obesity in news discourse in the US, Lawrence (2004) argues that the media acts as an important medium for framing public discourse and debate, which in turn can limit or extend governmental responsibilities for public health problems, as discourse shifts between individualized and systemic frames (Lawrence, 2004). The King's Fund also point to increased media and public attention to the potential costs of 'epidemics' such as obesity, as a factor helping to refocus government priorities for the NHS, to move it from a 'sickness service' to one that promotes health (King's Fund, 2005). In other words the focus and language of media reporting on health issues generally is also thought to influence political priorities, whilst individualised discourses on health in the media could also be argued to be 'victim-blaming' through constructions of an irresponsible other. There was no consideration of the impact of discourse generally, and where journalists did talk about their approach to health coverage, they did seem to talk largely in terms of providing information for individual health choices. The frequent claims to neutrality also suggest a possibly limited recognition of the role of media discourse in shaping debates, with allegedly 'neutral' perspectives often argued to be a reflection of dominant discourses (e.g. of individual choice). That said there were a couple of positive examples given. One journalist felt that their reporting was about - *'making the links between health and other parts of life and giving people the information they need'* (Med3-1).

In summary a couple of the media organisations seemed to be taking limited actions aimed at improving the health of wider populations. All of the journalists interviewed also considered that they had an ethically responsible approach to reporting, and a few practical examples could be found to support their claims. However, in order to properly consider media discourse and approaches it would be necessary to conduct an analysis of media texts, as this was not something that could be adequately explored in the interviews. Given that the majority of interviewees were journalists not managers it was also difficult to find out about corporate

behaviour, and perspectives on barriers/ facilitators similarly could only reflect the guesses of employees rather than employers.

Factors influencing activity

With regard to the key factors influencing approaches to the health of the wider population, the typical business oriented, laissez faire philosophy again came through as a key determinant of activity. However, variation between organisations in terms of the structure, ethos and perspectives of editors and journalists was also acknowledged. The money making priorities of most media organisations again shone through in considerations of drivers and barriers to social responsibility and health promoting activity. The Welsh Assembly interviewee again emphasised that selling newspapers is the priority, hence the preference for 'scare stories' and that everything else will be secondary, whilst a journalist similarly described journalism as a mercenary business, focussing above all on profit margins. As with the past two sections then, the message seemed to be that if more socially responsible activities and approaches were thought to undermine profit margins, most media organisations would probably not pursue them. Likewise if any such activity was thought to contribute positively to the saleability of the product then it would most likely be supported. Examples given of perceived benefits for the organisation included positive feedback received from promoting voluntary groups and a 'lot of praise and a lot of kudos' brought from campaigns like the Miners' Campaign. In other words it seems that business incentives can exist for media organisations to take a more positive approach to health given the apparent links between healthy approaches and good PR. In addition, there were also examples given to suggest that in some respects this relationship might have been strengthened in recent times given the interactive relationship of the media with society and the fact that society generally was thought to have become more socially responsible. The respondent here, talking about mental health coverage in the media considered that overall the media was more sensitive in these areas in the same way that *'I don't think stand up comics make jokes in the way they used to, so I think generally we are rather better'* (Med2-1). This kind of bottom-up influence on activity within media organisations could also be seen in the example of informal car sharing initiatives at one organisation, or in the Fair Trade canteen at another.

However, whilst market forces and societal trends seem to have a strong influence on media approaches to health, the perspectives of individual editors and journalists, along with the type of company were again also suggested to be important. Two journalists mentioned a code of ethics as something which they felt governed their approach, and again re-iterated the need for balanced, fair coverage. In the earlier section on consumer health it was also suggested that there was some scope for journalists to take a lead, suggesting internal influences on the style and focus of reporting. Many of the differences that exist between organisations have already also been explored in earlier sections and for obvious reasons are again relevant here, for example some editors being more public spirited than others and the size and structure of a company. However, the following suggestions specific to this section were also made, largely in relation to distinguishing between types of media organisation. The ethos of one organisation was again mentioned in relation to its public service remit, and distinctions were made between the broadcasting media and the tabloid press in particular. The lecturer in journalism explained;

