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Abstract

Purpose Contact centre advisors face significant health risks due to poor working conditions. Workplace health initiatives can improve advisor wellbeing, yet the factors influencing their adoption, implementation and evaluation remain underresearched. This two-phased mixed methods study explored UK contact centre health and wellbeing decision-makers' perspectives on these processes.

Methodology Phase one involved interviews with 11 decision-makers to explore factors influencing health initiative adoption and implementation and evaluation methods and outcomes considered important. Interviews were inductively coded using reflexive thematic analysis and mapped to behaviour change theory (COM-B and TDF). Phase two surveyed 38 decision-makers to assess consensus on phase one findings.

Findings Key factors influencing adoption included leadership buy-in, listening to advisors, money and resource availability, and the perceived need to support employees. Effective implementation relied on manager and team leader buy-in, time for leaders to prioritise initiatives, experienced leadership, and adaptability to employee needs. Centres employed diverse evaluation methods and considered multiple outcomes.

Originality These findings provide novel insights to guide the effective adoption, implementation and evaluation of workplace health initiatives in contact centres, ultimately supporting advisor wellbeing.

Keywords: contact centre; behaviour change; health; adoption; implementation; evaluation.

Introduction

Contact centres have ~~developed~~ evolved beyond the traditional 'call centre', now ~~offering~~ providing customer service through a range of digital channels (e.g. chatbot, email, social media, text, video support) and employing over 4% of the UK's working population (Leroux, 2024). Contact centre advisors work on the front line of customer service. This job role is often associated with high attrition and absenteeism (NICE, 2022) stemming from pay below the real-living-wage (Talent, 2024), monotonous, highly-monitored and sedentary work, difficult customers and limited career progression (Miller and Hendrickse, 2016; Morris *et al*., 2018). These issues contribute to stress, low job satisfaction, and poorer health than the general working population (Holdsworth and Cartwright, 2003), worsening health inequalities. Such conditions increase the risk of ~~P~~poor mental health, which costs the industry >£990 million annually (MaxContact, 2022). Conversely, ~~while~~ organisational wellbeing investment can improve resilience, engagement, sickness absence and performance (Owolabi, 2022). Supporting contact centres to adopt and implement effective health initiatives is therefore vital for worker health and economic growth.

~~Only two~~ Few studies have examined factors influencing the adoption and implementation of health initiatives in contact centres. ~~Those~~ For example, two studies aimed to reduce sedentary behaviour and/or promote physical activity, and observed that organizational benefits (reduced absence, attrition, and improved productivity) and concern for advisor wellbeing facilitated adoption, while barriers included lack of space, advisors' headset use and high workload, and the cost of height-adjustable workstations (Renton *et al*., 2011; Morris *et al*., 2018). While these findings offer valuable insights, their focus on physical activity and sedentary behaviour highlights the need to explore whether additional barriers or facilitators exist when adopting a broader spectrum of health initiatives in contact centres.

~~Beyond adoption, t~~There is also a dearth of research on implementation processes in contact

centres, despite their critical role in determining whether health initiatives succeed in practice. ~~Implementation research in contact centres is also limited.~~ Implementation barriers include team leaders' and managers' workload, conflict between health promotion and maintaining service levels (Morris *et al*., 2018; 2021), varied shift patterns and break schedules affecting promotion of movement initiatives (Morris et al., 2019) and time constraints for mindfulness programmes (Allexandre et al., 2016). While useful, these studies were ~~all~~ pre-COVID-19, after which home and hybrid work increased in the industry from 19% to 87% (Desmarais *et al*., 2022). The number of remote workers within an organisation may have a significant impact on ~~it's~~its decision ~~on whether~~ to adopt a health initiative. If a health initiative is only effective for in-office employees, it may be less important to employers with a large proportion of remote workers. It is also unclear if greater use of remote and hybrid working since the pandemic, and the associated reduction in face-to-face interactions, has made it harder~~more difficult~~ to implement health initiatives. Although recent research has highlighted the pandemic's disruptive impact on contact centre culture and health initiative implementation (Manner *et al*., 2024), further research is needed to expand upon these findings and inform the effective adoption and implementation of health initiatives amid more widespread remote and hybrid work patterns.

Evaluating health initiatives is essential for assessing impact, with industry guidance recommending mixed methods approaches (Investors in People, 2022). Limited research however has examined how contact centres evaluate their initiatives, which could be particularly difficult considering the industry's high attrition rates. One study found contact centres prioritise reductive business outcomes, such as customer service scores and sickness absence (Morris et al., 2018), mirroring approaches in other industries (Baxter *et al*., 2015). Further research is needed to explore the extent of reductive evaluation in contact centres and develop support strategies aligned with industry recommendations. Hence, t

This two-phased study i) explored decision-makers' perspectives on factors influencing the adoption and implementation of health initiatives in UK contact centres, and the evaluation methods and outcomes considered important, and ii) assessed consensus on the findings in a larger sample of UK contact centre decision-makers.

Methodology

Study design

This sequential, two-phased mixed methods study included interviews (Nov 2022-May 2023) and a consensus survey (March-July 2024). This mixed methods approach allowed for a more comprehensive understanding of the complexities behind stakeholder behaviours, whilst also assessing the broader applicability of qualitative findings across a larger UK-based population. [Institution] granted ethical approval [approval number] on 18th July 2022.

Phase one: Interviews

This study followed the consolidated criteria for reporting qualitative research (COREQ) (Supplementary 1) (Tong *et al*., 2007) and pragmatic philosophy. The authors have expertise in qualitative methods, and none have worked in the contact centre industry.

Participants and recruitment

A maximum variation sampling approach purposely recruited diverse contact centres by size and their number of health initiatives from centres with no-to-few health initiatives to centres with many health initiatives. Participants self-identified based on the eligibility criteria: position as a health and wellbeing decision-maker with a role above advisor level and knowledge of health initiative adoption, implementation and evaluation. The researchers provided example roles in recruitment material, including managers, human resource and health and safety professionals. Posters were shared with UK contact centres via partner [partner name] emails and social media, with a link to study information and a pre-interview online survey. Consent was collected via a tick box before survey completion, which

gathered personal (gender, job role) and workplace demographics (location, advisor count, work approach [remote, office or hybrid]), and details of health initiatives the centre implemented, to facilitate the sampling approach and inform interviews. Participants provided their email to arrange interviews. No financial incentives were offered in phase one.

