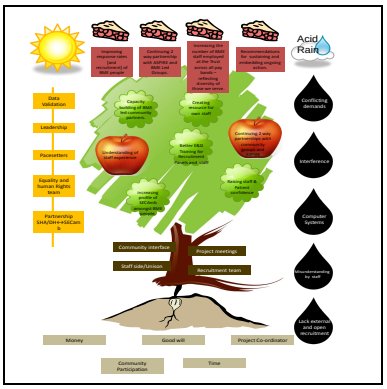

Pacesetters Workforce Development Evaluation

Final Report

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Contents

Executive Summary

1. This is the final report of the evaluation of the workforce development strand of the Pacesetters initiative. Three areas within workforce development were the focus for Pacesetters: Flexible Working, Bullying and Harassment, and Representation. This evaluation concerns eight change projects, representing the latter two areas, selected as case studies from both the Wave 1 and Wave 2 phases of Pacesetters. When the external evaluation was commissioned, the case studies were at varying stages of development within the multi-phase process of planning, learning and refining or developing the "change ideas. Some were still developing when the evaluation period ended. It was originally intended that the case studies would compliment and form part of a national evaluation. Building on the midterm review, the report provides an overview of the key themes that have emerged across all eight case studies, presents each of the case studies, presents the results of an on line survey and its follow-up across all Pacesetters workforce development sites, and finally, draws some general conclusions.

2. The case studies were selected by the Department of Health lead from a set of volunteers put forward by the contributing SHAs. An original total of 10 sites were selected: 4 focusing on disability, 2 on bullying and harassment, 1 on flexible working and 3 on BME representation. There were 7 PCTs, 1 Hospital Trust, 1 Ambulance Trust and 1 Region. Towards the beginning of the evaluation period, the Hospital Trust and Regional projects withdrew; both were Wave 1 projects and felt they would not gain by being involved. This meant that there was no flexible working project and only 2 bullying and harassment projects among the case study sites, both of these were Wave 1 sites and ended in March 2010. The evaluation approach drew on realistic and participatory evaluation using logic models, action learning sets and interviews to explore in depth in each site what worked and what did not work in each particular context. Particular attention was paid to issues of sustainability. To supplement the data in the absence of a national evaluation, two online surveys were undertaken. This meant it was possible to draw on the experience of all workforce development projects.

3. Each case study is presented in depth in this report. The case studies are as follows :

   Case Study A: Bristol PCT: Bullying and Harassment Initiative with particular reference to BME groups

   Appointment of a part-time staff participation manager in a temporary funded post to revitalise a staff bullying and harassment (BH) scheme that had been set up in 2003 in the form of a confidential helpline staffed by volunteers to offer support and advice to callers from NHS Bristol, Bristol Community

Health, NHS North Somerset, NHS South Gloucestershire and NHS Bath and North East Somerset. The scheme had been established with the aim of providing a trained staff volunteer to listen to any staff member experiencing bullying and harassment in the workplace and signposting them appropriately.

Case Study B: Hastings and Rother Bullying and Harassment Initiative

To work in partnership with TheatreAnd Ltd (a forum theatre training company) to explore how staff can be empowered to identify and challenge unacceptable behaviour and create a positive team working environment. The ultimate objective is to generate an environment of zero tolerance. The intermediate goal was to reduce the gap, which had been identified, between incidents of B&H and reports of B&H.

Case Study C: Lewisham PCT BME Representation

To address the problems of very low representation of BME staff in Lewisham PCT in band 7 (junior management level) and above, despite high levels of BME applications and short-listing to interview, by focusing on the interview stage of the job application process.

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The Dis-Solution Scheme was initiated after finding that less than 1% of employees had a declared disability. It was therefore also an intention of the scheme that, in conjunction with increasing the opportunities of the placement individuals, current employees would feel more confident to declare any existing disabilities. In partnership with local disability organisation, the Leicestershire Centre for Integrated Living (LCIL) 12 week voluntary placements are offered to support beneficiaries in their positions and beyond in sustained employment.

Case Study E: Lincolnshire PCT & United Lincolnshire Hospitals NHS Trust Representation of disabled people with reference to people with hearing impairments.

The project leads have linked up with DEAFLincs, which is a Lincolnshire based charity providing support and advice to deafened and hard of hearing people within the county. The project aims to find out what the experience is for deaf people working for the Lincolnshire PCT.

Case Study F: Leicestershire Partnership Trust (LPT) NHS Trust: Employment of people with lived experience of mental ill health.

An awareness campaign focussing on posters to dispel the myths around mental illness and employment. In the long run, this campaign underpins an overall policy within the LPT to develop capacity and capability to support and promote employment opportunities for mental health service users and review the support systems and policies that are in place for all staff.

Case Study G: South East Coast Ambulance Service: BME recruitment and employment

This is a workforce related project and a Wave 2 initiative. It centres on enhancing BME recruitment to SECAMB with retention as an added value. In a nutshell, the project leads are running an advertorial campaign targeted at specific BME groups within the Surrey Travel to Work Area (TTWA). The advertorial campaign featuring the publication of "life interest" stories from selected current BME employees is being run in conjunction with *The Voice*, which is a weekly tabloid newspaper, aimed at the UK African–Caribbean communities. The advertorials will raise the profile of job opportunities within the emergency care sector in the light of poor representation of BME people in this sector. SECAMB has a 7% BME client base in its operational area, but its BME employee percentage does not come near this figure. The national ambulance service has also recognised this low representation.

Case Study H: Cornwall and Scilly Isles: Employment of People with learning disabilities

This project seeks to increase the representation of individuals with learning disabilities within the workforce. It also seeks to train managers, create 'buddies' and simplify the recruitment and training of work experience employees. The training has focused on how to support and mentor people with learning disabilities in the workplace and was provided by an external partner with expertise in these issues. A project steering group has also been formed that includes trained job coaches and the people with learning disabilities whom they support. Other innovations are at various stages of development and include job carving, easy read information packs (including health and safety advice and job descriptions) and exploring the possibility interviews by work-based trials.

4. An overview of all the case studies indicates some general features that are crucial for ongoing change. There was no one formula for effective change as much depends on the context. Rather a range of factors need to be present .Of these factors, two are fundamental: passionate and enthusiastic champions within the NHS Trust and top management support for bringing about change in the chosen area. Other important elements include links with other initiatives and the embedding of the innovation among a set of champions within existing systems. Projects dependent on one project lead as champion were vulnerable if that person left. It is also clear from the online surveys and the case studies that Wave 2 initiatives were better thought through, more focused and structured. On the other hand the more resilient case studies also were those that were flexible and open so able to respond to change. Although some case studies have not completed all the PDSA cycles, all were using the approach with varying degrees of success, although those who adopted a more emergent approach to change seem to have been more successful in generating a potentially more sustainable process. Two case studies spent time researching the issue in depth using both quantitative and qualitative data. Other projects were much more focused on implementation and tended to rely on quantitative survey data. Those case studies who have taken time to really explore the issues in depth with

the community of interest have benefited from that ground work in developing well thought through and targeted changes.

5. Involving the community of interest in co design was crucial. Not only did it mean the intervention was more appropriate, it was also more widely owned. Another impact of community involvement has been has been that the participants who were the focus of the intervention have played an active role themselves in changing attitudes and behaviours.

6. Case studies that directly involved senior managers who played an active role were also more likely to move forward.

7. All the case studies had an impact, some unexpected and some expected. The greatest impact was on individual learning. Barriers to change included cutbacks in funding freeze on employment, organisational change and loss of key change agents.

8. Future sustainability and spread of ideas will depend on the same factors that operated to move the projects along in the evaluation period. Local circumstances such as the nature of organizational and staffing changes will influence future trajectories. Most case studies expressed concern that the issues that are being addressed would cease to be considered important in the light of public service cuts and the most vulnerable would suffer. However projects with the genuine commitment of senior managers and wide community ownership should be more resilient.

Pacesetters Workforce Development Evaluation

Final Report

1. Introduction

This is the final report of the evaluation of the workforce development strand of the Pacesetters initiative. Three areas within workforce development were the focus for Pacesetters: Flexible Working, Bullying and Harassment, and Representation. This evaluation concerns eight change projects selected as case studies from both the Wave 1 and Wave 2 phases of Pacesetters covering the latter two areas. When the external evaluation was commissioned, the case studies were at varying stages of development within the multi-phase process of planning, learning and refining or developing the "change ideas". Not all had completed those stages when the evaluation finished, so this is not a summative report; rather it presents the work achieved so far in those projects that are still ongoing and those who have "completed" in the sense they have ceased to be directly funded by the Pacesetters programme. Building on the midterm review, the report provides an overview of the key themes that have emerged across all eight case studies, presents each of the case studies, presents the results of an on line survey and its follow-up across all Pacesetters workforce development sites, and finally, draws some general conclusions.

The focus of the evaluation team in recent months has been on issues of sustainability and spread, and on identifying the lessons learnt. Where it is possible, clear outcomes and impacts have been identified. However, because some of the actions are part of a wider set of other initiatives, unpicking the precise impact of the Pacesetters change idea as a separate distinct element has been difficult in some specific cases. Finally, during the later stages of the evaluation period there has been a climate of uncertainty pervading the public sector in general, with prospects of further reorganisation within the NHS and cuts in funding, not necessarily in terms of the agreed Pacesetters funding but in alternative funding streams that had been identified for supporting an initiative. Other factors were also impinging on particular case studies, including a freeze on recruitment, local organisational change and local uncertainty about future sources of funding. Some key informants have also moved to new posts, making tracing the legacy of the change ideas challenging.

2. Background

The Pacesetters Programme was directed towards innovative approaches to tackling inequalities and discrimination on the account of age, disability, ethnicity, gender, religion and belief, and sexual orientation. This report relates to the evaluation of those projects directed towards creating working environments that are fair and free from discrimination. These areas are potentially highly sensitive and challenging, as the issues being addressed are as much related to leadership, culture, personality and relationships as to policies. Moreover, while the NHS is a national organization, it is in

reality composed of many different local organizations each with their own culture and history and competing priorities, as well as differences in geography. So what works in one context may not necessarily be easily transferred to another: each project has had to work out its own solutions.

Until recently in the areas of discrimination, bullying and harassment, as well as flexible working, the NHS has focused on the implementation of procedural and legal frameworks for managers, employees and HR professionals to operate within. Flexible working options have proved to be key distinctive recruitment and retention tools that the NHS can offer as an employer and fundamental in attracting a diverse workforce, as well as one of the key links to supporting the employee's need for a healthy work-life balance. This is also an area in which it is relatively easy to implement changes. More difficult is the tackling of discrimination and of bullying and harassment. The NHS, although aspiring to be an employer of choice amongst the communities it serves by recruiting and developing a workforce that is representative of those communities, still has a long way to go, as black and minority ethnic employees are poorly represented across several NHS professions and particularly among senior management teams. Disabled people are also poorly represented in the NHS workforce.
The most difficult area to deal with is bullying and harassment. Although often bracketed together, they can manifest in different ways and often require different approaches to bring about change. Bullying stems largely from unfettered hierarchical use of power, while harassment often focuses on cultural difference, for example, due to race or gender and is therefore linked to attitudes towards discrimination.

The Pacesetters programme aimed to be a partnership between local communities who experience health inequalities, the NHS and the Department of Health. The programme worked with six Strategic Health Authorities (SHAs) to deliver equality and diversity, improvements and innovations resulting in:

- Patient and user involvement in the design and delivery of services
- Reduced health inequalities for patients and service users
- Working environments that are fair and free of discrimination

The inequalities are those arising from discrimination on account of age, disability, ethnicity, gender (including transgender), religion and belief, and sexual orientation. In the language of the Programme these are the six equality strands. The SHAs involved were located in different parts of England. The trusts involved represent a spread of different types of NHS organisations (for example, Foundation Trusts, Mental Health Trusts, Primary Care Trusts and Ambulance Trusts). Each SHA and its trusts worked on a range of local and core issues. Workforce development was one of the "core" change issues.

The stated aim of Pacesetters sites is to identify innovative measures whereby focused interventions or development activities, linked to one of the six equality strands, can supplement the procedural framework and demonstrate a substantive impact on employee engagement, psychological well-being and conflict resolution in the workplace.

Pacesetters had a particular focus on three broad workforce issues:

- Tackling staff on staff bullying and harassment
- Improving flexible working options
- Improving the representation in the workforce of people from communities subject to discrimination.

In Wave 1 each Trust and SHA had to identify three workforce innovations – covering bullying and harassment, flexible work options and representation, thereby creating over 70 projects. Wave 1 ended March 2010. In a second wave, a further 18 trusts were recruited and asked to work on better representation in the workforce for either disabled or black and minority ethnic staff, creating a further 18 change ideas. DH funding for Pacesetters change ideas was expected to be short term only and to provide the kick start for innovative ideas that if "successful" would be subsequently mainstreamed and funded locally.

Two key elements are central to the approach to change expected by projects involved in the Pacesetters programme. The first is a service development approach that aims to integrate systematic research and evaluation in the generation and then the implementation of change initiatives, sometimes called the Plan Do Study Act cycle, developed by Deeming[1] in the United States. In the original model, it was expected that an initiative aimed at improvement would go through a series of cycles with an idea being repeatedly tested and refined before it is tested on a broader scale. The model was further refined by Associates in Process Improvement into the model for improvement that has been adopted by the Institute for Health Care Improvement in the US as "the scientific method used for action-oriented learning." [2] It was subsequently advocated by the NHS Institute for Innovation and Improvement, where the need to collect data and measure the degree of change is emphasised. The second core idea was the notion of co-design and community engagement: the planning, implementation and evaluation of a change idea should directly involve the communities whose issues were being addressed. In other words ideally there would be a participatory approach to decision making within the PDSA cycle.