'There's a tendency to take the very small number of journalists working on tabloid newspapers and then the very small numbers of them as the sort of ethical standard there is for the whole business and you know that's not true at all and most journalists work within all ethical guidelines....I think the broadcasting media has always been fairly socially responsible and the print media has always been sometimes rather less responsible in my view...and I don't think it's something that has changed all that much' (Med2-1)

3.6.6 Conclusion

All of the respondents recognised the influence that the media can have through reporting on health issues. However, the journalists interviewed were also quite clear that the role of the media was to be '*neutral informers*' who '*report on issues within the health community as they arise.*' However, they were able to offer various examples of how their activities contribute to the health of consumers and to a lesser extent the health of wider communities. In terms of consumers interviewees gave examples of how their organisation makes a potentially positive contribution to the health of consumers through advertising and promoting local groups and healthy events, running health campaigns and by providing useful health coverage through keeping consumers informed of important health issues and sometimes providing healthy tips. For the health of wider communities positive examples were given of promoting local events and local causes, as well as suggestions of more sensitive and considered approaches to reporting than the media are often charged with, although this will always be difficult to assess through interviews alone.

Insights were also gained into common factors influencing media approaches and activities. The first key influences to come across in all sections were the fundamental business principles of media organisations and their underlying concerns with productivity. Where positive actions were being taken, consumer demand, good PR and credibility were cited as benefits and incentives for taking these kinds of actions. This suggests that changing societal trends will have an important bearing on approaches, as was explicitly identified in suggestions of society becoming more health conscious and socially responsible with implications for media outputs and also workplace cultures.

However, as well as appearing fundamentally responsive to market forces and societal trends there were suggestions of more internal influences and drivers. A strong theme to come across throughout the interviews was to do with journalistic principles suggesting that general principles will also influence reporting. Another theme here was to do with differences, where it was suggested that the outputs and actions of media organisations will be driven not only by consumer demand, but also by the personal perspectives of editors and individual journalists and the 'type' of organisation.

Media activity and approaches therefore seem to be driven by both a mix of external and internal influences, with some implications for future activity. The first of these is that if society becomes more health conscious or socially responsible so probably will media organisations. However, there are also implications for how media organisations might be encouraged to develop a more pro-active approach to public health. Working on the basis of the widely identified need for newsworthiness and neutral coverage, there are some implications for the government with regard to generating more user friendly messages, statistics and examples for media organisations to enable them to cover important health messages in marketable forms. A final and less obvious implication could also be observed for teaching institutions and the education that they give trainee journalists to encourage more socially responsible reporting and awareness of the role of media discourse in shaping debates. Whilst most interviewees displayed an awareness of how explicitly negative reporting on groups of people and less often public services could negatively impact on public health, there was no discussion of the potential impact of discourse more generally e.g. the impact of individualised discourse on governmental acceptance of responsibilities for health or its victim blaming implications (e.g. see Lawrence, 2004). This is an area that will have particular relevance to inequalities agendas and could be usefully addressed in ethics courses given by providers of post graduate qualifications in journalism.

4. Conclusion

4.1 Roles and responsibilities in society generally

There was agreement across all sectors that responsibility for improving health should be shared with individuals having ultimate responsibility and organisations supporting and facilitating health choices, particularly for disadvantaged or vulnerable groups. In terms of organisational responsibility across sectors the majority highlighted a more prominent role for the statutory sector. It was noticeable that in the first phase of questioning about general roles and responsibilities, none of the interviewees identified responsibilities for private employers or the media. Variations in responses within sectors were most prominent in education and business. In the education sector one head teacher placed greater emphasis on responsibilities of the statutory sector, while two other heads placed greater emphasis on parents.

4.2 The role of organisations in improving health

This section prompted interviewees to consider the role of their own sector in improving health and well-being. All of the statutory sectors accepted that their organisations played a key role in health improvement. The local government sector acknowledged that it played a central role, particularly in tackling the wider determinants of health. This role had become more prominent in recent years with the 'reinvigoration' of local authorities as health improvement agencies and there was recognition that 'almost everything they do has an impact on health.' The education sector also acknowledged it had an important role mainly in educating for a healthy lifestyle, but also in providing for a healthy lifestyle and in terms of the health benefits of providing a good education. The health sector, particularly those concerned with public health, also recognised they played a key role in driving forward the health improvement agenda and this was likely to focus increasingly on the wider determinants of health. The voluntary and community sector is currently contributing substantially to the health improvement agenda taking a lead in some health education campaigns and providing some direct service provision.