Data collection tools, procedure and analysis

A semi-structured interview schedule, based on the Capability, Opportunity and Motivations surrounding Behaviours model (COM-B) and Theoretical Domains Framework (TDF; Michie *et al*., 2011; Cane *et al*., 2012), systematically examined factors influencing health initiative adoption, implementation and evaluation. Initial broad, non-theory driven questions were asked (e.g., what influences the adoption of health initiatives in your centre?), followed by prompts informed by the wider literature and theory (e.g., do you have the knowledge [TDF domain associated with psychological capability] of available initiatives?). The first author, a female researcher completing their PhD, conducted interviews in person (audio-recorded) or via Microsoft Teams (video-recorded) in private settings. Verbal consent was obtained and the researcher had no prior relationship with participants. Participants were informed that [initials] was completing the research as part of a PhD. Interviews continued until information power was reached, meaning the information provided by the sample allowed for sufficient analysis to answer the study aim (Malterud *et al*., 2016). This was assessed based on the study's relatively narrow aim, the strength of interview dialogue, sample relevance and variability, cross-case comparisons, and alignment with the behaviour change theory guiding the study. Interviews were analysed using reflexive thematic analysis (Braun and Clarke, 2019). [Author initials] transcribed interviews verbatim, anonymised data, and coded using NVivo (release 1.6.1). Initial coding followed a semantic, inductive approach. A public advisor [initials] (a UK-based contact centre change acceptance manager) and [initials] independently coded three interviews and compared interpretations to enhance

reflexivity (Clarke and Braun, 2021). A thematic map was created to visualise initial themes, which were reviewed, defined and named based on research questions. To situate the research in behaviour change theory, [initials] developed a mapping table on adoption and implementation themes with supporting quotations. [initials] independently mapped quotations to the COM-B model and TDF through iterative comparison, enhancing alignment with participants' accounts rather than imposing theory. ~~, facilitating discussion and interpretation~~. This analytical use of COM-B and TDF clarified whether barriers and facilitators related to capability, opportunity, or motivation and identified relevant TDF domains, which guided interpretation of behavioural mechanisms. This mapping informed the development of the phase two survey by translating salient COM-B/TDF constructs (e.g., physical opportunity) into measurable items (e.g., centres' financial ability to invest), ensuring continuity between qualitative insights and quantitative assessment. The reporting stage was recursive. Member checking was not conducted due to its realist/positivist approach conflicting reflexive analysis (Braun and Clarke, 2023).

Phase two: Consensus survey

Participants and recruitment

Participants were self-identifying decision-makers from UK contact centres of any size, regardless of the number of health initiatives implemented. Purposive and snowball sampling were used, with phase one participants emailed directly by [author initials]. Posters were distributed to UK contact centres via partner [partner names] email lists and social media, containing a link and QR code to the online survey and details of a prize draw for vouchers. Upon accessing the survey, participants were provided a link to the study information sheet and consented via a tick box. Survey completers could enter their email for the prize draw.

Data collection tools, procedure and analysis

The survey was developed and accessed using Jisc software (2.16.0) and collected personal and workplace demographics. Participants were presented with a list of factors that may affect health initiative adoption and implementation, informed by phase one findings and the existing literature. Participants rated the factors for perceived importance within their centre on a 5-point Likert scale. Participants also rated the methods used to evaluate health initiatives on a 5-point Likert scale for frequency and the outcomes considered to be important. Participants could provide additional details on any answers or suggest additional factors / methods / outcomes not in the survey, via a free text comment box. Likert scale responses were summarized as counts, percentages, median scores, interquartile range (IQR), and standard deviation (SD). Consensus was defined as at least 75% of people choosing 4 or 5 in the Likert scale (Diamond et al., 2014), with IQR ≤1.25 (Beiderbeck *et al*., 2021) and SD <1 (Giannarou and Zervas, 2014). IQR and SD help assess response distribution as high agreement may not always indicate strong consensus (Giannarou and Zervas, 2014). 'Nearly consensuses' was determined for items achieving 75% agreement plus one dispersion criterion (IQR ≤1.25 or SD <1). This pragmatic approach was guided by the literature ~~is recommended for consensus measurement~~ (Giannarou and Zervas, 2014) and reflects what a second Delphi round would typically be used to confirm. However, for practical reasons, a Delphi process was not feasible, and our aim was to assess consensus rather than achieve it. Including a 'nearly consensus' category allowed us to capture items with substantial agreement while acknowledging slight variability, ensuring nuanced interpretation rather than binary classification.~~.~~ Descriptive analyses were conducted in SPSS (v28). Free text comments were analysed thematically.

Results

Phase one

Participant and organizational characteristics

Eleven health and wellbeing decision-makers (1 in-person, 10 online; 8 women, 3 men) from different organizations were interviewed, with no dropouts. Interviews averaged 39 minutes (range 16-57 minutes). The organisations varied in size and location, but all offered a hybrid working approach (Supplementary 2). The results are organised into three sections aligned to the research questions: 1) adoption, 2) implementation, and 3) evaluation. Table I provides example quotations and mapping to the COM-B model and TDF for adoption and implementation themes.

[Table I here]

Adoption

1. Considering the financial implications. Return-on-investment often motivated centres of all sizes to adopt initiatives. Smaller and financially struggling centres perceived a lack of money or resources as a barrier and were incentivised by cheap or free initiatives.

2. Recognising a need to improve employee health. Participants perceived the COVID-19 pandemic (which started in 2020) and the UK cost-of-living crisis (started 2021) to worsen absence and attrition, and reduce societal support mechanisms. These crises increased the adoption of mental health initiatives, with the cost-of-living crisis also driving demand for financial wellbeing support.

3. Leadership buy-in. Leadership support was perceived to foster buy-in at every level and a wellbeing culture. Some centres reinforced this through policies and mission statements.