During the period over which Pacesetters has been operating, there has been a number of other equality schemes in operation, for example Race for Health and the development of Single Equality Schemes. There has been a number of policy influences too, for example, the Equality Act, which came into force in October 2010, the details of which were developed during the latter part of the Pacesetters programme, a report advocating developing a SES for people with learning disabilities and the formation of an NHS Equality and Diversity Council, to name just a few. There has also been at various times uncertainty over the future of the Pacesetters Programme due to organizational changes within the DH and a reduction in overall funding. As a result of the latter, there were overall fewer resources devoted to Wave 2 initiatives than Wave 1 and fewer cross -Regional learning events, which provided support and publicised the

[1] Deeming US. (2000) *The New Economics for Industry, Government, and Education*. Cambridge, MA: The MIT Press;

[2] http://www.ihi.org/IHI/Topics/Improvement/ImprovementMethods/HowToImprove/

programme amongst a wider audience. One such event did take place in June 2009 around the issue of bullying and harassment. Subsequent events have been local or regional and supported by individual SHAs where regional leads have been key drivers of the programme. Regional leads have played a role also in monitoring progress through their use of monthly monitoring reports as a performance management tool.

3. The Approach to Evaluation

When this evaluation was commissioned, it was intended to complement and contribute to an ongoing national evaluation of the Pacesetters programme through the use of case studies. The approach to evaluation that had previously been used in the national evaluation drew on realist, theory of change, and participatory evaluation approaches. Realist evaluation focuses on the relationship between context, activities and outcomes.[3] The argument underpinning the use of realist evaluation was that, although much as been written in the research literature about what works and does not work to reduce bullying, increase representation and provide flexible working arrangements, the application of such good practice depends very much on what works in what context.

Central to a theory of change approach to evaluation is the use of a logic model to map out participants' theories as to the change they expect to be achieved as the consequence of their actions, in the light of the resources they have at their disposal, and the context in which they are working. By comparing participants' theories of change over period of time the relationship between context activities and outcomes can be explored.

The use of a participatory approach is consistent with the ethos of Pacesetters, with its focus on co-design and community engagement. Moreover, since evaluation is integral to the Pacesetters approach (the "study" part of PDSA),) external evaluators using a participatory approach are able work alongside the internal evaluation process and provide a objective lens, asking questions to challenge the taken-for-granteds, while at the same time taking an overview across the case study sites. Moreover, since the focus of Pacesetters is innovation and learning, this approach to evaluation when combined with the use of action learning methodology can encourage the organized reflexivity necessary for any evaluation work to impact on and feed into the ongoing change processes. Action learning encourages people to reflect in groups called sets on their actions. A set consists of about 5-7 people who meet regularly to examine their practice. Effectively they are like focus groups but facilitated to encourage learning, reflection and action as well as provide external evaluators with a source of data.

To reflect the intended national evaluation, each case study combined the above approaches using a range of data collection methods consistent with such approaches. In the event there was no national evaluation of this part of the Pacesetters programme, so the case study findings were contextualized by undertaking a survey of all Pacesetters workforce development projects across the six participating regions in February 2010 with a smaller follow-up survey in September 2010.

[3] Pawson R and Tilley, N (1997) Realistic Evaluation Sage

3.1 Evaluation Questions

At the beginning of the evaluation, five evaluation questions were identified. The intention had been that these questions form the basis of a combination of data from the case study sites and the national evaluation:

- What works for whom in what circumstances?
- Do the innovations make a real difference?
- Why did these innovations work?
- Are the changes sustainable and replicable?
- How do participants' expectations change over time?

It is not possible to make generalizations concerning the answers to these questions from eight case studies alone as they comprise an unrepresentative sample of all the Pacesetters workforce development projects. What we can learn from the case studies is how local ideas developed in particular contexts and if there are any common themes that emerge across the case studies. Following the initial orientation meetings and through subsequent discussions with the Department of Health lead, questions concerning service improvement approaches, community engagement/co-design and sustainability became a key concern. The evaluation questions have therefore focused on:

- What is the local context in which the change idea or innovation is being implemented?
- What worked and what did not work and why?
- What was learnt?
- What are the prospects for sustaining the change process and spreading the innovation ideas more widely?

3.2 Methodology

The evaluation has involved the use of a case study multi-method approach, collecting data from a variety of sources. Where projects have gathered their own evaluation data, we are drawing on such data. The team has also conducted a number of primary research activities in relation to most of the case studies and on cross-cutting issues at a more general level. These are specified below.

3.2.2 Selection of Case Studies

Based on a judgement of viability, the case study sites were selected by the Department of Health lead from a set of volunteers put forward by the contributing SHAs. These case study sites covered projects from both Wave 1 and Wave 2 and a variety of core ideas, different Trusts and geographical spread. An original total of 10 sites were selected: 4 focusing on disability, 2 on bullying and harassment, 1 on flexible working and 3 on BME representation. There were 7 PCTs, 1 Hospital Trust, 1 Ambulance Trust and 1 Region. It became clear, however, that some sites had been "volunteered" rather than had they actively chosen to be part of the evaluation, and this has impacted on commitment to the evaluation. Towards the beginning of the evaluation period, the Hospital Trust and Regional projects withdrew; both were Wave 1 projects and felt they would not gain by being involved. This meant that there was no flexible working project and only 2 bullying and harassment projects among the case study sites, both of these were Wave 1 sites and ended in March 2010.

3.2.3 Data collection methods

Orientation: June to September 2009

An introductory workshop took place in London to which all the case study sites were invited. This was followed by site visits and discussions with each of the sites. The aim of this process was to gain a mutual understanding and to orientate the evaluation team with regard to the projects in terms of context, activities and intended outcomes. At the workshop, participants were encouraged to think "evaluatively". At subsequent initial meetings, a process of clarifying aims and objectives and how projects intended to track changes themselves in terms of indicators of change and definitions of success were explored. In addition, project leads were asked to clarify what they are trying to do, reflect on activities and actions so far and identify the baseline data they were using. As part of the initial orientation, observations were made by two members of the evaluation team at the Community of Influence meeting around the issue of bullying and harassment, which took place in Leicester in June 2009. Copies of SHA monthly monitoring reports and local documents were also used to support this early phase.

Main data collection period: October 2009 to September 2010

Each case study site was asked to participate in up to 5 action learning sets/focus groups over a ten month period. Taking an action learning approach was seen as consistent with the underlying premise of PDSA and community engagement. The intention was that participants who had been identified as representing stakeholders by project leads would be encouraged to reflect on actions taken and learning using a series of questions aimed at exploring the change idea's progress. Each project was encouraged to produce a logic model for their project through the metaphor of the tree. During the evaluation, these "trees" were revisited at different stages to help initiatives

to develop their evaluations and to help identify changes both in actions and in expectations among participants. All case study sites were given information on how action learning sets work (including Mersey Care's excellent easy to read guide[4]), and the importance of a core group, reflecting a mix of people who have been involved in the change initiative and that comes together regularly, was emphasized. However, time, staff turnover and sickness, together with other factors, have meant that participation has varied across the case study sites. Two of the case study sites were unable to take part at all in an action learning set, and two learning sets did not get going for some time. Three action learning sets ceased in March, owing to either the completion of the initial project, or staff leaving, or both. In all cases, traditional interviews were conducted with key stakeholders to supplement the data from the action learning sets or where such sets had not taken place as intended. An exit interview was also undertaken where a project lead had left. So in practice, different approaches to data collection had to be adopted for each case study site depending on local circumstances.

A second method was the Evaluation Café, which was took place on March 17th 2010 This was a response to a request by case study sites after the introductory workshop that they should be brought together to share learning in March. In the end representatives from only four case study sites attended together with a regional lead from one of the SHAs alongside two DH leads. The sites that did attend tended to be those who saw some form of continuance of their innovation after March 31st. The data was generated using World Café methodology supplemented by researcher observation. This generated dialogical data around three themes: what worked and what did not work and why, sustainability and sharing the learning with others (spread).

A third method of data collection was two confidential online surveys of all Pacesetters workforce sites, which were was undertaken in February 2010 and September 2010, developed using the Bristol Online Surveys package (for more details see Appendix I). Each survey was issued to Pacesetters project and programme leads with workforce responsibilities identified by the DH, giving potentially 52 respondents. In the first survey, following an advanced email, a number of the original 52 indicated they were unable to take part and some offered substitutes. This resulted in the same number of 52 being potential respondents. In the end, 28 of these responded giving a healthy response rate of 53.8%. This first survey generated information on 6 Flexible working projects, 9 Bullying and Harassment projects and 27 Representation projects. For each area, flexibility, bullying and harassment, and representation, the survey explored stakeholder involvement in design of the change idea, types of baseline data used, current status of the initiative, outcomes, sustainability and learning. Barriers to change were also identified. Respondents were also asked about the change models and methods used to guide the introduction of innovations. Finally, a space was left for general comments. Six respondents took advantage of the opportunity to do this.

In the second, much smaller survey, the emphasis was on exploring any further change since February and the issue of the legacy of Pacesetters. The 52 persons invited to take part in the February 2010 survey formed the initial population for this survey. Following receiving advance notice about the follow-up survey, some replied that they were no longer part of the Pacesetters programme, and some of these helpfully gave

[4] Available from Mersey Care

contact email addresses of those who were now likely to be suitable to take part in this follow-up survey. The net result was that 50 persons were actually invited to take part in the follow-up survey. Of these 50 persons, 15 responded. Nine of these 15 had taken part in the February survey. Of the 6 new participants, 4 had been suggested by participants from February's survey who could not take part in the follow-up survey, and 2 had been invited to last February's survey but had not taken part then. Fourteen of the respondents from the February survey did not participate this time. Fifteen respondents from a population of 50 is a response rate of just 30%. However, only 35% (14 projects from a total of 40) of the first sample's projects were expected to be still running at the time of this survey and 85% (17 projects from a total of 20) of the follow-on sample's projects were still running: it appears that most of the original sample whose projects were still running did respond to the follow-up survey, but most of those whose projects were no longer running did not respond. In addition, one person contacted the team to apologise for not being able to participate, since "due to the organisational change taking place in the Trust, it is not the right time to carry out such an evaluation."

3.2.3 Limitations of the Data

The data collected is largely qualitative, but by using a combination of a range of data collection methods and by involving case study sites in the coproduction of the reports, the interpretation and analysis has been verified. The evaluation team had been led to expect that local projects had collected both quantitative and qualitative evidence to provide a baseline to their own evaluation of the impact of their ideas consistent with the PDSA approach. This was also a requirement for participation in Pacesetters. However, some of the case study sites had not collected robust data, in part because the statistics available were partial or, because of issues of disclosure, were not representative of the true picture. Interpretation of data relating to issues that otherwise have been hidden is difficult and in some instances because the initiative had increased awareness or provided increased confidence that disclosure was possible, data used to test the impact of the change idea revealed an apparent increase in the number of people experiencing problems.

Evaluation, too, depends on a level of trust developing between participants and the evaluation team[5]. This trust takes time to build. It also depends on a clear understanding of what evaluation is and how it can be used in supporting and developing innovations. Such knowledge and understanding have varied across sites, as did expectations concerning the evaluation team's role. For example, initially there was some confusion among the sites about how the external evaluation related to local efforts since the external evaluation had not commissioned at the beginning of the Pacesetters Programme. Overall commitment to the evaluation process, despite the case study sites having volunteered to participate, was variable. Also issues such as staffing changes, time pressure, financial cutbacks, swine flu and a hard winter all affected both the progress of the initiatives and the data collection. Again the impact of

[5] Geva-May , I and Thorngate,W (2003) Reducing Anxiety and Resistance in Policy and Programme Evaluations. A Socio-Psychological Analysis Evaluation 9(2) 205-227

these varied across sites but they were particularly severe on the action learning groups.

4. The Case Studies

The eight case studies are summarized below.

4.1 Wave 1 Change Ideas

Case Study A:

Bristol PCT: Bullying and Harassment Initiative with particular reference to BME groups

Appointment of a part-time staff participation manager in a temporary funded post to revitalise a staff bullying and harassment (BH) scheme that had been set up in 2003 in the form of a confidential helpline staffed by volunteers to offer support and advice to callers from NHS Bristol, Bristol Community Health, NHS North Somerset, NHS South Gloucestershire and NHS Bath and North East Somerset. The scheme had been established with the aim of providing a trained staff volunteer to listen to any staff member experiencing bullying and harassment in the workplace and signposting them appropriately.

Case Study B,

Hastings and Rother Bullying and Harassment Initiative

To work in partnership with TheatreAnd Ltd (a forum theatre training company) to explore how staff can be empowered to identify and challenge unacceptable behaviour and create a positive team working environment. The ultimate objective is to generate an environment of zero tolerance. The intermediate goal was to reduce the gap, which had been identified, between incidents of B&H and reports of B&H.

Case Study C:

NHS Leicester City and Leicester City Community Health Service Disability Representation- Dis-solution Scheme

The Dis-Solution Scheme was initiated after finding that less than 1% of employees had a declared disability. It was therefore also an intention of the scheme that, in conjunction with increasing the opportunities of the placement individuals, current employees would feel more confident to declare any existing disabilities. In partnership with local disability organisation, the Leicestershire Centre for Integrated Living (LCIL) 12 week voluntary placements are offered to support beneficiaries in their positions and beyond in sustained employment.

4.2 Wave 2 Change Ideas

Case Study D

Lewisham PCT BME Representation

To address the problems of very low representation of BME staff in Lewisham PCT in band 7 (junior management level) and above, despite high levels of BME applications and short-listing to interview, by focusing on the interview stage of the job application process.

Case Study E:

Lincolnshire PCT & United Lincolnshire Hospitals NHS Trust Representation of disabled people with reference to people with hearing impairments.

The project leads have linked up with DEAFLincs, which is a Lincolnshire based charity providing support and advice to deafened and hard of hearing people within the county. The project aims to find out what the experience is for deaf people working for the Lincolnshire PCT.

Case Study F:

Leicestershire Partnership Trust (LPT) NHS Trust: Employment of people with lived experience of mental ill health.

An awareness campaign focussing on posters to dispel the myths around mental illness and employment. In the long run, this campaign underpins an overall policy within the LPT to develop capacity and capability to support and promote employment opportunities for mental health service users and review the support systems and policies that are in place for all staff.