Interviewees expressed some reservations about the extent to which these roles could be fulfilled. In the main, these concerns came from the local level organisations, those closest to the point of implementation. For example, in the education sector, head teachers questioned the role of schools in the face of parental responsibility. Furthermore, within the health sector, health care services acknowledged a limited role in health improvement with treatment and care as priorities. Outside the statutory sectors, there was greater ambivalence regarding roles and responsibilities. This ranged from recognition of potential impact, but denial of a health promotion role (amongst the media sector) to bewilderment about being asked questions on health-related issues (amongst the business sector). The media sector interviewees recognised the potential influence of the sector on reporting health issues and promoting health messages. However, they saw a role as 'neutral informer', providing the public with all sides of a story so that they could make up their own minds. Business sector interviewees did not prioritise health improvement actions as they felt it threatened their profitability.

4.3 Organisational relationships

Within sector relationships

One of the main themes to emerge from the interviews regarding relationships within sectors was the need for more direct links between the national and local levels. For example, local authority

interviewees voiced concern about having 'too many tiers' and the failure of national government to recognise the important role local authorities played at the local level. Similar views were expressed in the voluntary and community sector where local organisations expressed a preference for direct links to the national level and it was felt that central government needed to develop a greater empathy with local situations. This criticism was slightly more diluted within the education sector where both the national government and the local education authorities were viewed as playing a supportive role in working with schools although there were some criticisms of the extra pressures created by government directives and changing policy agendas. Within the health sector, in addition to local level organisations taking a more pro-active role in influencing national agendas, it was noted that there were some further barriers to overcome including the different organisational priorities within the sector together with variations in local level expertise across Wales. Organisational complexities were also highlighted in the voluntary and community sector with particular reference to the structure of the independent voluntary sector and the potential mismatch with statutory sector infrastructure.

Relationships between national government, intermediaries and local level organisations were not significant issues for the media sector and the business sector. The business sector felt they were driven by international regulations on health and safety issues. For the media, reporting on health issues was driven by the underlying principle of newsworthiness rather than directives emanating from national government.

Across the sectors, there was a mixed response to Health Challenge Wales with some examples of actions taken at a local level. Within each sector there were some interviewees who had not heard about it and some who had not responded. Alongside lack of awareness and inaction, there was some concern about the future development of Health Challenge Wales. This included concerns about measuring the success of the Health Challenge Wales concept and a perceived over-emphasis on lifestyle issues.

Across sector relationships

Positive steps to working with organisations outside the sector to tackle health improvement were reported across all the statutory sectors. For example, in the education sector, interviewees reported positive collaborations between schools and local agencies, whilst in the health sector work had been undertaken with local authority, voluntary and community representatives. However, all sectors also identified room for improvement in inter-sectoral relationships and some reported particular difficulties with certain sectors. For example, the voluntary and community sector identified competing agendas and lack of credibility as the main barriers to them furthering links with health care professionals. Within the independent sectors there had been minimal activity in collaborations with organisations outside the sector although media organisations had made some concessions regarding supporting and publicising local issues.

4.4 Actions to improve the health of employees

Across all sectors there were limited strategic drivers or formalised frameworks for promoting action to improve health beyond health and safety legislation. The Corporate Health Standard was referred to by the local government sector as fostering some benefits for organisations but this was viewed as falling short of addressing wider corporate social responsibility. Most headway with employee health seemed to be made in the education sector with the development of Prepare Plan and Assess (PPA) and the associated benefits for freeing up staff time and promoting better work life balances. Tackling stress was a key concern across the sectors. Although there have been some steps taken, such as counselling, and family friendly policies, it was felt that there was still some way to go. Across a number of statutory and independent sectors, the most pro-active

organisations tended to be those where the management were signed up to a health improvement agenda and acknowledged a role for their organisation.