4. Identifying advisors' wants and needs. Listening to advisors via surveys, discussions, and wellbeing champions was valued, as initiatives shaped by advisor input were more likely to be adopted, empowering staff through inclusion.

5. Organising around events. Global, national, local, cultural and religious events provided opportunities to adopt health initiatives and "*piggyback"* (P5) on external resources to educate and engage employees.

Implementation

1. Importance of timing. Well-timed implementation and not overwhelming advisors with multiple wellbeing initiatives and messaging simultaneously, were perceived to improve acceptability. Implementing initiatives during quieter periods (regarding customer demand) was perceived to increase advisor participation.

2. Leader buy-in, time and capability. Managers and team leaders were perceived responsible for communicating health initiatives to advisors and encouraging participation, but their lack of buy-in, often due to high workload and limited time, often hindered implementation. Low competence of individuals leading initiatives was also a barrier.

3. Adapting initiatives. The rise of remote and hybrid work due to COVID-19 forced centres to deliver initiatives virtually. Leaders struggled with the best format (in person, online, or hybrid) and timing (i.e. if most people came into the office on a certain day). Initiatives sometimes needed adapting to ensure all employees could participate; managers' and team leaders' knowledge of employee needs and relevant resources enabled this.

Evaluation

1. No single measure of wellbeing. Organizations used informal (verbal) and formal (survey) methods to evaluate health initiatives. Wellbeing was perceived as difficult to quantify, so multiple techniques were deemed necessary to 'build a picture' of an initiative's impact. Absence and attrition data were perceived important for cost-benefit analysis, which often informed decisions regarding initiative cessation, revision or maintenance. Despite this, these indicators were often seen as long-term indicators of employee wellbeing that alone gave little insight into organisational culture or reputation. Employee feedback, satisfaction and internal reputation were therefore also perceived as important.

Phase two

Participant and organizational characteristics

The 38 contact centre decision-makers surveyed were mostly White, 35-54 years old, and consisted of 20 women, 17 men and 1 participant who preferred not to describe their gender (Supplementary 3). Two participants were disabled. Participants were located across Northern Ireland and three regions of England, and mostly team leaders or managers/directors, with one human resource and one health and safety professional. On average decision-makers had been in their role 17 years (ranging from 1.5 years to 31 years). Most participants worked hybrid and were employed by large organizations (200+ advisors). Two decision-makers worked for a small organization (10-50 advisors).

Adoption

Table II presents the level of consensus for each of the factors perceived to influence the adoption of health initiatives within phase one.

[Table II here]

95% of participants felt confident in answering the questions on adoption (29% somewhat, 40% fairly, 26% completely). Consensus emerged for five factors: 1) leader buy-in and support, 2) listening to advisor wants/needs, 3) resource availability (staff and time), 4) recognising the need for support during societal events, 5) financial ability to invest. Staff attrition and sickness absence rates nearly reached consensus. There was no consensus for: 1) having policies and mission statements to demonstrate commitment to improving employee health, 2) event awareness, 3) evidencing return-on-investment. One decision-maker explained that they rated return-on-investment as low importance, as they prioritised the need for supportive initiatives regardless of advisor engagement: "*Obviously you would like a return-on-investment, however I feel these services should be readily available regardless of the volume of people needing to use them*" (P1).

Implementation

Table III presents the level of consensus for each of the factors perceived to influence the implementation of health initiatives within phase one.

[Table III here]

95% of participants felt confident in answering the questions on implementation (21% somewhat, 45% fairly, 29% completely). Consensus emerged for five factors: 1) manager and team leader buy-in, 2) allowing leaders time to prioritise health initiatives, 3) having experienced leaders to deliver initiatives, 4) flexibility to tailor initiatives to individual needs, 5) adaptability across virtual, hybrid, or in-person formats. Appropriately timing/pacing health initiatives did not receive consensus but free text comments indicated that finding time to release advisors from their work was a key implementation barrier: "*The most important factor in any contact centre is being able to schedule time for a front-line advisor to be able to take part in the activity vs serving customers*" (P9). Decision-makers emphasised the need to adapt initiatives to ensure "*all teams/people are able to access the initiative - taking into account work from home/work from office/part-time/roster patterns*" (P3). This was vital for organizations with multiple locations, time zones, and night-shift workers: "*Onshore and operational centres, meaning we must design initiatives so that they work across locations and time zones"* (P9).

Evaluation

Table IIII presents how often methods were used to evaluate health initiatives. Consensus was not assessed as the aim was to assess current practices.

[Table IIII here]

94% of participants felt confident in answering the questions on evaluation (17% somewhat, 43% fairly, 34% completely). Each centre used at least one of the six evaluation methods identified in phase one. Centres mainly used existing software/systems to capture employee

data as indicators of health and wellbeing, followed by surveys, informal discussions, employee forums, focus groups and interviews.

Table V presents the level of consensus for the importance of each outcome when evaluating health initiatives.

[Table V here]

There was consensus for 10 outcomes: 1) employee engagement, 2) customer service scores, 3) performance/productivity, 4) employee motivation, 5) employee satisfaction with the initiative, 6) workplace satisfaction, 7) absence rates, 8) employee satisfaction with managers, 9) attrition rates, 10) employee satisfaction with peers. Presenteeism and average call handing times did not reach consensus. Regarding employee engagement, one decision-maker noted that employees feel satisfied with the offer of health initiatives without necessarily engaging with them, which may reflect why decision-makers reported workplace satisfaction as important: "*Whilst health initiatives are good for all that take part, the real benefit as an employer is the 'perceived' benefit they offer. i.e. even if an employee doesn't take part, they will feel good that we are offering them*" (P20).

Discussion

This is the first study to explore factors influencing the adoption and implementation of contact centre health initiatives, and how initiatives are evaluated, from the perspective of health and wellbeing decision-makers in UK contact centres post-COVID-19. The COM-B and TDF frameworks helped reveal the complex interplay between capability, opportunity, and motivation driving organisational behaviours. This informed survey item development and toolkit recommendations, ensuring interventions target specific behavioural mechanisms rather than generic organisational factors. Items that reached consensus suggest priorities that decision-makers broadly agree on, whereas items with wider dispersion indicate areas requiring tailored approaches across organisations.