Case Study G:

South East Coast Ambulance Service: BME recruitment and employment

This is a workforce related project and a Wave 2 initiative. It centres on enhancing BME recruitment to SECAMB with retention as an added value. In a nutshell, the project leads are running an advertorial campaign targeted at specific BME groups within the Surrey Travel to Work Area (TTWA). The advertorial campaign featuring the publication of "life interest" stories from selected current BME employees is being run in conjunction with *The Voice*, which is a weekly tabloid newspaper, aimed at the UK African–Caribbean communities. The advertorials will raise the profile of job opportunities within the emergency care sector in the light of poor representation of BME people in this sector. SECAMB has a 7% BME client base in its operational area, but its BME employee

percentage does not come near this figure. The national ambulance service has also recognised this low representation.

Case Study H:

Cornwall and Scilly Isles: Employment of People with learning disabilities

This project seeks to increase the representation of individuals with learning disabilities within the workforce. It also seeks to train managers, create 'buddies' and simplify the recruitment and training of work experience employees. The training has focused on how to support and mentor people with learning disabilities in the workplace and was provided by an external partner with expertise in these issues. A project steering group has also been formed that includes trained job coaches and the people with learning disabilities whom they support. Other innovations are at various stages of development and include job carving, easy read information packs (including health and safety advice and job descriptions) and exploring the possibility interviews by work-based trials.

5. Overview

5.1 Introduction

The workforce development issues that are being tackled by change ideas under the Pacesetters banner are complex and challenging. The issues reflect attitudes and behaviours in the wider community, not just the NHS. But they also reflect issues people may be reluctant to face because of the fundamental institutional culture of an organization, because of a lack of awareness that there is discrimination operating against a particular group, or preconceived notions about a particular group, for example disabled people, concerning their capabilities.

As was stated in the introduction, this is not a summative evaluation. Some of the initiatives are still ongoing with continued investment of resources; others have stalled, but may or may not be reactivated in the future, while still others no longer receive funding and are considered by all parties to have completed their task. It is possible to categorise the case studies into those initiatives that have adopted an emergent approach to change, either expanding or developing the original idea as they learn what works and as they respond to opportunities and circumstances, and those that have chosen a small scale intervention with a clear remit and which have achieved their aims but have not been developed further. Within the first category, in some cases it is not yet clear, because the process is still continuing, whether the short term impact will generate a long term mainstreamed sustainable change. In the latter category, even if the initial change idea has not been mainstreamed there has been some legacy either in the form of the lessons learnt or some aspect of the original idea being taken up elsewhere. In the on-line survey, individual learning was perceived by respondents as being the greatest impact of the innovation process.

It is the view of the evaluation team that there is no one formula for effective change, rather a range of factors needs to be present. Of these, two are fundamental: passionate and enthusiastic champions within the NHS Trust and top management support for bringing about change in the chosen area. Other important elements include links with other initiatives and the embedding of the innovation among a set of champions within existing systems. A project was less likely to achieve change where the project lead was in a temporary post or was absent for a period of time. Also, if training or other project components were subcontracted to external agencies, where issues of quality have not been addressed, this could have an impact on progress.

Involving the community of interest takes time and good planning, but there was pressure to demonstrate measureable outcomes and of monitoring monthly reports. This created anxiety amongst those project leads who were trying to ensure participation and involvement through the development of the right forums and networks, which generates a qualitative outcome not easily measured by statistics. While many welcomed the ethos of PDSA with its emphasis on trying things out, there was however still the perception that everything had to be justified, measured and shown to be a success almost immediately. Yet crucial groundwork, if done properly, provided the very necessary basis for effective longer term action and projects which did the groundwork were more likely to retain the impetus for innovation adoption. In these case studies, Pacesetters funding provided the opportunity to create the necessary relationships, and the outcomes were the achievement of those relationships. In others where the ground work was already there and the necessary relationships already existed, the change ideas were planned and implemented more quickly. As with successful initiatives in any field change becomes cumulative over time.

Tensions and unexpected consequences that run counter to the original intention of an initiative can inevitably emerge. For example, in the most challenging area, that of bullying and harassment, a change initiative may in fact increase the number of people disclosing in staff surveys, thereby making a Trust and the project concerned to be seemingly failing in achieving change, if this indicator alone is used. On the other hand people may be reluctant to disclose because the fundamental institutional culture of the organization, particularly the attitude of key managers, creates an environment that makes small bottom-up change impossible without major change from the top that allows people to challenge those managers. Similarly, there may be many legitimate reasons why people do not want to be recognized as different, for example, in representation projects. Here, disclosure or participation in a particular forum for a particular group of people creates a sense of not being normal, which may set them apart from others. Here again numbers of people participating in a change initiative may or may not reflect true need or effective change.

Finally, it is clear from the online surveys and the case studies that Wave 2 initiatives were better thought through, more focused and structured. In Wave 1, some sites put forward projects that were already in existence for which Pacesetters provided additional and welcome resources. However, in some cases, including one of the case studies here, insufficient ground work was undertaken to understand the issues and explore whether the service provided was an appropriate solution to the issue from the perspective of the targeted group. In this instance there was no comprehensive costing undertaken and the capacity to mainstream when resources were removed was not

considered. In another Wave 1 Case Study, similar ground work, particularly in terms of embedding the initiative in the organization, had not really taken place. In both cases, the project leads and participants were placed in situations that led to difficulties in achieving expected outcomes through no fault of their own. It is important that the learning from those experiences is capitalized upon. In the third Wave 1 study the second phase of the work benefited considerably from learning during the first cycle and allowed the project to take forward the idea and mainstream it.

The following analysis is taken largely from the case study sites. For understanding Pacesetters elsewhere, reports of the two on-line surveys are presented separately in Appendices I and J. The first report covers 42 projects at different stages of development across all three areas: flexibility, bullying and harassment, and representation – some complete and some continuing. In that survey, a number of suggestions and insights have been provided by the respondents. The second report, which is a follow-up, covers a total of 20 projects. The aim of the latter was to explore what had happened since February and unpick the likely legacy of Pacesetters.

5.2 Planning and implementing the change ideas: What worked and did not work.

As has been stated, the case study sites included mostly Wave 2 projects with only 3 Wave 1 remaining in the evaluation. To reiterate for emphasis, it seems clear that Wave 2 projects while receiving fewer resources than Wave 1 projects, were able to build on that experience with the result that projects were more appropriately focused with greater clarity and fit between aims and actions, they saw greater community of interest involvement and also followed the cycle of PDSA more clearly, drawing on a range of data sources to identify need and choose interventions. However, notwithstanding the emphasis in Pacesetters on testing out ideas and changing them in the light of what has been learnt through a cycle of reflection and action, some case study sites seem to still retain a "need to prove success" mindset rather than an "improvement" mindset. This may be due to particular local organizational cultural factors or due to skill and understanding needs. It was thought by the evaluation team that the type of performance culture of Pacesetters may have been a factor, for example, pressure from the use of Monthly Monitoring Reports (MMR). However, one case study participant reported using a bad MMR as a tool to generate more resources and a change in managers' attitudes towards the project. This example illustrates one of the key advantages of having some external monitoring to create incentives to keep the momentum of change going. Similarly, being recognized or perceived as an example of good practice nationally potentially could contribute to maintaining momentum and raise profiles locally, perhaps persuading local trust directors to commit publically to change. Although in one instance this public commitment was not followed through in practice although it did provide a turning point in attitudes.

Overall flexibility and openness to change remained of overriding importance as all the projects experienced setbacks either of a practical or structural nature and, as can be expected, none of them went precisely as planned. Inevitably, where projects committed themselves to co-design with the community of interest, the direction

changed in the light of learning amongst the participants. Thus, for example, in the Dis-Solution initiative (Case Study C), learning from the first cohort was able to inform recruitment in the second cohort. Other projects did not go through more than one cycle during the evaluation period but nonetheless modified their original plans. In Lewisham, where the project was stalled due to an employment freeze, adjustments had to be made as a major reorganization also took place. In many case studies reflection and learning cycles occurred through a series of related iterations. Some focused on the considerable groundwork to be undertaken to understand the nature of the problem and plan the appropriate change idea. In Cornwall, there was a series of cycles that interwove as initial setbacks led to a modification of the original approach: the change idea was not delivered by an outside community agency, which had been the original intention, but within organization itself with additional productive outcomes.

The Model of Improvement advocated by Pacesetters lays great emphasis on a scientific approach and particularly measurement of outcomes when testing an innovation to see if it works. So, central to Pacesetters has been the use of data as an evidence base to inform needs and generate the innovation, as well as inform the process. Data from the first online survey indicates that the source of the ideas from which an initiative originally developed varied considerably. The use of data to understand the nature of the problem has also been variable. In some cases there has been an overreliance on quantitative data alone to understand the issues without any real questioning as to the quality of that data or its appropriateness. The innovations being tested are often directed at small numbers of people in the first instance; it is normal in innovation theory to see a cumulative change over time with increasing numbers of people "infected". However, this is not likely to be revealed early on in data collection. Quantitative data has been used for monitoring with greater effect, but the same critique applies.

Greater awareness of issues, greater willingness to disclose, for example a disability or bullying, may actually apparently lead to an apparent quantitative increase in the problem. Some case studies recognized the danger of an overreliance on general surveys and concentrated on getting real insights into the nature of the issues and potential solutions either through the use of forums or focus groups. Indeed those case studies that have actively involved the targeted groups in co-design from the beginning have relied much more on systematic use of focus groups and workshops in general. These was done to great effect in SECAMB BME project and in the Lincolnshire Deaf representation project, while in Cornwall participants have been encouraged to maintain records of their experiences. Qualitative data is of particular value where small numbers of people are involved and where you need to understand why something works or does not work. In Leicester Partnership Trust, while there was some recognition that a survey alone does not provide adequate information on progress and that service user groups should be involved more in assessing change, there was a reluctance to engage with qualitative data collection to evaluate the impact of the change initiative. When the results of a follow up survey amongst staff revealed no real difference in changes in attitude, anecdotal evidence was used as evidence of some impact. A deeper understanding may have been obtained if the quantitative data had been supplemented with qualitative data. In some case studies, while there was enthusiasm for baseline data collection in analyzing the issue, measuring impact was less widely achieved. In the other Leicester case study, follow-up data collection did not

happen, and again anecdotal evidence, myth and story, rather than systematic evaluation, were more important for moving the initiative on. Lewisham stands out as an example of good practice partly because it was able to build on the master's dissertation of one of the project's participants, which was undertaken in his own time and which provided a wealth of data that was subsequently explored in forums. This enabled the participants to pinpoint exactly what was happening and tailor the input appropriately. Meanwhile, the SE Coast Ambulance project was on course for good use of data and evaluation, but the absence of a project lead for 6 months halted the process. Overall across the case studies where there has been a high level of formative evaluation, the interventions chosen have been well focused and appropriate.

Finally, it is the observation of the evaluation team that people working in the NHS focus very much on doing, and reflection and spaces to reflect or evaluate are rare. Pacesetters tries to build learning in through its use of the PDSA cycle with its emphasis on improvement. However the level of formal evaluation remains low. There seems an overall reluctance to engage in evaluation to learn and improve rather than prove. Rumours circulating during the evaluation period about project funding being withdrawn also accentuated the need to prove. Overall understanding of and commitment to evaluation was rare. There was a general wariness about the external evaluation with an underlying fear of being judged and of "failing"; although by the end of the evaluation period this was beginning to change. Commitment to the action learning sets was poor and in a couple of cases non-existent. Attendance, for whatever reason, was patchy and the same people did not always attend each set, with the exception of Cornwall, where there was a consistent group of people. In Cornwall, the local approach to change through the use of action learning sets was reinforced. Here, there was already an environment for mature exchange and dialogue that went beyond the fear factor and allowed learning to take place in an open manner across management levels and between beneficiaries and project coordinators. Overall, where the action learning sets did take place, the sets, in whatever form they manifested, did appear to reinforce the Pacesetters way of working, providing a discursive space or arena for dialogue where it felt safe to engage in critical questioning of taken-for-granteds, conversations for understanding, if not direct action, and empowering people to have a dialogue with senior managers.

5.3 Community Engagement and Co-Design

A central plank of the Pacesetters approach is co-design, that is: the involvement of the targeted community and people with lived experience of the issues, in the development and delivery of the innovation or change. Co-design requires commitment from the organizations themselves, with senior managers working alongside the participants. Co-design certainly has been a key factor, in developing good and well targeted interventions, in gaining an understanding of the nature of the issues and in delivering the change idea. In the case studies, co-design was used variably ranging from complete involvement to patchy, if at all. There were also variations in the way the community of interest was represented or involved. Sometimes an external organization believed to represent the knowledge and experience of the target group has been used with varying success. In two instances, this had drawbacks either for reasons of quality control or because the organizations themselves were not able to entirely accommodate the

specific needs of the NHS Trust them. In one instance, it has worked very well. Deaf Links has been a strong driving force and well focused in its approach. For this PCT (Lincolnshire), however, the main challenge is retaining relationships and securing impact in a very rural area that does not have the same possibility of face to face contact that urban conurbations can initiate a little more easily.

A major impact of co-design where it involved a range of people from the target group as participants is that it increased the momentum of the initiative and created pressure on management to deliver their side of the bargain. But it also often meant that the original aims of the project became modified or in one case widened, changing scope and direction. An important impact has been when the participants who were the focus of the intervention have played an active role themselves in changing attitudes and behaviors. Volunteer involvement in Bristol was important, changing the way the service was delivered. In Leicester City (Dis-Solution) and in Cornwall (Health Champs) and in Lincolnshire (DeafLinks) the very presence of people with disability changed attitudes: they became the ambassadors of their own cause, introducing changes in ways of working that impacted on the organization in a way that improved things for everyone. Overall those projects that actively involved service users from the beginning in all aspects of the projects development have flourished. A particular challenge with co design however is maintaining commitment through periods of inactivity, as was the case in the South East Ambulance project.