4.5 Actions to improve the health of communities served

In this section interviewees were asked to respond in terms of the main communities they influenced. Across sectors this ranged from local communities (local government sector); consumers, readers and viewers (media sector) to customers (business sector). Addressing the health of the communities served was prioritised by all of the statutory sectors. This was seen as less of a priority for the media sector although interviewees were all able to cite positive examples of how their organisations had contributed to consumer health. As for the business sector, they complied with regulations regarding safety and quality of products but the majority did not see a responsibility to improve customer health and any approaches were seen as 'health marketing spin' rather than effective action. However, there were variations in the level of actions taken by individual organisations. For example, within the education sector, all schools reported taking some actions to improve pupil health but some had adopted a more holistic approach than others. Similarly, some public health organisations had gone beyond an advisory role and had taken up a more active, participatory approach to tackling community health. Factors determining such variation mirrors issues raised above, with management perspectives or corporate principles appearing to influence the extent to which organisations take on board health improvement action for their communities served.

4.6 Action to improve the health of the wider community

Most interviewees provided limited commentary on this sphere of influence because of the minimal actions taken and a focus on their main communities served. However, there were some actions taken and this included supporting groups beyond their main remit (such as working with children of clients in the voluntary and community sector), dissemination and contribution to strategy development (such as in the health sector) and environmentally friendly action (reported in the education sector, business sector and media sector).

4.7 Implications

This study has provided further insight into *who* is acting to improve health and well-being, *why* these actions are being taken, *how* health improvement is being enacted and *who organisations are working with* to achieve this. The gaps and weak points in this framework for action should be the focus of future research and policy development, and priorities for each part of this framework are considered in turn below.

Firstly, in terms of *who* has taken action, responsibility is largely taken and enacted by the statutory sector, with the non-statutory sector on the periphery in terms of acceptance of responsibility and action taken. However, this study has added further dimensions to this understanding of organisational responsibility for health. At one level, it has illustrated that there is a spectrum of more and less active organisations within all of the sectors. This differentiated level of response has implications for policy. Broad brush approaches to engaging sectors as a whole are unlikely to work and one area of focus should be the more active organisations with a different approach needed to engage with those who have been least active to date.

Secondly, in terms of *why* actions are taken, the main drivers for the most active organisations seem to be management perspectives and awareness of the benefits of taking health improvement actions. However, even for those perceived to be at the core of activity on health

improvement, there are limits to their role and although they may be active in one sphere of influence other spheres tend to be overlooked, particularly action to address wider corporate social responsibilities. Therefore, for the most active organisations there is still scope to understand fully the drivers behind their decisions. In addition, there is also a need to understand in more detail the nature of corporate responsibility in the less active organisations and unpack influences on management perspectives. Corporate responsibility needs to be examined at a number of levels, including: moral stance; value judgement; assessments of effectiveness (who is best placed to take responsibility) and assessments of secondary outcomes (the unintended outcomes of actions taken). Further research to explore these nuances of organisational behaviour should be a research priority particularly in terms of the non-statutory sectors and developing a deeper understanding of how business cultures develop over time. At one level, appropriate intervention might be enforcement or regulation but it will be important to recognise the unintended outcomes of this action such as in the case of businesses where one unintended outcome of taking health improvement action might be decreased profitability. At another level, appropriate intervention might involve trying to shape values and morals through wider societal changes. As illustrated in the media sector, these sorts of changes are beginning to make a difference at the organisational level but this is a slow process. A better understanding of how these wider societal changes are diffused within and between organisations will enable this process to be better supported.

Thirdly, in terms of *how* health improvement is enacted, this study has highlighted a number of good examples of work undertaken within different spheres of influence. However, there are policy implications for the way in which the more active organisations could be better supported including providing access to dedicated funding (which is sustainable in the longer term), together with opportunities to profile their achievements with others. Also, developing an evidence base on what works in terms of health improvement could quickly be put into motion across different sectors.

A final area of consideration for policy and further research relates to *who organisations should be working with*. Examples of good practice in terms of inter and intra sectoral working were reported but similarly there were also concerns about the need for more effective collaborations. Short term measures to address this include utilising existing mechanisms for cross-sector working such as the Power of Well-Being approach suggested by the local government sector. Further research to explore perspectives of different personnel within organisations might also uncover ways in which these processes can be best supported.