Adoption

The phase one finding that financial ~~considerations~~ motivations influence health initiative adoption aligns with previous contact centre research (Renton *et al*., 2011; Morris *et al*., 2018). Miller and Haslam (2009) suggest a strong business case can encourage organizations to adopt health initiatives, particularly higher-level activities and resources (e.g., Employee Assistance Programmes). However, in phase two, *evidencing a return-on-investment* received the lowest agreement for importance, with participants emphasising that maintaining a centre's reputation took precedence. This supports Miller and Haslam's (2009) argument that alongside return-on-investment, business cases often appeal to people management, corporate reputation, and strategic alignment. Although the increase in hybrid working did not appear to influence adoption decisions directly, it may shape how centres assess the value of initiatives for their workforce, particularly in relation to strategic alignment and people management. Similarly, while phase one underscored the role of leadership commitment through business policies and objectives, this did not reach consensus in phase two. Instead, leadership buy-in and active support for initiatives were perceived as crucial, reinforcing findings that management support is key to adoption (Linnan *et al*., 2008). These findings highlight the necessity of leadership engagement in health initiatives, and need for further research on the role of financial justification and alignment with organizational policies.

~~Our finding that smaller organizations lack the opportunity to adopt health initiatives due to limited money and resources (staff and time) supports previous research (Linnan *et al*., 2008). To overcome this, decision-makers prioritised low-cost or free initiatives, often structured around global, national, religious, cultural and local events. The increase in hybrid working may further support these organisations by enabling the adoption of virtual or asynchronous health initiatives (e.g., webinars, online fitness programmes, mental health apps), which are typically low-cost and can help reduce barriers related to time, space and staffing (Whitsel *et*~~

~~*al*, 2023). While phase two lacked consensus on the importance of event awareness for adoption, the inability to explore reasons behind these ratings suggests caution in interpreting this finding, especially when unrelated to low-cost/free resources. Supporting smaller and financially struggling centres and ensuring equitable access to health initiatives and resources seem important.~~

Aligned with previous research (Renton *et al*., 2011), another key motivation for contact centres to adopt health initiatives is a moral obligation to safeguard employee wellbeing ~~motivated centres to adopt health initiatives~~. Phase one participants attributed the increased adoption of mental health initiatives to a broader societal shift in reducing mental health stigma, further evidenced in post-COVID-19 contact centre research (Manner *et al*., 2024). They also noted a rise in financial health initiatives in response to employees' financial struggles amid the UK cost-of-living crisis and typically low advisor pay (Talent, 2024). This indicates that, beyond their duty of care, contact centres are motivated to support employee wellbeing, are an important source of support, and adopt initiatives in response to societal and economic shifts.

Crucially, regardless of these motivational drivers, this study revealed that opportunity barriers were more decisive for successful adoption. Specifically, smaller organizations lacked the opportunity to adopt health initiatives due to limited money and resources (staff and time), supporting previous research (Linnan *et al*., 2008). To overcome this, decision-makers prioritised low-cost or free initiatives, often structured around global, national, religious, cultural and local events. The increase in hybrid working may further support these organisations by enabling the adoption of virtual or asynchronous health initiatives (e.g., webinars, online fitness programmes, mental health apps), which are typically low-cost and can help reduce barriers related to time, space and staffing (Whitsel *et al*, 2023). While phase two lacked consensus on the importance of event awareness for adoption, the inability to

explore reasons behind these ratings suggests caution in interpreting this finding, especially when unrelated to low-cost/free resources. Supporting smaller and financially struggling centres and ensuring equitable access to health initiatives and resources seem important to facilitate organisational opportunity.

Employee-led initiatives that address their needs and wants, were perceived to be more effective, promote employee engagement and empower employees. This aligns with evidence that involving employees in decision-making promotes adoption (Morris *et al*., 2018) and addresses barriers such as perceived lack of interest (Linnan *et al*., 2008; Renton *et al*., 2011). This study demonstrated how both decision-makers capability (knowledge of what employees want and need) and opportunity (creating psychologically safe communication channels) are important to consider when involving employees in decision-making processes~~Involving employees in decision-making processes appears vital for the adoption of health initiatives to benefit advisors and contact centres~~. This is especially important given the rapid rise in hybrid working, which can make it increasingly difficult to understand employee needs and foster engagement. It also raises questions about organisational accountability for health in distributed work settings, reinforcing the need for adaptive policies and integrated wellbeing systems. Actively involving employees can help initiatives remain relevant, inclusive, and responsive to evolving wellbeing challenges.

Implementation

Phase one highlighted the need to align health initiatives with employees' physical opportunity (i.e., time) and implement them during lower customer demand periods. Limited time hinders the implementation of and engagement with initiatives (Allexandre et al., 2016; Manner *et al*., 2024; Morris *et al*., 2021), a challenge tied to the industry's high-pressure, low-control environment (Miller and Hendrickse, 2016). Despite this, phase two lacked consensus on the importance of timing, possibly due to unclear survey wording with no

examples. Free text responses suggested advisors' time availability was crucial. While further research is needed, initiative timing likely affects implementation and engagement and should be prioritised in future health promotion efforts.

Participants emphasised the importance of team leader and manager buy-in for successful implementation, consistent with recent research showing leaders' support had the potential to increase advisors' awareness and engagement (Manner *et al*., 2024). Phase two decision-makers agreed that giving leaders time to prioritise initiatives was crucial, aligning with findings that high workloads, service level conflicts, and lack of knowledge hinder managerial support in contact centres (Morris *et al*., 2018; 2019; 2021). Understanding these barriers and facilitators through COM-B and TDF clarifies why middle management's behaviours can influence the implementation process: leaders' motivation was shaped by their responsibility to communicate initiatives and the boundaries of their roles, while opportunity depended on organisational conditions (i.e., workload and time) that allowed wellbeing to be prioritised. Capability was often a barrier when leaders lacked ~~This study also highlighted the importance of leader~~ capability and experience, suggesting the need for targeted training and support for implementers. ~~External partnerships (e.g., with industry, academia) may support contact centres to enhance implementation effectiveness.~~It is recommended that contact centres not only target middle management motivation to promote initiatives, but also enhance capability and shape the environment to support implementation. External partnerships (e.g., with industry, academia) may support contact centres to enhance implementation effectiveness.