5.4 Developing the Infrastructure to support Change

As argued earlier, the momentum by which change was possible was influenced by the degree to which important ground work had been undertaken to build the necessary infrastructure to support change. This also has fundamental implications for sustainability. Failure to embed the processes or the project in the organization's developing or existing structures and processes creates the danger that once the project lead that drives the process leaves, for example at the end of funding, all the learning and the actions undertaken for change will be lost, and effectively an opportunity to capitalize on an investment will not be realized. Those projects that have the greatest potential to realize their aims in the longer term, even if they have not achieved quantitative outcomes in the short term have the following characteristics: focused on getting the issue properly defined, worked on establishing some fundamental clarity of what could be achieved, as well as how and when, developed networks, built up alliances, created appropriate forums and identified change champions at all levels in the organization. Building this infrastructure is an important outcome of the Pacesetters process in itself. Where local project leads have been able to resist the need to demonstrate immediate concrete quantitative outcomes and have favoured getting the relationships right, have more likely to have developed a platform that can create the momentum for shifting to a new level of change. In those projects where that ground work was not done or there was no supporting infrastructure, for example in terms of clear policy and procedures, then the project stalled or did not "takeoff"".

Most of the projects are about changing attitudes, which can take a long time, and the first stage is about raising awareness. However, once that awareness has been raised

people need practical help in changing the way they work. Here managers are key players in the system, and movement has been greatest where management has been the focus of action. This can be seen very clearly in Lewisham where action was taken both at this level and in supporting the community of interest members themselves. Alongside creating the networks, properly identifying appropriate interventions, having the right policy and procedures and building relationships, top management support that is visible, and not merely lip service, is a key important infrastructural element that is required.

As stated previously, co-design through community engagement lies at the core of Pacesetters. It also is clear that active ownership and involvement by all parties meant that not only was the intervention appropriate but also not over dependent on the participation of particular individuals, including project leads. Lack of ownership by the organisation meant, for example, further funding not found or a key post not filled leading to the stalling of an ongoing project, or the learning from the initiative was not capitalised upon. Where the participants and beneficiaries themselves became their own advocates, demonstrating either that previous perceptions as to capability were incorrect or that there were easy solutions to participation in the workforce were possible, ownership at all levels of the organisation increased.

This brings us to the issue of skills and experience. Reference has already been made to the importance of lived experience in framing the change idea and in maintaining commitment. It is also important for understanding some of the wider issues. However, lived experience alone is insufficient. Skill development is required both in helping those managers who wish to achieve change find practical solutions and in helping project leads and those involved directly with the PDSA approach. Although training was given, the skills for working in this way seem variable, and one respondent in the first online survey remarked that the Pacesetters Workforce Development workshop/training had been poor. Reference has already been made to the limited evaluation skills. There was also a wide variation in the skills people had in understanding data and types of appropriate data required to understand an issue.

A consistent finding across the case studies and in the online survey is the importance of people with a passion for the area of interest. However, passion and drive like lived experience are not sufficient: a particular world view is helpful, namely one that engages with a positive mind set and nurtures relationships. This however has to be combined with a skill set that builds social capital across boundaries, is facilitative and has associated ability to "translate" between cultures and languages, whether across different organisations, between levels in an organisation or with community partners. Being able to identify the right partners is also part of the skill set. Those projects which spent time building relationships or had a history of good relationships were more productive in bringing about change. These boundary spanning skills, however, need to be coupled with a clear vision and good project management skills as well as the previously referred to in-depth knowledge of the particular issue. Finally, these key people are also inherent problem solvers, so whatever challenges they face they find a solution within the resources at their disposal. They are also able to make the most of any opportunity that comes their way, knitting together, for example, different sources of funding. Such leadership skills are a necessary prerequisite for a successful innovation, but those projects that were over reliant on one person with those skills to

move the project forward are more vulnerable to a project stalling or not being taken forward when that person moves on. Thus, one respondent in the online survey remarked:

"We have not managed to find a way to really embed the project and disseminate the taking on of similar projects. The project will succeed because of the enthusiasm of a small group of people – but as soon as they leave, any continued progress will stop. It seems (as with many things) employee commitment and a personal desire to contribute to the achievement of an equitable society are the main push factors in terms of success."

5.5 Change: Impact and Outcomes

The approach of the Pacesetters model is to seek small but significant changes and adjust during the PDSA cycle before implementing a change initiative more widely. Within this framework, most of these initiatives have focussed on attitude and behaviour change (changes in practices). There is not necessarily a linear causal relationship between the two. The following Table tries to capture the sorts of changes that took place.

Table 1: A selection of changes at each site

Trust	Changes
Lincolnshire PCT	In-depth study of the issues through focus group results. Easy Read application forms Staff network launched. Disclosure of disability increased. Shift in recruitment practice: Instead of sending deaf people away at the inquiry stage now included in recruitment. Solid partnership established between PCT and DeafLinks: submitted to NHS Partnership Award
Lewisham PCT	BME Forum with 28 members established and addressing wider issues than recruitment interview practice. More discussions in the organisation generally on race issues. Joint working with providers on BME issues under the ULT umbrella. Raised profile of Lewisham (as example of good practice). Gold training delivered to 90% of interviewees Issues tackled at the organisational and individual level
Cornwall PCT	Recruitment of 9 Health champs and buddies.

	Securing substantive contracts. Increased self-esteem of Health champs. Changed attitudes of managers and real inclusion in departments. Wider publicity and interest. Active involvement of Chief Executive. Highlighting the need to make systems generally better as what works for LD helps all. Generally affirmative but some tensions as wider workforce still feel uncomfortable around exposure to LD Wider ownership means not dependent on one person.
Leicester City PCT	Good experience of first cohort of placements. Adjustment of approach for 2nd cohort. Real inclusion in departments: participation seen as valuable. Increased awareness of what small changes are required. Improved training. Changes in attitudes of staff to patients with disability. Efficiency improvement due to changes suggested by people with disability. Members of HR team learning sign language. Further Funding secured by CE from PSA16 Roll out to mainstream
Leicester Partnership Trust	Baseline questionnaire executed. Service users engaged. Posters developed. Posters put up. Evaluation undertaken. Poster idea picked up by other Trusts Action learning taken forward
SECAMB	Workshop/focus group with leads from local BME and Faith groups in Barnstead Surrey Travel to work area. Voice Advertorial distributed with real life stories of clear career progression demonstrating opportunities. Conference at Epsom showcasing issues, participatory with AL sets and Story Boards. National support and profile acquired.

	Local Support of Director secured. Support from national BME committee of the Ambulance service. Stalling of project in absence of lead
Bristol PCT	Support for volunteers. Links with BME forum established. New publicity in place of scheme. New recruits trained. Infrastructure for BH in place. Increase in number of referrals. Increase in numbers of BME staff volunteers (anecdotal).
Hastings and Rother	Internal questionnaire. Focus group run. Well received theatre workshops run which have been adjusted to local needs following evaluation. Participation included Directors but coverage and participation patchy across Trust. More disclosure of BH in staff survey leading to an in depth inquiry locally revealing victims and witnesses feel unsupported. Harassment element addressed but bullying dimension No real ownership of the initiative.

5.6 Barriers and Challenges to Change

Pacesetters is about learning from challenges, so some barriers and challenges discussed here were either overcome or presented a good learning experience, thus encouraging changes in approach or direction. In some instances, they have remained major challenges. Across all the sites, the recession and its impact have presented a particular challenge, particularly where a change idea involved some form of employment. A recruitment freeze affected four of the sites directly; a training freeze affected SECamb and Lewisham; the cutting of the Future jobs fund has affected the recruitment and employment of mental health service users in Leicester Partnership Trust and the further employment of people in the Dis-Solution project.

A second major challenge has been the availability of resources. This might be manifested in the form of the limited capacity of project leads within HR teams to take on extra work or where funding cuts have challenged the ability of the project to maintain the co-design element or competing priorities have drawn key personnel away from the change work. Recent cutbacks on funding have been particularly hard on initiatives that have been engaged in necessary groundwork before developing momentum. Projects need time to adapt, and those that focus on issues of equality are seen to incur extra marginal costs.

In some important instances, NHS procedures and policies or organisational changes have acted against the change. In some instances this has been specific to the Trust concerned, for example where absence of clear procedures, such as good personal performance management through staff appraisal, has acted as a confounding factor and acted against change. In other cases the very process of normalisation across the NHS of recruitment forms and employment procedures has acted to discriminate against people with disability, creating effectively, through its computer systems or operational procedures and requirements, and institutionalised discrimination.

5.7 Sustainability and Spread: the Pacesetters Legacy.

The success and rate of adoption of an innovation are as much to do with the perceptions of the players involved as they are inherent in the innovation itself. Moreover, what is innovative in one place may be normal practice in another. An innovation that is perceived as successfully solving a need is more likely to take off than one imposed[6], so the potential for sustain and spread is likely to be related to the degree to which it is perceived as serving local needs. This means those sites that are spending time digging deep into what the issues are and what costed solutions will work locally have greater potential to sustain and spread, given a supportive environment. Those projects that are sensitive to the involvement of a particular person as project lead or named person are likely to be vulnerable to not building on the short lived changes. What is clear from the case study reports that follow and from the follow-up online survey, the combination of factors that contribute to the particular trajectory of an initiative are as varied as the initiatives themselves.

Specific questions regarding legacy were asked in the second online survey. While responses varied, individual learning, the generation of new related initiatives and raised awareness were considered the main legacies. In particular, individual respondents had learned that changes in practice do bring about improvements, especially for the disabled, BME and LGBT sections of the workforce and that flexible working policies can benefit both the organisation and the individual. Some expressed concern as to whether such learning will be sustained given expected changes in the future, for example when primary care trusts will no longer be operational. Some in BME and LGBT projects reported that these projects had helped raise awareness of the difficulties faced by these groups. No respondent thought there would be not be a legacy from a workforce development project.

A pervasive feature within the case studies and more broadly has been a concern as to whether there has been sufficient time to embed the ideas or practices or reinforce the changes in attitudes amongst a wider population than those directly impacted. While some case studies are beginning to embed their practices within their organisations more widely, for example, Dis-Solution and Health Champs, others potentially could, like Lewisham. The real question is whether such innovations can be adopted more widely within the NHS without central facilitation or investment in processes, such as learning events, to do so. In the absence of any such strategy the dissemination of change ideas will depend on the change agents themselves.

[6] Rogers, EM (2003) The Diffusion of Innovations Free PressNY

In the next section the individual trajectories of each of the eight case studies is explored in detail.

6. Case Studies

6.1 Case Study A Wave 1:

Bristol PCT: Bullying and Harassment initiative with particular reference to BME groups

6.1.1 Context

This is a wave 1 workforce related project centred on the effective assessment and management of the current bullying and harassment helpline (BHHS) with an added focus on BME representation. The Bristol PCT staff bullying and harassment policy states that any harassment is not tolerated. Harassment is defined as being, 'Any conduct based on age, sex, sexual orientation, gender assignment, disability, HIV status, race, colour, language, religion, political, trade union or other opinion or belief, national or social origin, association with a minority group, domestic circumstances, property, birth or other status, which is not reciprocated or wanted and which affects the dignity of men and women at work.' The Bullying and Harassment Policy underpins the current (BHHS) can be located at:
http://www.bristol.nhs.uk/Staff/HR/Policies_Guidelines/bullying%20&%20harrassment%20policy.doc

6.1.1.1 The Current Bullying and Harassment Helpline

The current bullying and harassment helpline scheme (BHHS) had already been in operation since 2003 as part of the Trusts' priorities to tackle bullying and harassment. The scheme worked as a confidential staff helpline serviced by staff volunteers offering support and advise to callers over a wide geographical spread including NHS Bristol, Bristol Community Health, NHS North Somerset, NHS South Gloucestershire and NHS Bath and North East Somerset. The aim of the BHHS was to provide a trained staff volunteer to listen to any staff member experiencing bullying and harassment in the workplace and to signpost them appropriately. To ensure confidentiality staff volunteers matched with a caller from a different trust. The BHHS was located and managed within the HR department and over the years had experienced some resourcing difficulties. This had impacted on the consistent, effective management and leadership of the scheme and it had been recognised that it had, 'lost it's' way' (project stakeholder) leading to a mis-match between policy and implementation.
The scheme was underutilised and monitoring information for the period May 2008 – May 2009 indicated that just 17 calls had been made to the helpline. The current staff helpline volunteer cohort was 11 and did not reflect the demographic profile of the

organisation relating to BME staff with only one volunteer self identified as being from a BME background.

6.1.1.2 National and local data – bullying and harassment in the NHS

Since the (BHHS) was set up tackling the issue of bullying and harassment continues to be a key concern for the Trust. The extent of bullying and harassment within the NHS is still reflected in both national and local survey data. On a national level evidence indicates that BME staffs are more likely to experience bullying and harassment than their colleagues. The NHS Staff Survey 2008 reported that 10% of BME staff and 7% of White staff experience bullying and harassment from a manager or team leader. Further NHS survey data reported in the Health Service Journal, 2008 indicated that whilst staff from BME backgrounds make up around 16% of the workforce, they are involved in more than twice as many bullying and harassment cases. In addition, nearly a third of grievances are taken out by staff from minority ethnic groups (Health Service Journal, 6th November 2008). The more recent Healthcare Commission report, 2009, 'Tackling the Challenge: promoting race equality in the NHS in England' highlights that, 'people from minority ethnic groups play a critical role in the delivery of NHS services, but there is evidence to suggest discrimination within the NHS, as well as disproportionate involvement in bullying, harassment and grievance cases...'
Local data from the Trust reported that between 2008 and 2009 12% of staff reported bullying and harassment from colleagues or managers. Whilst this score was in the lowest (best) 20% of PCT's in England, Bristol wanted to improve on this figure by focussed work and energy in this area.