5. References

- Baric, L (1993) 'The settings approach – implications for policy and strategy' *Journal of the Institute of Health Education*, 31(1): 17-24.
- Bowling, A (1997) *Research Methods in Health. Investigating Health and Health Services*. Buckingham: Open University Press.
- Dahlgren, G & Whitehead M (1991) *Policies and Strategies to promote equity in health*. Copenhagen: World Health Organization Regional Office for Europe
- Denman, S, Moon A, Parsons, C & Stears, D (2002) *The Health Promoting School. Policy, Research and Practice*. London: Routledge, Falmer.
- Department for Education and Skills (DfES) (2002) *Extended schools: providing opportunities and services for all*. London: DfES.
- Ford, K (1999) *Social Action for Health: Hopes, Expectations and Progress*. London: HEA.
- Goddard, T (2004) 'Can corporate sector philanthropy be included in a new vision for community health programmes?' *Australian Occupational Therapy Journal*, 51: 106-109.
- Grit, K (2004) 'Corporate Citizenship: How to strengthen the social responsibility of managers?' *Journal of Business Ethics*, 53: 97-16.
- Health and Safety Executive (1992) *Workplace Health, Safety and Welfare Regulations 1992: approved code of practice and guidance*. Sudbury: HSE Books
- Jenkins, H (2004) 'Corporate Social Responsibility - Engaging SMEs in the Debate.' *New Academy Review*, 3(3): 76-95.
- Joseph Rowntree Foundation (1999) *Monitoring poverty and social exclusion*. York: Joseph Rowntree Foundation.
- King's Fund (2003) 'Health in the News: Risk, reporting and media influence.' London: King's Fund.
- King's Fund (2001) *What's to stop us? Overcoming barriers to public sector engagement with local communities*. London: King's Fund.
- King's Fund (2004) *Choosing Health? A consultation on improving people's health*. King's Fund submission to the Department of Health. London: King's Fund.
- King's Fund (2005). 'Managing for Health; What incentives exist for NHS managers to focus on wider health issues?' London: King's Fund.
- Lawrence, R (2004) 'Framing Obesity: The Evolution of News Discourse on a Public Health Issue.' *Press/Politics*, 9(3): 56-75.
- National Assembly for Wales (2000) *Voluntary Sector Scheme*. Cardiff: National Assembly for Wales.

National Assembly for Wales (2000b) Public opinion on health and well-being. Health Promotion Research Summary No. 1. Cardiff: National Assembly for Wales.

National Assembly for Wales (2000c) Promoting health and well-being: a consultation document. Cardiff: National Assembly for Wales.

Parry, O, Platt, S, Thomson, C (2000) Out of sight, out of mind: workplace smoking bans and the relocation of smoking at work. *Health Promotion International*, 15 (2): 125-133.

People and Work Unit (2005) Mapping Support Available to Communities First Co-ordinators and Partnerships (unpublished report).

Stewart Burgher, M, Barnekow Rasmussen, V & Rivett, D (1999) The European network of health promoting schools—the alliance of education and health. Copenhagen: WHO Regional Office for Europe.

St Leger, L (2004) What's the place of schools in promoting health? Are we too optimistic? *Health Promotion International*, 19(4): 405-408.

Welsh Assembly Government (2002) Building Strong Bridges: strengthening partnership working between the voluntary sector and the NHS in Wales. Cardiff: Welsh Assembly Government

Welsh Assembly Government (2002b) Well Being in Wales. Cardiff: Welsh Assembly Government

Welsh Assembly Government Health Promotion Division (2005) 'Fast Facts' The Standard: Workplace Health. News from Around Wales, Issue 12.

Welsh Assembly Government (2005) Power to Promote or Improve Economic, Social or Environmental Well-being. Draft Guidance to local authorities from the Welsh Assembly Government.

Welsh Office (1998) Better Health Better Wales. Cardiff: Welsh Office.

World Health Organization (WHO) (1997) The Jakarta Declaration on Health Promotion into the 21st Century. Fourth International Conference on Health Promotion, Jakarta.