Participants highlighted the importance of adaptable health initiatives across virtual and in-office settings, particularly for centres across locations and time-zones, and for disabled, night shift and part-time advisors, with the latter's industry presence rising to 59% in 2023 (Call Centre Helper, 2023). Supporting disabled (Weil *et al*., 2002) and night-shift

(Anthonisamy *et al*., 2022) advisors is critical due to elevated health risks, including obesity and disordered eating. Managers' and team leaders' ability to manage adjustments for hybrid working (Teng-Calleja *et al*., 2024), their knowledge of employee needs and wants (capability), and the ~~ability~~ physical opportunity to make adaptations was deemed crucial. Accordingly, with a dramatic increase in hybrid working and legislation advancing workplace adaptations for disabled employees (UK Government, 2023), contact centres' capability and opportunity to tailor initiatives to a hybrid/remote working environment and the individual advisor is vital, with managers having a key role. Additionally, researchers designing interventions for contact centres should ensure that delivery approaches are inherently adaptable, enabling flexibility across diverse working patterns and employee needs.

Evaluation

Consistent with industry guidance (Investors in People, 2022), centres evaluated health initiatives using qualitative and quantitative measures. However, phase two revealed a preference for organizational software and surveys over discussions, interviews, forums and focus groups, likely due to efficiency, cost and anonymity. Decision-makers found wellbeing hard to measure, suggesting a need for support on valid and feasible evaluation methods. This is especially important as hybrid/remote working means that managers have fewer in-person interactions to gather informal feedback. External partnerships for training or evaluation are recommended, though cost barriers need addressing to ensure equitable access for all. Absence and attrition data were often used to evaluate workplace initiatives and justify their continuation, consistent with wider literature (Baxter *et al*., 2015). Participants described however that this provides less insight than employee feedback and engagement statistics. With an increase in hybrid working, absenteeism becomes more complex as remote work can facilitate presenteeism (Schmitz *et al*, 2023), meaning this data may become less reliable for evaluating health initiatives. Phase two revealed no consensus for presenteeism or call

handling time as evaluation measures, contrasting prior research valuing the latter (Morris *et al*., 2018). The complexity of presenteeism may explain this (McGregor and Caputi, 2022), though this outcome is important to consider, with mental illness-related presenteeism costing UK employers >£15 million annually (Miraglia and Kinman, 2017). These findings highlight the need for more nuanced evaluation metrics to better assess health initiatives' impact on employee wellbeing.

Strengths and limitations

Selection bias may exist, as decision-makers who participated may have been more inclined to discuss health than their peers. The phase-two survey was exploratory and primarily aimed to validate qualitative findings and inform recommendations rather than test hypotheses. We acknowledge potential response bias, as participants may hold socially desirable or pro-health positions; anonymity and neutral item wording were used to mitigate this. Snowball sampling was used due to access constraints, which, alongside the dominance of large organisations represented in the sample, limits generalisability. However, the sample included small, medium, and large centres, and the dominance of hybrid-working organisations reflects current UK contact centre trends (Desmarais *et al*., 2022). No formal power calculation was conducted, as the survey was not intended for hypothesis testing. Further research is needed to assess the generalisability of the findings, particularly outside the UK. However, rigorous qualitative methods provided confidence that most relevant influences and outcomes were captured (Keeley et al., 2016), with phase two revealing no new factors. Phase two combined three consensus measures, as each alone is not a good proxy of consensus (Giannarou and Zervas, 2014) and no standard method exists. A Delphi survey, though useful for expert consensus, was not used due to concerns about participation rates, confidentiality and data privacy for centres. Additionally, survey data could have been triangulated with document

analysis or employee data which may have strengthened the internal validity, however, as the survey was anonymous to reduce social desirability bias this approach was not feasible.

Implications

This research can inform the development of industry-specific guidance and training for contact centres to improve the adoption, implementation and evaluation of health initiatives. This study has demonstrated that employee-led initiatives are perceived to be more effective, therefore, it is recommended that guidance and training resources are co-designed with contact centre stakeholders to encourage centres to adopt a bottom-up approach when consulting advisors on their needs and preferences. These findings can also inform the design of health initiatives specific for the contact centre industry, including initiatives suitable for the remote and hybrid working environment and to advisor needs. By promoting health in the workplace, employers can contribute to the reduction of health inequalities by creating a supportive environment that fosters overall wellbeing for contact centre advisors who typically experience low pay and poor working conditions, with limited money, support and time to improve their health outside of work (Bambra *et al*., 2009).

Conclusion

Multiple factors influence contact centres' capability, opportunity and motivation to adopt, implement and evaluate health initiatives. By applying COM-B and TDF, the findings provide a behavioural lens for understanding organisational decision-making and offer a foundation for designing initiatives that address capability gaps (e.g., understanding what advisors want/need), opportunity constraints (e.g., considering low-cost initiatives) and motivational drivers (e.g., company reputation and moral obligation to promote employee health). Managerially, the results underscore the importance of leadership buy-in, ~~Leadership buy-in, employee input, resource availability, perceived need to support employees, and financial capacity were important for adoption. Return-on-investment was not agreed as~~

~~important, with some decision-makers preferring benefits like organizational reputation.~~ ~~Successful implementation requires~~ adaptability to hybrid, part-time and night workers and employee needs, and adequate support and time for those leading initiatives. From a policy perspective, findings suggest the need for sector-wide support to ensure equitable access to health promotion resources, particularly for centres with financial or staffing constraints. External partnerships with industry and academia could strengthen evaluation capacity. ~~To enhance evaluation, particularly regarding employee health outcomes, greater external support for centres is recommended.~~ Future research should examine how to tailor health initiatives ~~can be tailored~~ for hybrid and remote working contexts, ~~and~~ how decision-makers maintain effective feedback loops for advisors to communicate their wants and needs, and, ~~-~~ ~~Future research~~ ~~should~~ assess the long-term sustainability and impact of health initiatives across diverse organisational settings. ~~work should prioritise equitable access to health promotion and evaluation services and resources, particularly for contact centres with financial and resource constraints.~~