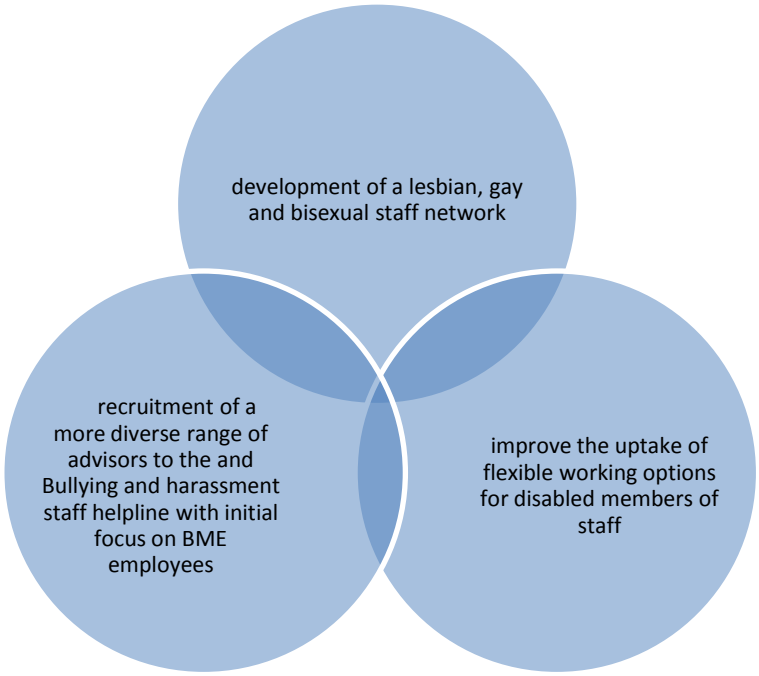
6.1.1.3 Organisational context and resources

A key driver for focussing on BME representation within the scheme is reflected in the current Equality and Diversity agenda within Bristol PCT, which is seen as a core commitment for the organisation. This agenda is embedded in policy documents, the development of equalities posts and the equality impact assessments process. It was deemed important to reflect such policies in practice.

A core ambition for the PCT was for its' workforce to be more representative of the local community with a clear commitment to equality and diversity workforce issues. This is clearly highlighted in item 3 of the PCT's value statements,
'We will embrace diversity and aim to be a major player in reducing discrimination in the workplace and in our communities by being a model employer and an agent for change in Bristol. In addition, our aim is to be equitable in delivering services and our approach will be to work with individuals in communities to meet their needs.' Hence the decision was made to focus on an area where BME staff was under-represented.

The Pacesetters initiative provided the opportunity to appoint a Staff Participation Development Manager between August 2008 and February 2010 to undertake the Pacesetters Action in the Workforce development programme. The post was positioned at a band 5 level on a fixed term contract of 18.75 hours a week and the post was developed through Bristol Primary Care Trust (NHS Bristol and Bristol Community

Health) and managed through Bristol Community Heath (BCH) HR department (the provider function of the organisation since the commissioner provider split in 2009) serving all 4 participating PCT's referred to above. Within the Pacesetters context of staff participation and engagement the post focussed on 3 areas of diversity work to allow targeted work to take place, addressing recognised areas of discrimination (see fig. 1 below). This work included work to increase the diversity of the BHHS with a focus on BME staff, developing a lesbian, gay and bisexual staff network and improving the uptake of flexible working options for disabled members of staff. Although there are links between all 3 diversity areas the focus of this evaluation report is on the specific piece of work around the BHHS for which the staff participation and development manager was the project lead.



Areas of work included in the staff participation development manager development manager remit

The project came under the remit of the Associate Director of Public Health, Equality and Inclusion who was the overall lead for the whole of the Pacesetters programme. However, unlike the other Pacesetters projects under her remit this project as part of the workforce development agenda was located and managed within the HR directorate (now the People and Development Directorate). It was envisaged that the appointment of the staff participation development manager would provide targeted input into the current BHHS and would constitute, a *'real piece of work that was to be sustainable and that we could (realistically) take forward...and could be a kick start to eventually mainstreaming"*(Associate Director).

A number of other key members of staff within the organisation provided further resources and support to the staff participation and development manager. Key stakeholders included the Chair of the BME Staff Network, a HR advisor (who already had a working knowledge of the scheme) and the HR operational team. Equalities

officers and health improvement and health promotion personnel constituted a more periphery but strategic resource. The current BHHS volunteers provided ongoing commitment and useful feedback regarding the scheme.
Both the HR staff and the Chair of the BME network were allocated dedicated time to support the development of the project. Helpline volunteers were given the agreement of managers to attend BHHS related meetings although this support was reported as variable.

6.1.2 Aims and Objectives

The aim of the work related to BME representation was:

- The recruitment of a more diverse range of advisors to the Bullying and Harassment scheme that would reflect better the profile of the organisation, by initially focusing on Black and Minority Ethnic Employees

The objectives identified to meet this overall aim were:

- Engaging with current helpline volunteers to gain feedback concerning about the BHS
- Engaging with the BME staff network to provide mutual support and advise concerning the current scheme and issues impacting on BME staff
- Supporting and motivating current volunteers
- Publicising the scheme to a diverse range of staff and monitoring of caller information.
- Recruiting and supporting new volunteers with a particular focus on BME staff

6.1.3 Project mechanisms and activities

The key focus of the project work was that of embedding the infrastructure of the BHHS within the context of BME representation. To enable this number of related activities have taken place. The first and major element of this work was the initial contact and ongoing engagement work with current helpline volunteers and the BME network staff. This work took up much of the project lead's time in the early stages but was key to effectively laying down the foundations for the subsequent project activities.

6.1.3.1 Engaging with helpline volunteers

In order to make an assessment of what input was needed regarding the BHHS an initial mapping exercise was conducted with current staff helpline volunteers. Information and feedback was obtained via phone, email and face-to-face contact from the registered helpline volunteers and also the human resources team. Current volunteers were asked about their experience of the scheme, what original training they had received and what management input that had been available to them. As a result of this exercise it was established that 8 volunteers were active. An ethnic breakdown of these volunteers was not available.

6.1.3.2 Engaging with the BME network

A key area of work for the project lead was the engagement of the BME network which had been identified as a valuable resource, potentially playing a key role in encouraging and supporting BME staff recruitment to the helpline. At the beginning of the project work members of the BME staff network had little knowledge of the BHHS and it was some time before effective communication with the network was possible due to a changeover in personnel. The BME network had been through some changes and once re-launched with a new committed chair in place the project lead was able to meet regularly with network members who provided valuable support and information in relation to the project remit.

The project work around BME representation sat well with recent work around the re-launching of the BME staff network and was supported by the CEO of Bristol PCT who had profiled the network during a keynote speech, 'Race Equality – A commissioners' perspective' at the Inaugural National BME network conference in June 2009. A 'Meet the CEO' session had also taken place with Network members.
In addition to the ongoing engagement work a number of other activities were undertaken to progress the project work including:

- Regularly information and support meetings with the current helpline volunteers (3 meetings in 2009).
- Regular contact with the BME network
- A recruitment drive was undertaken in consultation with the BME network, Human Resources, helpline volunteers and the ACAS Equality and Diversity trainer (who provided initial training to newly recruited helpline volunteers) and in collaboration with the NHS Bristol Communications Team during summer 2009. New recruitment publicity material was published in the form of posters and leaflets to appeal to a more diverse group of staff. This was distributed to the participating PCT's.
- Initial pieces about the BHHS were posted in the staff bulletins. These can be accessed at

http://www.bristolpct.nhs.uk/Staff/Communications/BristolNews/2008/images/october.pdf

- The BHS scheme was presented at a BME network meeting in July 2009
- The training of new helpline recruits took place in February 2010
- Attendance of the key stakeholders at 2 action learning/focus group meetings in October 2009 and February 2010 to reflect on the project work to date

A logic model has been completed to reflect the demonstrate the projects' inputs, outputs and outcomes (Appendix A1)
The evaluator met with a range of project stakeholders twice during the project to allow for reflection and review and sharing the learning. This included representatives from HR, the project lead and members of the BME Network.

6.1.4 Project outcomes

Establishing the workforce remits for the Pacesetters programme and setting up the Pacesetters post enabled targeted work to take place, addressing recognised areas of discrimination in the workplace including work around BME representation regarding the BHS.

The key outcome of the BME representation focus of the project work has been the establishment of a solid infrastructure for the BHHS which has made it possible for the range of focussed activities to take place. The BHHS now has a named co-ordinator and 20 active volunteers who have access to regular support and feedback sessions. Clear and ongoing links have also been established with the BME Network. The resourcing of the staff participation managers' post and the commitment and support of key stakeholders allowed for this focussed activity and the re-launching of the scheme. The engagement of both the BME network and the current helpline volunteers was central to the project work. Plans are in place to continue building on the links made. The BME network has been strengthened and a small budget has been agreed to help support it in addition to the other various staff networks included in the staff participation development manager's remit.

The regular meetings and updates with the BME network resulted in some network members expressing an interest in becoming helpline volunteers and attending the forthcoming February 2010. The longer term commitment was made to keep the BHHS on the network agenda.

The new publicity for the BHS had a definite impact on the number of people coming forward and ringing the helpline. The project manager reported that, 'although there weren't a huge number of referrals to the BHS, calls did increase after the publicity. This increase didn't necessarily indicate that more bullying and harassment was taking place in the organisation but it certainly meant that there was an increased awareness of the support available. The project lead contributed to a staff seminar detailing the project work in a power-point presentation.

Over the duration of the project the total number of staff helpline volunteers increased from 9 to 20 with 2 volunteers self-identifying as being from BME backgrounds. It is hoped that more BME staff will volunteer to the helpline in the future, particularly as links with the BME network continue to be strengthened.

6.1.5 Barriers and challenges

Despite some important work achieved around the engagement and participation of staff and developing positive relationships within the project remit a real challenge has been the amount of time needed for these processes to take place. A key barrier to engagement and participation was the wide geographical spread of the 50 bases within the organisation. This impacted on the opportunities for staff wishing to attend meetings regarding the BHHS and the BME network. The project lead commented, 'The BHHS is across 4 PCT's which means bringing people from all over and getting people in

can be a barrier to coming to meetings.... and a barrier to them becoming a volunteer.' The difficulty of reaching seldom heard staff was also highlighted, particularly in an organisation so vast and hierarchical as the NHS. Whilst various methods of communication were used to engage staff in the project it was acknowledged that frontline staff in particular typically had different work patterns than staff based at head office, Bristol and at times found attending meetings or accessing emails difficult. (For example, some staff do not have daily access to emails).
The project lead highlighted such difficulties, 'Frontline staff may only access email for 15 minutes a day, may be out and about with different work patterns than head office staff....so if there are changes on the frontline and getting to meetings, for example. Getting to the BME network and then volunteering needs to be factored in when you are engaging staff.' Service demands such as swine flu and other competing service priorities also impacted on staff availability.
Another related challenge to staff participation was the absence of a formal policy for staff network participation and protected time for staff to attend meetings. Support from managers for staff wishing to attend such meetings was variable as mentioned previously.

Once the project lead's post had come to an end in February 2010 it was a number of weeks before a decision was made as to who would take over the role of the management of the BHHS. This was due to a capacity issue within HR regarding resources to input into the BHHS. A key learning point is the possibility of future challenges regarding the future of the BHHS if the scheme isn't resourced effectively and consistently. There is also the need when project planning to explore the cost implications of a legacy.

6.1.6 Learning from the project work

There were a number of lessons learnt from the project work.

- As is now widely known the effective engagement of staff does take time. Engagement and participation of staff from the various diversity strands within the identified staff networks is a long and continuous process. The issues around commitment, trust and sharing common values are even more complex given the experiences of such groups within organisational contexts and structures. As the project work progressed it had become clear that outreach work was an effective element to engaging particularly frontline staff. However, time constraints of this part-time post restricted further outreach development work.
- Volunteer participation, motivation and engagement is maintained with regular contact. If volunteers feel consulted and involved they have more of a sense of ownership of the process.
- Whilst the HR staff supporting the project proved to be invaluable a wider involvement of HR staff in the planning of the work would have been useful.
- The importance of personally motivated, enthusiastic and committed individuals to take this area of work forward as change agents or key drivers was highlighted by a number of individuals. Key individuals were referred to as

'dynamic' with the project lead referred to as, 'a fantastic change agent.' The project lead spoke about the personal motivation, focus and values necessary to take forward the project work, 'It helped that I was personally focussed and personally motivated and had a clear remit and just went for it...that helped me to build up the strength.' Her personal and professional experiences underpinned everything she had done

- The success of such key change agents to progress their work relies considerably on support from senior managers located higher up in the organisation. Such senior staff in this project were seen as project enablers playing an important role in profiling this work and ensuring it is kept on the agenda at various levels whilst maintaining clear links between organisational equality and diversity policies and practice. This was the case both for some middle and top level management.
- Interventions such as BHHS can get lost in very large organisations with a wide geographical spread and many bases and which often experience processes of change in structure. The need for cross-organisational commitment to the ethos of the BHHS was highlighted as an important element for the success of the BHHS, 'There is a need for across the organisation visible commitment to bullying and harassment and I think that is here , I'm more aware it has to be organisational, across the board, …has to be a good spread..'
- Recent history indicates that without a named person to manage and develop the scheme it fails to flourish

6.1.7 Making a difference

A number of key stakeholders commented on the impact of the Pacesetters process reflecting on the opportunity to put in focussed resources and energy to progress work around BME representation in the work force. It was reported that, 'Pacesetters gave us the opportunity to do things we wanted to do...in terms of resources and ability...' One senior manager speaking about Pacesetters overall reported on the, 'huge added value to our equality work, it enabled us to put issues on the agenda and to work things up, less about small innovations than growing capacity, skill, focus and discourse ....that previously weren't focussed.' In relation to the workforce development element of Pacesetters the structure and management of Pacesetters was said to be different and more limiting than other Pacesetters remits in that, 'We put a lot in compared to what we got out of it.' Certainly it was noted by one key stakeholder that the work made a 'massive difference' in terms of analysing and looking at what was needed and getting the BHHS going again For example, the refresher courses were useful and something that HR didn't have the capacity to do.

The complex area of bullying and harassment is one where real changes in attitudes and behaviours are desirable. It is difficult to say whether this took place or is likely to take place in the longer term within this specific project. However, the project lead spoke about how participation in the processes of BHS training, including attending meetings and listening to helpline callers was likely to have such an impact on volunteers and

their colleagues: *'if you have staff members who are trained in BH behaviours then this has to be a good thing in the workplace as it makes you mindful of what bullying behaviours are ..So some of the actual impact wouldn't be measured but we have people who are more aware of what bullying behaviours are about…….'*
The work achieved is due to continue with the decision being made in June 2010 to embed the role of management of the BHS within an existing HR post. A member of the HR department has been identified for this role and is planning to meet with helpline volunteers and the BME staff network representatives within the near future.

6.1.8 Sustainability

Recent history has indicated that without a named person to manage the BHS it won't flourish and it is encouraging that the BHHS is now under the management of the HR team. However, as previously mentioned one concern is that as the key change agent within this project has left the organisation there needs to be enough capacity within the HR directorate to effectively resource the BHHS and continue to focus on increasing the representation of BME staff. If this is not the case the recent project achievements would be short lived. On a more general level regarding current public sector developments, while it is too early at present to see the full impact of the recent change in government for this organisation (apart from the current job freezes), it is likely that there will be a shrinkage of the sector that will impact on equality and diversity work. Whilst the main legacy left from the project work has been the development of a more solid infrastructure for the BHS and an increased number of helpline volunteers it was suggested that there was still some important evaluation work to do around this complex area of bullying and harassment. One stakeholder reflected this complexity in the following comment, *'I think BH is really, really complex there are so many issues involved that if someone is ill from bullying then I think they can loose the ability to deal with it effectively especially if it's a senior person who is bullying them they may feel very vulnerable and statistics do show that the bullied person is often the person who leaves the service … not necessarily here but nationally…so I think it's very complex.'*
The project has not reached a point where users' experiences of the service have been evaluated. It was suggested that an online confidential survey to evaluate the effectiveness could be built on the project work. Further work in the future around the experiences of bullying and harassment was also suggested in the light of staff's reporting in the staff survey.

The profile of the BHHS will continue to be raised by publicising the scheme within the PCT through the HR networks with ongoing link up with the BME network. Regular quarterly meetings with the helpline volunteers are also planned to share ideas. An advantage with the scheme being situated in HR is that the scheme is managed in one place from start to finish.

In terms of the organisations' broader context around work force equality and diversity priorities in the future, i.e. the single equality scheme, workforce element around participation and involvement and supporting staff networks, a key focus will be around recruitment and retention of staff. The BHHS links into the retention element of this focus in addition to the intended work around grievances and complaints. The Trust

hopes to look at these issues in more depth gaining a much fuller picture for underrepresented staff groups.

6.2 Case Study B Wave 1: Hastings and Rother Bullying and Harassment Initiative

6.2.1 Context and rationale

Hastings & Rother PCT is one of six trusts in the South East Coast region working on the Pacesetters programme. The overall lead for the equalities agenda in the PCT remains a corporate function, with an Equality and Diversity sub-committee. The Pacesetters Steering Group and Project Board (which includes senior managers and Pacesetters Co-ordinator) directed this Wave 1 Bullying & Harassment project and feeds into the E&D sub-committee.

In September 2007 Hastings and Rother Primary Care Trust employees completed the NHS staff survey. The results were a serious cause for concern as the Trust performed very poorly with respect to 'staff experiencing harassment, bullying or abuse from staff in last 12 months'. This put the Trust in the highest 20% nationally. Hastings & Rother became a Pacesetters Trust in April 2008 and as with all participating Trusts has committed itself to 'Reduce bullying and harassment by identifying and tackling underlying issues'. The chronology of events leading to the commissioning of this innovation is not clear but it appears that, following informal discussions with colleagues across networks about both what people want and what has worked elsewhere, senior managers took the decision to enter into a partnership with *Theatre And Development Ltd* (a forum theatre training company) to deliver a bespoke awareness raising package. It was hoped that this would help empower staff to identify and challenge bullying & harassment and create a more positive working environment.

As part of the project plan 935 questionnaires were delivered internally to Trust personnel in September 2008 to inform the intervention design. Over 200 completed questionnaires were returned and 52 of these reported having been bullied or harassed during the past year - 5% of the *total* workforce. Following this, *Theatre&* ran also ran four focus groups with Trust staff. Using this material, they developed a drama based training workshop which ran 15th July 2009, 30th September 2009, 5th November 2009 and 17th February 2010. Each of these events was evaluated by attendees with 'pre' and 'post' questionnaires and the data was presented in interim and final reports by *Theatre&* (see Appendix B1).

6.2.1 Data Collection

Participation in this evaluation has been difficult to secure. Meetings and data gathering has therefore been opportunistic and with a variety of different 'set' members. The burden of work for the evaluation (and wider project management) fell on the Engagement and Equalities Manager who was working on a fixed-term contract which has now ended. Because bullying & harassment is a structural issue it was important to

engage with a range of personnel in this evaluation. Interviews and focus groups were therefore undertaken with a variety of participants including Board members and senior managers. Unfortunately, it was not possible to recruit anyone who had been bullied from within the Trust but given the difficulties of 'coming out' on this particular issue, this is to be expected. That said, several participants did have experience of being bullied in their *previous* place of work. Victims of bullying were also identified in the two internal questionnaires undertaken in September 2008 (IQ1) and June 2010 (IQ2) and were therefore able to make anonymous contributions indirectly. The findings of these should, however, be regarded as indicative only given both the small response rates (particularly IQ2) and difficulties meaningfully quantifying poorly defined and contested issues over the relatively short period of this evaluation.

The first internal questionnaire yielded a response rate of about 22% and the second was even lower. Attendance at the initial focus groups with *Theatre&* was also poor. 700 invitations to participate were sent out, only 7 people turned up. Though poorly attended, these at least made it possible for *Theatre&* to gain some insight into the working environment and culture of Hastings and Rother PCT. Participation was confidential and anonymous and these sessions provided an opportunity for attendees to talk through and discuss issues with professional training advisers from outside the Trust.

Despite encouragement (and attendance) from the Board of Directors, the theatre workshops themselves were not always well attended (See Appendix B2) and two were even cancelled due to low numbers. Over one quarter of total bookings either withdrew or failed to show. For senior managers this figure was more than 40%. Community services were also poorly represented as a result of lack of communication (e.g. being unable to access emails) and work commitments. Data from the second internal questionnaire suggests a wide range of other reasons for people not signing up, including:

- Unaware course was running/ who course was aimed at
- Of no interest
- Unable to take time out of office
- Unsatisfied by previous outcomes of bullying/harassment situations and question benefit of course
- Consider course irrelevant due to not suffering bullying/harassment
- Already attended a course
- Considered irrelevant
- Manager did not book staff member on to course
- Not enough staff to cover
- Assumed was aimed at managers only
- On waiting list

6.2.3 Aims and objectives

The ultimate aim of the Trust, as one of the Board members stated, is to generate *'a culture of mature exchange'* throughout the workforce. While clearly beyond the remit of

this particular innovation, it was hoped that the workshops could at least begin this process. The intermediate aim was not simply to reduce bullying & harassment but to reduce the identified gap between (perceived) incidents and actual reports of bullying and harassment – which may, counter intuitively, lead to an *increase* in official statistics. The immediate aim was to explore the particular tensions and challenges Hastings & Rother PCT faces. The workshops therefore deliberately avoided issues of legislation, policy and procedure, but instead focussed on practical application looking at both individual and collective responsibility through drama and dialogue.

By re-creating typical working environments in a learning arena it was hoped that the Trust's behavioural dynamics and its impact on effective working could be explored constructively. According to *Theatre&* (See Appendix B1) this would be achieved in the workshops by:

1. Understanding the impact of bullying, harassment and exclusion on the workplace
2. Understanding the personal and organisational consequences that can arise from inappropriate behaviour
3. Exploring the differences between banter and harassment
4. Understanding the difference between bullying and effective performance management
5. Exploring how we manage and challenge inappropriate behaviour in the workplace

6.2.4 Outcomes

As already noted all workshop attendees completed 'pre' and 'post' evaluation measures which were written up in interim and final reports by *Theatre&.* Overall results show that attendees benefited positively from participation but it was the style and quality of the workshops which most impressed. According to figures returned by *Theatre&*, on a scale of 1-5, 94% rated the overall workshop in the top two categories (37%=4; 57%=5). 97% rated the trainers knowledge in the top two categories (scale of 1-5, 33%=4; 64%=5). 96% rated the training style in the two top categories (scale of 1-5, 25%=4; 71%=5). Other positive results reported (see Appendix B1) include:

- A general increase in the level of understanding the consequences of bullying & harassment
- A general movement upwards in the understanding of the behavioural difference between bullying and performance management
- Increased confidence in challenging unacceptable, inappropriate behaviour in the workplace
- Improved understanding of the internal Bullying and Harassment support procedures

6.2.4.1 Independent evaluation

Additional evidence gleaned from participants in this independent evaluation support much of the *Theatre&* evaluation. In particular there was universal agreement on the high quality of the workshops, **'***The workshop was very professional and conducive towards debate'* stated one Board member, who attended, adding, **'***it's very easy in that*

kind of thing to present black and white scenarios. They presented some areas where there was room for disagreement and room for a conversation about what our expectations as an organisation were. I recommend it. And I recommend that way of exposing the issues...Just getting a conversation going is not a bad start'. A senior manager similarly commented. *'One thing we can take away from this innovation is that it's a great way of delivering awareness training on a subject'*. The workshops also impressed other participants, encouraging them to *'think differently' as* someone else put it, adding, *'[It] made me more aware of how I'm treated in the workplace. It also highlighted how people have different thresholds'.*

According to participants in this independent evaluation the workshops appear to have achieved their immediate aims. Despite almost universal agreement on the quality of the workshops, however, some concerns were also expressed which will be summarised briefly under *Theatre&'s* 5 stated objectives, not to undermine their evidence but only to supplement it.

1. Understanding the impact of bullying, harassment and exclusion on the workplace

Interviews and focus groups suggest that the first objective was achieved well. The workshops were particularly good at raising awareness of the complexity of the issues raised by bullying and harassment. However, sometimes clarity rather than confusion was desired by participants. **'***What bothers me more',* a senior manager said, *'is that the real bullying isn't being talked about and the real suffering isn't being addressed'.*

2. Understanding the personal and organisational consequences that can arise from inappropriate behaviour

The workshops were thought to be particularly good at showing *personal* consequences of inappropriate behaviour. In particular, the importance of trust and how individual sensibilities can only be respected by discerning appropriate boundaries. It would have helped, however, if the scenarios and/or workplaces connected more clearly with Hastings & Rother PCT or were at least a little more health specific.

3. Exploring the differences between banter and harassment

Participants in this independent evaluation also felt that the third objective of the workshop was achieved well. In particular, issues raised by stereotyping, even positively, were drawn out nicely. It was however suggested that there was too much emphasis on male-female relationships which is not particularly 'typical' of the PCT (and dominated by females) so few could relate to displays of machismo or the reactions (or lack of reaction) to it. Other scenarios were also a little too obvious (e.g. dealing with negative responses to homosexuality) which *'just wouldn't happen in the NHS'* because, one participant observed, it has an *'ultra PC atmosphere'.*

4. Understanding the difference between bullying and effective performance management

The fourth objective was, according to participants, not established particularly well. Historically, 'performance management' has not been consistently part of the Trust's culture. In the past expectations were implicit rather than explicit and informally agreed rather than part of a formalised process. As a result, one participant parodied, *'I don't know what my job is. My boss doesn't like what I'm doing but won't tell me what they*

expect'. This has, however, started to change he added with regular objective appraisals becoming embedded to facilitate the transition from acting like 'mates' to working together as colleagues for the benefit of service users. The workshops by way of contrast tended to focus on old-style management, *'in one scenario'* someone else observed, '*the manager made someone work over the weekend'.* Adding, **'***You just couldn't do that in the NHS.*

5. Exploring how we manage and challenge inappropriate behaviour in the workplace

The fifth objective was perhaps least satisfactory though not necessarily because of the workshops. As one participants made clear, *'[The workshop] made me more aware of how I'm treated in the workplace. I wouldn't necessarily do anything about it coz that could affect my career'.* Few in fact felt better equipped to challenge inappropriate behaviour in the workplace**.** Policies and procedures are already unclear so steps and, several people reported, clear strategies to help respond to instances of bullying & harassment would have been of greater benefit.

6.2.4.2 Closing the gap

While the workshops, on the whole, appear to have achieved the Trust's immediate aims, intermediate and long-term outcomes remain uncertain. Indeed, according to official statistics from the NHS national surveys bullying & harassment appears to have got worse in the Trust (increasing from 17% of respondents in 2007 to 24% in 2008 and 23% in 2009). As already noted, this may in fact be expected as raising awareness is likely to initially lead to increased (anonymous) disclosures of bullying and harassment in the workplace. A more reliable test of success may therefore be whether people are taking more *action* - thus narrowing the gap between 'felt' (or perceived) and reported incidences. Anecdotally, this does in fact appear to be happening with one official case of bullying and harassment in both 2007 and 2008 and 6 cases in 2009 (figures combined with East Sussex Downs and Weald PCT). It is, of course, impossible to say whether this increase suggests a new trend or is indeed representative but it is corroborated by the second internal questionnaire in which 4/13 (31%) disclosures of bullying and harassment resulted in (unspecified) action. Never-the-less, these are encouraging signs that suggest action, and not just words, is being taken.