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Table I: Themes based on thematic analysis and mapping to behaviour change theory

Theme	Explanation and supporting quotations	COM-B	TDF	Explanation
Adoption				
Considering the financial implications	"*From a management perspective, they always like to see a return on investment*." (P7) "*We're a small organization, we don't, unlike larger organizations, have a budget for health and wellbeing. So, cost would always be the biggest influence for me […] which is why we look for things that don't involve too much cost.*" (P4)	Reflective motivation	Goals	Achieving a return on investment
			Beliefs about consequences	Achieving a return on investment
		Psychological capability	Knowledge	Knowledge of effectiveness outcome measures
			Memory, attention and decision making	Making a decision about whether an initiative will be beneficial
		Physical opportunity	Environmental context and resources	Lack of money/resources
Recognising a need to improve employee health	*"Support mechanisms outside of work had diminished." (P8)* "*We knew that our people were in debt and really struggling with the knowledge element of financial well-being. We know that some people in our centres use food banks because they are absolutely up against it". (P2)*	Physical opportunity	Environmental context and resources	High absence and attrition rates, COVID-19 and cost of living
		Reflective motivation	Goals	To support advisor wellbeing and retain employees
		Social opportunity	Social influences	Social norms for wellbeing changed with pressure on centres to improve advisor health
Leadership buy-in	"*I had the sponsorship of my managing director. There has never once been a battle with my directors to say we need this [health initiative].*" (P1) "Our *wellbeing strategy guides and motivates a lot of initiatives.*" (P11)	Physical opportunity	Environmental context and resources	Developing organisational values and culture
		Reflective motivation	Goals	Strategy goals to promote wellbeing
			Beliefs about capabilities	Professional confidence and empowerment from leaders to adopt health initiatives

		Social opportunity	Social influences	Social support from leaders
Identifying advisors' wants and needs	*"[Initiatives] will happen [be adopted] if it is led by the employee voice, so it comes from them." (P5)* "*I might be a small fish in a big pond, but if I make a suggestion, then people do listen. I think a lot of people felt that people power.*" (P7)	Physical opportunity	Environmental context and resources	Creating a wellbeing culture and encouraging 'people power'
		Psychological capability	Knowledge	Knowledge of what advisors want and/or need
		Social opportunity	Social influences	Social support from colleagues for advisors to voice their views
Organising around events	There would be "*a lot of planning in the background, maybe towards the end/start of the year, looking at what social events are coming up internationally and nationally." (P3)* "*I'm very much about piggybacking on stuff. There's so much stuff out there. Why rewrite it?"* (P5)	Physical opportunity	Environmental context and resources	Global, national, local, cultural and religious events and resources
		Psychological capability	Knowledge	Of the events and resources available
Implementation				
Importance of timing	"We *tried pace things a little bit more, so people don't feel overwhelmed.*" (P8) *"One of the priorities for us is making sure when we're implementing something, we're implementing it when we know it's quiet.*" (P4)	Physical opportunity	Environmental context and resources	The internal climate of the contact centre and the busy nature of contact centre work
		Psychological capability	Knowledge	Of other company initiatives or issues
		Automatic motivation	Positive/negative affect	Overwhelming advisors with too many health initiatives
Leader buy-in, time and capability	"B*uy-in from the team leaders or the operations manager, in terms of how important they think it is in relation to any operational challenges* [negatively impacted the implementation of initiatives]." (P4)	Reflective motivation	Social/professional role and identity	Leaders' responsibility to communicate health initiatives and the professional boundaries within their job role to prioritise staff wellbeing

	"*For somebody in particular's development, it [M*ental Health First Aiders (MHFA)] *was given to them to lead. However, this is a fairly junior member of the team and their competence in leading that group isn't very good." (P9)*	Social opportunity	Social influences	Modelling of health behaviours and social support from managers
		Physical opportunity	Environmental context and resources	Time availability and the busy nature of contact centre work
		Psychological capability	Skills	The competence of leaders
Adapting initiatives	*"We have Wellbeing Wednesdays,* which *is about having a coffee and a chat. Easily done face-to-face, but it's not the same over Teams. But the conversation can be the same as long as you've got your video on. So, it does have to be adapted."* (P5) "*We're still struggling to find that balance.* W*hat works and what days to do things. What days are the busiest in the office? Can we encourage people to do things then?*" (P7)	Physical opportunity	Environmental context and resources	Changing to remote and hybrid working
		Psychological capability	Skills	Interpersonal skills of those delivering and participating in health initiatives virtually
	"*Our team is quite varied and the only way we get around that is we know our staff. So, I know what works and we tend to offer a couple of different ways about it [delivering a health initiative]. Having that capacity to be able to do things in different ways, it's huge and amazing. Sometimes we can do it and sometimes we can't*". (P11). *"We have disabled advisors who may not have felt comfortable doing the more physically active things we used to do pre-pandemic. So, it's trying to make sure that anything you do is inclusive as well*". (P7)	Physical opportunity	Environmental context and resources	Having the ability to make modifications
		Psychological capability	Knowledge	Company knowledge of employees' needs
		Reflexive motivation	Goals	Company goal to be an inclusive employer
Evaluation				

There is no single measure of wellbeing	"*In terms of the measures of impact, wellbeing is really difficult to measure. So, our approach is to look at lots of different ways." (P11).* "[Absence reporting] *would certainly give us some weight behind our argument [to keep the health initiative] and our proposals [for new health initiatives]." (P9)* *"We ask, are you happy in your work? Are you proud to be in the organization? Are you a good advocate of the organization?" (P8).*

Table II: Consensus indicators for factors perceived to affect the adoption of health initiatives.