6.2.4.3 Bullying & Harassment: defining the problem

There is no evidence to suggest that a particular group or section of the community is being targeted in Hastings and Rother PCT but according to the first internal questionnaire (IQ1), in the majority of cases (82%) the perpetrators were senior to the victim. This figure fell to 65% in the second (IQ2). A detailed analysis has been undertaken by the Trust and some of the key findings are summarised in the appendices (Appendix B3&B4). According to IQ2 bullying and harassment is usually manifested through humiliating, undermining behaviours and verbal abuse but overworking staff is also common. The consequences of this can be devastating leading to low morale, stress and sickness (IQ1). Despite the seriousness of these issues, IQ1 suggests witnesses and victims still felt unable to address the issue with the perpetrator or manager. This

appears to be because they fear reprisals and feel unsupported. *'From all this'* concluded a senior manager *'we realised that it's not a discriminatory issue but a management one, not knowing who to report to and not knowing if they'd do anything'.*

Each focus group and interview in this evaluation started by discussing the nature of bullying & harassment and the consensus was that bullying, by definition, is usually done by someone in a more senior position and, as one participant suggested, the perpetrator usually *'isn't aware that they are doing it'.* Harassment, by way of contrast, relates to the (more often conscious) abuse of someone because of social difference (e.g. gender, race, ability and so on). This distinction is echoed by ACAS which define each separately as follows:

> *Bullying may be characterised as offensive, intimidating, malicious or insulting behaviour, an abuse or misuse of power through means intended to undermine, humiliate, denigrate or injure the recipient.*
>
> *Harassment, in general terms is unwanted conduct affecting the dignity of men and women in the workplace. It may be related to age, sex, race, disability, religion, sexual orientation, nationality or any personal characteristic of the individual, and may be persistent or an isolated incident. The key is that the actions or comments are viewed as demeaning and unacceptable to the recipient.*

Whereas it is not possible to make a legal claim directly about bullying, moreover, complaints can be made under laws covering discrimination and harassment. What the data (national or local) seldom picks up, however, is whether bullying *or* harassment is the issue and, as a result, two distinct problems become conflated and responses become confused. It would perhaps be helpful therefore to start consistently distinguishing between the two as separate issues requiring separate interventions. As already noted, according to data provided by the internal questionnaires, the problem at Hastings & Rother PCT is *not* linked with social divisions within in the workforce (such as gender or race) and so should *not* strictly be regarded as harassment – which in fact seldom seems to occur. Rather, it appears to link with seniority and hierarchy and so constitutes *bullying* – a much more difficult problem to identify and address – either individually or as an organisation.

The workshops, as already stated, tended to focus on (negative and positive) stereotyping particularly regarding traditional male-female roles and attitudes. The more problematic and pernicious issue of *bullying*, by way of contrast, was far less clear. As one senior manager commented, **'***We needed awareness raising about what bullying is, and what it isn't. That's what I hoped Theatre& would deliver and I'm not sure that happened. I think it just muddied the water***.** Indeed, according to some participants Hastings & Rother PCT is in fact a much better place to work than previous organisations – including other PCTs – with respect to *harassment*. The danger then, by focussing on these other issues, however important they may be, is that the real problems faced by the Trust will be overlooked.

6.2.4.4 Causes of Bullying at Hastings & Rother PCT

Given the difficulties defining and interpreting bullying & harassment, which the workshops brought out so well, it has often been suggested during the evaluation process that it is impossible to gauge whether the reporting of it is 'real' or 'imagined'. This is perhaps unimportant as Hastings & Rother is performing poorly *relative* to other PCTs. There are many possible reasons for this but participants of all grades in this evaluation, generally felt it is linked to the merging of two Trusts and restructuring (in 2006) which has led to both a sense of uncertainty, exposure to new work cultures and/or 'different' styles of management *'and when people are asked to do things differently',* a Board member observed, *'then people may feel bullied'*. A senior manager concurred, stating, *'Historically we have allowed pockets of people to think they can do what they want so that when somebody comes in and says you can't do what you want...they can't cope with it and see it as bullying'.*

Again, bullying transcends other (social) divisions and can therefore be more difficult to identify than, for example, sexism or racism. Perceptions of bullying are further clouded by culture. There has been quite a traditional culture at Hastings & Rother PCT, which is, according to one Board member, *'too triangular, giving people the benefit of their wisdom rather than say 'you know your job better than we do. We want you to do your job''.* This is further confounded, as several contributors have pointed out, by on-going organisational pressures (including lack of capacity, financial cuts and structural strain). **'***What drives the perception of bullying is work pressure and the ability of some managers who handle that well and pass that pressure down as opposed to others who others who don't.'*

Certainly poor management styles mask bullying and perhaps make it more likely. It may be that the objectives are perfectly legitimate, therefore, but the way they are both communicated and interpreted is not. Indeed several others felt that people are often appointed inappropriately and with little or no training or understanding of the new environment, for example, when promoted from clinical to non-clinical posts with very different work cultures. As already noted, performance management is not part of the culture at Hastings & Rother PCT and, as a result, there can often be a lack of clarity regarding goals and expectations which if unchecked leads to undue pressure when not 'performing'.

6.2.5 Sustainability

It has been made abundantly clear that the workshops provided an excellent product. They were informative, entertaining and had a high impact value. The workshops are not, however, a replacement for good organisational values and culture. There is a strong case for mandatory attendance at awareness raising/training sessions but these need to be more targeted and tailored programmes designed specifically for the needs of distinct groups of employees directors, senior managers, providers, and so on, rather than mixed audiences which may not only inhibit participation but also demands generic information that may lack relevance.

While nobody expected wholesale change, as already noted above, the workshops acted as 'conversation starters' which have continued into the workplace. A senior manager, for example, has observed a 'ripple effect' as people are now much more conversant:

'you get these circles of conversation which I hear as I walk round. That has kick started some of these conversations and teams have had to moderate their own behaviour and what's right for their behaviour'. It is not just conversations between colleagues that is required, however, but conversations between managers and those whom are managed.

To build on the 'conversation' that *Theatre&* has started appraisal procedures need to be applied much more rigorously and regularly but, as one focus group participant cautioned, this must not become a 'tick box exercise': *'Just by following a format doesn't make it better. It's very easy to hide behind tick boxes. It's about making staff feel valued, understood and having a channel to go somewhere with something'.* To this end, bullying & harassment training should become mandatory for all staff with management responsibilities. This may or may not involve Theatre& but whatever mechanisms are used training must be tailored to reflect the local culture and needs of Hastings & Rother PCT. Evidence from questionnaires, interviews and focus groups strongly suggest that issues of sexism, homophobia, and other forms of discrimination and harassment are not substantive issues in the Trust. The focus should therefore be on improving appraisal systems and communication so that expectations are clear and workers feel valued. Other suggestions for action from IQ2 include:

Train management
Act upon complaints quicker
Raise issue in supervision
Improve communication and listening skills
Make staff feel valued
Senior staff to be aware of when they may come across as bullying
Make bullying training mandatory for all staff at all levels
Identify and define terms
Continue training courses
Reduce hierarchy of staff
Monitor workload to prevent overwork
More 1:1 time to prevent build up of bullying
Make clear guidance more available
Stronger disciplinary procedures
Regular supervision

A programme of sustainability is therefore required that meets the needs of individuals as well as directorates and the Trust as a whole. This is only possible by generating a mature culture of open exchange and dialogue. **'***A strong culture***,'** one Board member observed, **'***has a near equality between the manager and the managed so that there can be a real conversation between the two'.* However, given the traditional culture at Hastings & Rother PCT, much of the (past) re-structuring has been 'top-down' with little regard for the needs, strengths or wishes of the workforce meaning that *'Poor performers were rewarded even if not skilled, and good workers forced into jobs they didn't want because they were more flexible'.* Further restructuring is inevitable and indeed imminent in the PCT and there have been indications that this will be managed differently. One focus group participant had, for example, noticed that communication is getting better in the Trust and recalled a recent Away Day in which the team talked about the coming restructuring and learning from previous experience to put steps in

place now. She added: '*Last week the Chief Exec provided briefing and responded to suggestions made from our Away Day. So there was a dialogue. When I went back to office I heard people complimenting him for being so open... In the last restructure everything came from above. Our Director is trying to get to the bottom of it'.*

6.2.6 Conclusion

Though often viewed as a personal problem, bullying & harassment has consequences for organisations beyond individual victims, perpetrators and even witnesses. Stress, loss of self-confidence and self-esteem caused by bullying & harassment are all well documented but it may be that bullying & harassment is also a marker of a social climate, contributing to illness and absenteeism even if not personally exposed to it[7]. Certainly, ACAS add, job performance is almost always affected and relations in the workplace suffer. Wider consequences may therefore include poor employee relations, low morale, inefficiency and, potentially, the loss of staff[8]. Bullying & harassment is a serious issue affecting *everyone* in the workplace.

It is clear that the *Theatre&* workshops have met the core objective to raise awareness about bullying and harassment within Hastings & Rother PCT. It is also worth noting that the majority of concerns about the workshops raised in this independent evaluation were outside the control and original mandate of *Theatre&* and should not, therefore, reflect on the quality of the product – which was exemplary. It is, for example, unfortunate that more people, especially managers, did not take advantage of the opportunity attend the workshops – particularly senior managers. A greater emphasis on *bullying* (rather than 'harassment') with some scenarios and strategies specific to Hastings & Rother PCT would also have been beneficial.

These issues may have been avoided had more time and dialogue been invested in commissioning and design of the innovation. Clearly a conversation has now started but a programme of sustainability is also needed so that any momentum gained from the workshops is not lost. This indeed seems to be happening already with the promise of less top down decision making, regular and rigorous appraisals and mandatory training for managers.

6. 3 Case Study C: Wave 1 NHS Leicester City and Leicester City Community Health Service Disability Representation – Dis-solution scheme

6.3.1 Context and Resources

This Dis-solution scheme, which is part of Pacesetters wave 2, was intended to address the under-representation of disabled people in Leicester City Community Health Service (LCCHS), a local NHS organisation which comes under the legal umbrella of NHS Leicester City, but is managed and run independently. Less than 1% of employees had a declared disability, far less than the local average. Therefore, working in partnership

[7] Voss M, Floderus B, Diderichsen F (2001) Physical, psychosocial, and organisational factors relative to sickness absence. *Occup Environ Med* 58:178–184.
[8] Bullying and harassment at work (April 2009). Available at www.acas.org.uk.

with a local disability organisation, the Leicestershire Centre for Integrated Living (LCIL), a scheme was developed to offer 12 week voluntary placements within LCCHS for people with disabilities. The administrative placements were intended to provide useful experience for the individual in order to gain sustainable employment within the NHS.

LCCHS (2010; online) state that the organisation: 'want developments in services that will better meet the needs of all sections of the community regardless of their ethnicity, gender, disability, sexual orientation, religion and belief, transgender identity and age' The organisation also states that they value equality, diversity and human rights in all of their actions and seek to promote equal opportunities for all. The aims of the Dis-solution scheme (section 2) are commensurate with these espoused values. The Dis-solution scheme was an initiative of the Human Resources (HR) team at LCCHS. The HR Leader and her team initially secured two-years funding for the scheme, receiving £15,000 from Pacesetters for the first year. However, alternative funding had to be secured for the second year when some of the expected Pacesetters funding was withheld due to budget cut backs. Although the HR team provides support, the project team consists of the HR Manager a HR Assistant/Advisor and the Pacesetters Project Officer. The HR Manager and one of the Assistants are full time members of LCCHS, whilst the Pacesetters Project Officer was involved with numerous Pacesetters schemes within the East Midlands area. When the planned funding for this particular Wave 1 project ran out, the Pacesetter project moved on as planned. A request was made to the Regional Pacesetter team for additional funding to continue the project and build on the lessons learnt. The request was refused but funding was received from other sources as the local chief executive was keen to move forward. However there was a perception locally, albeit erroneously, that was reflected in the action learning sets and in the evaluation trees produced, that a second year of funding had been withheld. The project minutes in February 2010 also made this assertion.

The aims of the scheme were to address the apparent under-representation of disabled people within the workforce. Before implementing the scheme, initial data collection revealed negative managerial attitudes towards the employment of individuals with disabilities. The belief that the time and resource requirements for people with disabilities would be too onerous, or that they were simply unable to undertake meaningful employment was revealed. It was therefore also considered important to address the potentially restricting opinions of managers as a consequence of this scheme. In order to achieve this, disabled individuals would be given placements with a view to sustainable employment within the NHS. It was also an objective to provide greater support for current members of staff to declare existing disabilities. As well as enabling change within the local Leicester area, it was also a desire for wider dissemination of results and experiences, to other areas of the NHS to address national inequalities of under-representation.

6.3.1.1 Aims and objectives

The project has intended short-term outputs, medium and long-term outcomes associated with both the placement individuals and the organisation. They can be summarised as:

Outputs

- Provide work experience opportunities for people with disabilities.
- Improve the skills and confidence of disabled placement individuals to apply for employment opportunities.
- Challenge assumptions of existing management regarding skills and abilities of disabled employees.
- Send out a positive message and help to educate existing workforce.

Medium term Outcomes

- Sustainable employment for the individual.
- Increased application from people with disabilities.

Long term Outcomes

- Increased representation of disabled people within the workforce.
- Increased dissemination of the scheme's impact with help of support organisations.
- Improved skills of front-line staff when treating patients with disabilities.
- Incorporation of lessons learnt into mainstream workforce strategy.

The above information is also illustrated on the logic tree model (appendix C1) as buds (short-term outputs), apples (mid- term outcomes) and apple pies (longer-term outcomes).

6.3.2 Project Mechanisms

6.3.2.1 Project Processes

Two phases of placements were provided between June 2009 and April 2010. The scheme was initiated with a questionnaire that was posted to staff members. Although there was a poor response rate, it did reveal certain negative perceptions and attitudes towards employing people with disabilities. The consistent beliefs centred on the ideas that employing individuals with disabilities would result in greatly increased complexity, or that they were simply unsuitable for employment. Such taken-for-granted assumptions were considered barriers to increasing the representation of disabled employees.
An initial information workshop for managers and the senior management team was followed by an open-day for candidates. This was designed to promote the scheme to interested parties and reassure them as to the continued support of the HR team during the placement. Managers who wanted to offer a placement opportunity were then required to create a brief job description for the position. HR then interviewed a number of potential candidates based on general selection criteria, such as information

technology skills and previous experience of working in administration. Selection criteria were identified in order to maintain a level playing field, with a belief that positions should not be awarded unless the candidate demonstrated desirable skills and qualities. Successful candidates were then provided with a list of all of the available positions and asked to select their preferred three roles. HR then placed the participants in a position, aiming to offer a preferred option to all participants.
An immediate consequence of allowing successful candidates to self-select the role they wanted to experience was that most participants selected the same opportunity. After discussing the reasoning behind their choices, it became apparent that the rationale was one of location. The central Leicester site was the preferred choice for most as it was the most convenient location for transport links. This could have potentially reduced the potential success of an explicit aim of the scheme; that of providing practical work experience for the participants.