Factor	Number (%) for each Likert scale score					Median	Percentage agreement	IQR	SD
	1 not at all important	2 slightly important	3 moderately important	4 very important	5 extremely important				
Leader buy-in and support	0 (0%)	0 (0%)	1 (3%)	13 (34%)	24 (63%)	5	97.4%	1	0.64
Listening to advisor wants/needs	0 (0%)	1 (3%)	4 (11%)	18 (47%)	15 (40%)	4	86.9%	1	0.75
Resource availability (staff and time)	0 (0%)	1 (3%)	5 (13%)	20 (53%)	12 (32%)	4	84.2%	1	0.74
Recognising the need for support during societal events (e.g. cost-of-living crisis) *	0 (0%)	1 (3%)	4 (11%)	18 (49%)	14 (38%)	4	86.4%	1	0.75
Financial ability to invest	0 (0%)	2 (5%)	6 (16%)	23 (61%)	7 (18%)	4	78.9%	0	0.75
Staff attrition rates	1 (3%)	5 (13%)	3 (8%)	16 (42%)	13 (34%)	4	76.3%	1.25	1.10
Sickness absence rates *	0 (0%)	4 (11%)	5 (14%)	14 (38%)	14 (38%)	4	75.6%	1.5	0.99
Having policies and mission statements that demonstrate the centres' commitment to improving employee health *	0 (0%)	3 (8%)	8 (22%)	12 (32%)	14 (38%)	4	70.2%	2	0.97
Event awareness (e.g. mental health awareness day)	0 (0%)	5 (13%)	9 (24%)	13 (34%)	11 (29%)	4	63.1%	2	1.02
Evidencing return-on-investment	3 (8%)	6 (16%)	9 (24%)	15 (40%)	5 (13%)	4	52.7%	1.25	1.15

* Missing one data set. IQR: interquartile range; SD: standard deviation.

Boxes in green show scores that reached the limits set to determine consensus (at least 75% agreement; IQR ≤1.25; SD <1) and boxes in red show scores that were below the limit.

Table III: Consensus indicators for factors perceived to affect the implementation of health initiatives.

Factor	Number (%) for each Likert scale score					Median	Percentage agreement	IQR	SD
	1 not at all important	2 slightly important	3 moderately important	4 very important	5 extremely important				
Manager and team leader buy-in *	0 (0%)	2 (5%)	1 (3%)	17 (46%)	17 (46%)	4	91.8%	1	0.78
Allowing leaders time to prioritise deliver initiatives	0 (0%)	2 (5%)	5 (13%)	21 (55%)	10 (26%)	4	81.6%	1	0.79
Having experienced leaders deliver initiatives	1 (2.6%)	1 (3%)	6 (16%)	20 (53%)	10 (26%)	4	78.9%	1	0.89
Flexibility to tailor initiatives to individual needs *	0 (0%)	0 (0%)	8 (22%)	21 (57%)	8 (22%)	4	78.4%	0	0.67
Adaptability across virtual, hybrid or in-person formats *	1 (3%)	2 (5%)	5 (14%)	18 (49%)	11 (30%)	4	78.3%	1	0.96
Appropriately timing/pacing the release of health initiatives (e.g., in accordance with other health initiatives)	2 (5%)	5 (13%)	11 (29%)	17 (45%)	3 (8%)	4	52.6%	1	1.00

* Missing one data set. IQR: interquartile range; SD: standard deviation.

Boxes in green show scores that reached the limits set to determine consensus (at least 75% agreement; IQR ≤1.25; SD <1) and boxes in red show scores that were below the limit.

Table IIII: Frequency of method use to evaluate health initiatives.							
Factor	**Number (%) for each Likert scale score**					**Median**	**Percentage of centres using measures sometimes, almost every time or always**
	1 never	2 rarely	3 sometimes	4 almost every time	5 always		
Existing organizational software/systems e.g. that collect data on employee absence, attrition, performance, etc...	2 (5%)	1 (3%)	12 (32%)	13 (34%)	10 (26%)	4	92%
Surveys	2 (5%)	9 (24%)	13 (34%)	7 (18%)	7 (18%)	3	84%
Informal discussions	1 (3%)	5 (13%)	20 (53%)	6 (16%)	6 (16%)	3	84%
Employee forums	2 (5%)	5 (13%)	23 (61%)	7 (18%)	1 (3%)	3	82%
Focus groups	4 (11%)	7 (18%)	20 (53%)	6 (16%)	1 (3%)	3	7%
Interviews	5 (13%)	8 (21%)	14 (37%)	10 (26%)	1 (3%)	3	66%

Table V: Consensus indicators for outcomes perceived important when evaluating health initiatives.

Factor	Number (%) for each Likert scale score					Median	Percentage agreement	IQR	SD
	1 not at all important	2 slightly important	3 moderately important	4 very important	5 extremely important				
Employee engagement	0 (0%)	0 (0%)	2 (5%)	21 (55%)	15 (40%)	4	94.8%	1	0.58
Customer service scores	0 (0%)	1 (3%)	6 (16%)	20 (53%)	11 (39%)	4	91.5%	1	0.75
Performance/productivity	0 (0%)	0 (0%)	3 (8%)	22 (58%)	13 (34%)	4	92.1%	1	0.60
Employee motivation	0 (0%)	0 (0%)	5 (13%)	18 (47%)	15 (40%)	4	86.9%	1	0.69
Employee satisfaction with the initiative	0 (0%)	1 (3%)	4 (11%)	19 (50%)	14 (37%)	4	86.8%	1	0.83
Workplace satisfaction	1 (3%)	0 (0%)	4 (11%)	19 (50%)	14 (37%)	4	86.8%	1	0.83
Absence rates	0 (0%)	2 (5%)	4 (11%)	17 (45%)	15 (40%)	4	84.2%	1	0.83
Management satisfaction e.g. are employees satisfied with their managers *	0 (0%)	0 (0%)	6 (16%)	21 (57%)	10 (27%)	4	81.6%	1	0.66
Attrition rates *	0 (0%)	1 (3%)	6 (16%)	17 (46%)	13 (35%)	4	81%	1	0.79
Peer satisfaction e.g. are employees satisfied with their peer support	1 (3%)	2 (5%)	5 (13%)	23 (61%)	7 (18%)	4	78.9%	0	0.88
Presenteeism	0 (0%)	2 (5%)	10 (26%)	18 (47%)	6 (16%)	4	63.2%	1	0.80
Average call handling times	3 (7%)	2 (5%)	11 (29%)	15 (40%)	7 (18%)	4	57.9%	1	1.11

* Missing one data set. IQR: interquartile range; SD: standard deviation.

Boxes in green show scores that reached the limits set to determine consensus (at least 75% agreement; IQR ≤1.25; SD <1) and boxes in red show scores that were below the limit.

COREQ (COnsolidated criteria for REporting Qualitative research) Checklist

A checklist of items that should be included in reports of qualitative research. You must report the page number in your manuscript where you consider each of the items listed in this checklist. If you have not included this information, either revise your manuscript accordingly before submitting or note N/A.

Topic	Item No.	Guide Questions/Description	Reported on Page No.
Domain 1: Research team and reflexivity			
Personal characteristics			
Interviewer/facilitator	1	Which author/s conducted the interview or focus group?	4
Credentials	2	What were the researcher's credentials? E.g. PhD, MD	4
Occupation	3	What was their occupation at the time of the study?	4
Gender	4	Was the researcher male or female?	4
Experience and training	5	What experience or training did the researcher have?	3
Relationship with participants			
Relationship established	6	Was a relationship established prior to study commencement?	4
Participant knowledge of the interviewer	7	What did the participants know about the researcher? e.g. personal goals, reasons for doing the research	4
Interviewer characteristics	8	What characteristics were reported about the inter viewer/facilitator? e.g. Bias, assumptions, reasons and interests in the research topic	4
Domain 2: Study design			
Theoretical framework			
Methodological orientation and Theory	9	What methodological orientation was stated to underpin the study? e.g. grounded theory, discourse analysis, ethnography, phenomenology, content analysis	3
Participant selection			
Sampling	10	How were participants selected? e.g. purposive, convenience, consecutive, snowball	3
Method of approach	11	How were participants approached? e.g. face-to-face, telephone, mail, email	3
Sample size	12	How many participants were in the study?	6
Non-participation	13	How many people refused to participate or dropped out? Reasons?	6
Setting			
Setting of data collection	14	Where was the data collected? e.g. home, clinic, workplace	4
Presence of non-participants	15	Was anyone else present besides the participants and researchers?	4
Description of sample	16	What are the important characteristics of the sample? e.g. demographic data, date	6 (supp)
Data collection			
Interview guide	17	Were questions, prompts, guides provided by the authors? Was it pilot tested?	4
Repeat interviews	18	Were repeat inter views carried out? If yes, how many?	4
Audio/visual recording	19	Did the research use audio or visual recording to collect the data?	4
Field notes	20	Were field notes made during and/or after the inter view or focus group?	4
Duration	21	What was the duration of the inter views or focus group?	4
Data saturation	22	Was data saturation discussed?	4
Transcripts returned	23	Were transcripts returned to participants for comment and/or	5

Topic	Item No.	Guide Questions/Description	Reported on Page No.
		correction?	
Domain 3: analysis and findings			
Data analysis			
Number of data coders	24	How many data coders coded the data?	4
Description of the coding tree	25	Did authors provide a description of the coding tree?	N/A
Derivation of themes	26	Were themes identified in advance or derived from the data?	4
Software	27	What software, if applicable, was used to manage the data?	4
Participant checking	28	Did participants provide feedback on the findings?	5
Reporting			
Quotations presented	29	Were participant quotations presented to illustrate the themes/findings? Was each quotation identified? e.g. participant number	Table 1
Data and findings consistent	30	Was there consistency between the data presented and the findings?	6-7
Clarity of major themes	31	Were major themes clearly presented in the findings?	6-7
Clarity of minor themes	32	Is there a description of diverse cases or discussion of minor themes?	N/A

Developed from: Tong A, Sainsbury P, Craig J. Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. *International Journal for Quality in Health Care*. 2007. Volume 19, Number 6: pp. 349 – 357

Once you have completed this checklist, please save a copy and upload it as part of your submission. DO NOT include this checklist as part of the main manuscript document. It must be uploaded as a separate file.

Supplementary 2

Phase one participant and organisation characteristics

Participant	Gender	Job role	Advisor number	Centre location	Work approach
1	Woman	Operations manager	200+	Northwest England	Hybrid
2	Woman	HR wellbeing lead	200+	Nationwide	Hybrid
3	Man	Head of health	200+	West Midlands England	Hybrid
4	Woman	Site director	51-200	Southwest England	Hybrid
5	Woman	Senior HR generalist	200+	Southwest England	Hybrid
6	Man	Director of compliance	1-9	Southeast England	Hybrid
7	Woman	Health and safety coordinate	200+	Scotland	Hybrid
8	Woman	Head of customer services	10-50	Northwest England	Hybrid
9	Woman	HR business partner	10-50	Southwest England	Hybrid
10	Man	Functional training lead	51-200	Southwest England	Hybrid
11	Woman	Wellbeing lead	51-200	Southwest England	Hybrid

Supplementary 3

Phase 2 participant and organisation characteristics.			
Demographic variable		Frequency	Percentage (%)
Gender	Woman	20	52.6%
	Man	17	44.7%
	Prefer not to say	1	2.6%
Age (years)	25 to 34	10	26.3%
	35 to 44	13	34.2%
	45 to 54	12	31.6%
	55 to 64	2	5.3%
	Prefer not to say	1	2.6%
Ethnicity	Asian or Asian British: Indian	1	2.6%
	Mixed or multiple ethnic groups: Any other mixed or multiple ethnic background	1	2.6%
	White: English, Welsh, Scottish, Northern Irish or British Irish	33	86.8%
	White: Any other white background	3	7.9%
Disability	Disabled participants	2	5.3%
Location of the participant	Northwest England	13	34.1%
	Northeast and Yorkshire England	12	31.6%
	Southeast England	4	10.5%
	Northern Ireland	1	2.6%
Participant job role	Team leader	18	47.4%
	Manager/director	18	47.4%
	HR professional	1	2.6%
	Health and safety	1	2.6%
Years within job role	0-5	4	10.5%
	6-10	10	26.3%
	11-15	4	10.5%
	16-20	5	13.2%
	21+	15	39.5%
	In-office	11	28.9%

Organisation work approach	Hybrid	27	71.1%
Advisor number	10-50	2	5.3%
	51-200	10	26.3%
	200+	26	68.4%