However, the first phase of placement individuals commenced throughout June and July 2009 and located the 5 successful participants a placement opportunity within the organisation. All placement participants established objectives with the support of their manager for the duration of the placement. Learning logs were maintained by the individuals and a fortnightly video diary entry was made to record the experiences of both participant and their line manager. A buddy-system also provided further support for the participants. The 'buddy' is a volunteer employee, responsible to offer individual support in relation to locating employment opportunities within the NHS and offering a personal point of contact. Support is maintained after completion of the placement, with the organisation and 'buddy' offering continued assistance with the search for employment.

The second phase of 5 placements commenced in January 2010, albeit with an altered selection process. Following learning from the first phase, existing opportunities were again identified by line managers and interviews for candidates were conducted by the HR team. However, unlike the first cohort, successful candidates were not provided with the opportunity to select their preferred position. Rather, individual candidates were placed against the particular requirements of the job description. However, issues such as site-suitability (for example, accessibility for certain disabilities) and transportation requirements were also considered. These decisions were made to offer both the participant and their respective NHS department improvements in terms of matching skills against specific requirements.

Associations with local and national charities and supporting agencies, such as Vista and Action Deafness have provided further support to the participants and their managers. The provision of British Sign Language assistance and specialist equipment has served to educate existing organisational members as to the support available for people with disabilities.

Action learning sets were conducted during the second phase of placements. It was decided that owing to the first phase of participants approaching the completion of their placements, this group was not to be included within the sets. The first action learning set took place during the second week of placements. Three action learning were completed in total (one each month of placement) to capture and evaluate the experiences of those participants involved. Upon completion of the placement,

interviews with a number of placement participants were conducted to complement this material. Finally, an interview with the HR Manager was conducted over the telephone on the 12th July, in order to further consider the extent of impact and sustainability of the scheme.

6.3.3. The Evaluation Process

As indicated, key stakeholders have been included within the design and implementation of the evaluation of this scheme from its initiation. The project lead (Head of HR) attended the LJMU orientation event in August 2009 and along with the two other members of the project team has continued to be heavily involved in the evaluation. A further meeting between the LJMU evaluator, the Head of HR and the lead HR Assistant was conducted on the 18th of September in order to meet and again communicate the nature of the sets.

The first action learning set was held on the 4th February, facilitated by the external evaluator. Set members included 4 placement individuals, their 4 line managers, the project lead for East Midlands Pacesetters, the Pacesetters Project Officer and 2 HR Assistants/Advisors. Although 13 members (including facilitator but not interpreter) could be considered a large number for a viable set, it was considered that in order to hear the experiences of those involved such numbers were required, at least in the initial set meeting. The first set meeting provided an opportunity for members of the organisation to understand the nature of the evaluation and also meet one another for perhaps the first time. This was a valuable exercise as initial issues, expectations, experiences and barriers were discussed.

The second set meeting took place on the 4th March and was attended by 3 placement individuals, the same 4 line managers, 2 HR Advisors and a further 2 HR Advisors that were attending in their role as 'buddies' to the placements. This meeting allowed for the issue of evaluation criteria to be explored further, whilst the final meeting provided a further opportunity to consider and evaluate the intended outputs and outcomes of the scheme and ultimately summarise the process involved in the action learning sets.
The final action learning set was conducted on the 1st of April and was attended by 4 placement individuals, 3 line managers, the Pacesetters Project Officer, 1 HR advisors and a further 4 HR advisors that were attending in their role as 'buddies' to the placement participants. This final set meeting coincided with the completion of the placements. To recognise the achievements of the participants and to encourage other managers to become involved in the scheme, an awards ceremony was held (as it was at the conclusion of the first phase). All placement participants received certification of their time within LCCHS and a number of them spoke to the group about their experiences. Furthermore, a number of line managers and team members also spoke about their own experiences working with someone with a disability. This meeting was also attended by the Chief Executive Officer of the health service and other members of senior management.

6.3.4 Challenges and barriers to the evaluation process

When the evaluation project commenced, the first phase of placements was approaching their conclusion. Therefore, owing to the short term nature of the placements, it was considered by all parties that action learning sets would begin with the intake of the second phase. This allowed for appreciation of how participants' expectations and experiences have changed over time.

The attendance at the action learning sets has had some slight variation owing to sickness and other commitments. Furthermore, during the first set a challenge was experienced that could be considered symptomatic of issues experienced by some of the placement individuals. Initially, the regular British Sing Language interpreter could not be booked for the session. Therefore alternative arrangements were made. However, it was commented upon by the two members with hearing impairments that this created some issues in terms of unfamiliarity and style. To further compound the challenge, the interpreter was scheduled to leave the set prior to the end. Another interpreter arrived to replace them, but immediately stated he would have to leave due to illness. The result of this challenge was that the first set had to be brought to a somewhat premature end, owing to the exclusion from discussion of those with hearing difficulties.

6.3.5. Project Outcomes

6.3.5.1 Improved Internal Attitudes and Awareness

The baseline survey of managerial attitudes towards employing people with disabilities identified the misconceptions related to the ability to undertake the position and the added complexity of associated demands. Such beliefs can be considered an immediate barrier to the intended outcome of increasing representation of people with disabilities. The provision of employment opportunities was intended to overcome such stigmas. Providing managers with a volunteer placement to undertake necessary tasks immediately removed obstacles to the engagement of some managers. The assurance of continued support from the HR department can also be considered to have reduced some of the potential opposition. Indeed, managers were assured that if the participant were to prove unable to undertake the necessary tasks, the HR team would re-place them.

The challenging of taken-for-granted assumptions was essential to the continuation of this project. One line manager commented that the scheme had required her to consider the way she communicated with members of her team. Although suggesting it required a small increase in time initially; *"At first you think it's difficult to change what you do. It's not; it's just the way you do it."* For example, the installation of JAWS (screen reading software) or voice recordings enabled effective communication that removed the need for hand written instructions to provide information to a visually impaired individual. The support offered by HR and other organisations such as Access to Work, Vista and Action Deafness improved managerial awareness (including the HR team) of the support infrastructures available for disabled individuals to access work. This learning reduced the stigma associated with the employment of people with disabilities. During the final action learning set, the same participant who had previously stated that the difficulties associated with change are less than perceived, also commented that; *"You have to commit the time to find the right way to get it done*." It was asserted that

although there are additional time requirements, this is not the fault of the individual with a disability. Furthermore, the HR Manager also commented that after a relatively short amount of time, *"the disability becomes insignificant"* as the individuals and their teams adapt to the situation.

Additionally, for the majority of participants, the work being undertaken was not necessarily new. All participants had undertaken placements in other organisations (such as Vista and RNID), and although requiring new ways of doing tasks, most demands were met without concern. The realisation that the majority of participants have relevant work experience did go some way to appease the concerns of managers regarding the ability to undertake administrative roles.

6.3.5.2 Meaningful Work Experience

The placements offered had to provide meaningful employment to candidates, with the HR team insisting that placements would only be available for positions that offered more than menial tasks. Therefore greater inclusion within departments has resulted in the situation whereby the participants were accepted as an active team member. Unlike previous placement experiences in other organisations, all participants passionately discussed their belief that they had been truly included in their respective departments. Each participant was aware of their position within a large and complex organisation and how their work impacted on other departments.

Placements were not being used merely as an inexpensive means of fulfilling basic tasks that others did not want to complete. Instead, participants were viewed as valuable team players who could provide benefits to the department they worked for and the organisation at large. This has been demonstrated by one participant being utilised by other departments when her workload has provided opportunities to do so and another being heavily involved in a project to resolve an issue regarding parking between staff and a local community.

There were however barriers, to the success of the placement. Some supporting infrastructure was initially restrictive to the needs of the participants and required adapting. Evaluations by Access to Work identified the requirements of each individual, although some I.T. software has proven more difficult to implement than others. The requirements of each individual could not be predicted in full prior to commencing the placement. However, such delays in implementation have resulted in lost opportunities for the individual and organisation. It was considered that such delays can often impact upon new employees within the organisation. However, this issue is more acute for those with disabilities.

Certain I.T. facilities can adversely affect the experiences of both placement participants and managers. Considering both existing and potential employees, this situation is most profound for people with visual impairments. Believing that *the "software was still not up to scratch for visual impairment,"* led to the statement from one manager that it*; "made me feel bad that we couldn't help* [the participant]." It could be considered that such practical difficulties have the potential to reinforce the previously considered issue of managerial stigma, associated with employment of people with disabilities.

It would therefore appear that some processes are not disability-friendly, although it was considered that the majority of information systems could be addressed to conform to the requirements of the users. However, the use of touch-screen photocopiers was discussed by the participant with visual impairment as something which had not been adapted during her placement. The small screen on the photocopier prevented the participant from being able to independently use the machines, instead requiring someone else to effectively programme the machines for each use. The lack of networked machines was cited as restrictive towards improvements.

It was the belief amongst some members that this was one issue that could not be resolved locally. However, a further member suggested speaking directly to the supplier of the machines, to ascertain the potential of adapting current machines. This served as a final action point for a member of the group and such commentary demonstrates the inherent potential for involvement of individuals and groups, resonating with the rationale of action learning. At the time of writing the line manager had called the supplier and was awaiting a response, which does suggest that such services may not be as readily available as first hoped.

In order to address the specific I.T. related concerns, it was considered that the I.T. department should be involved from the start of placements and also more widely in the context of ensuring accessibility of existing and new systems. It was also understood that owing to the voluntary nature of the placements, services and funding such as that from Access to Work was restricted. If disabled people were employed, additional support would also be available.

To address the reduced opportunities, owing to a lack of supportive systems being in place, placements were extended by two weeks to compensate. This additional time requirement is now to be factored into the placements of future participants, providing them and their teams with sufficient time to realise the potential.
Similar to the requirement for increased I.T. resources, was the unfortunate situation during the first phase of placements where resources had to be shared across two placements. For example, at certain times a British Sign Language interpreter could not be identified for the two participants with hearing difficulties. Realisation of such a potential barrier was incorporated into the decision making process when considering the second phase of placements. Additionally, it was also commented upon that some buildings within the local NHS were not fully compatible for disabled access. Although a legal requirement, older buildings were often unsuitable and as such when matching a candidate to an opportunity, it was necessary to consider the physical practicalities and the potential for any reasonable adjustments.

It would appear that the current operating systems of the NHS are not fully compatible with the needs of varied disabilities. It is therefore necessary in the short term to ensure that appropriate supporting services are included within the design of projects that address under-representation and that current capacity and resources are factored into decision making. In the longer term, there is an apparent need to address these shortcomings with the design of systems that are better able to provide the necessary services that adhere to the requirements for equality, diversity and human rights in all LCCHS activities. Improved understanding and knowledge of supporting services also

need to be shared within the NHS. This would again provide potential benefits in terms of reducing managerial stigma and reluctance to employ those with disabilities.

The Dis-solution scheme may be positively impacting the lives of those immediately involved. However, extension and replication of the benefits is only feasible within the current constraints of NHS culture and operating procedures. It was considered by one line manager that the values of Pacesetters are consistent with those of the NHS. However, within an organisation of such complexity it was also suggested by the action learning set participants that operational requirements can often conflict with motivations associated with well-being. Even such issues as the availability of I.T. software was subject to their 'fit' within the broader NHS systems, and as such could result in the denial of essential systems. One participant considered that; "as an organisation, we should start with how accessible we are." This normative approach was posited in contrast to the practical experience of some and was believed to "contradict national and local NHS policies." The inherent value of the DH and the NHS surrounding the 'better health and well-being for all' (DH, 2010; online), was often perceived to *"conflict with operational issues."*

LCCHS is also recognised as a two-tick employer by Jobcentre Plus, whereby people with disabilities who meet minimum criterion will be interviewed for vacancies and if successful, are supported in their development. The HR Manager commented that where necessary, reasonable adjustments are required to create a "level playing field." Additionally, during the awards ceremony at the conclusion of the placements, the HR Associate Director commented that it is the responsibility of the NHS to provide *"jobs that they* [participants] *want, with a future they deserve."* Such commentary provides direct synergies with the values and objectives of health care provision, whilst the Chief Executive Officer also commented that whilst the NHS has values, *"what we don't do well is engage with the community."* The Dis-solution scheme appears to provide this linkage between the NHS and the 'community.' Indeed the active engagement of supporting agencies appears to have allowed for greater realisation of participant potential. The HR Manager commented that specialist support agencies *"get excited"* when someone wants to help people in their interest group. It was believed that the sharing of project plans and discussion with groups such as Vista, Action Deafness and RNIB had fostered a greater understanding of the aims and objectives of the scheme. Similarly, internal stakeholders have been informed through staff briefings, newsletters and open events.

6.3.5.3 Sustainable Employment and Increased Representation

When the Dis-solution scheme was initially conceived, the general UK economy was in a far healthier position. The HR Manager believed that all of the participants that demonstrated the sufficient requirements would be absorbed within the NHS. However, at the conclusion of the placements, the situation was far bleaker. Restrictions in public spending had created a freeze on new employment within the NHS.
This has resulted in the situation whereby participants were being supported in their search for alternative employment, whereby 'buddies' would help identify and apply for positions that were suitable. This has resulted in employment for two individuals (one with Action Deafness, one of the supporting organisations) and a further participant has entered into full time education. Although the initial desire was to employ all successful

participants, the improved opportunities for some are apparent. Furthermore, participants regularly spoke of their improved confidence and skill sets, providing advantages to the search for further employment.

An additional and somewhat unintended consequence of the freeze on employment has been the creation of an administrative 'job bank.' All willing participants are included on this list that provides a 'bank' of potential administrative employees, utilised to identify candidates for short-term opportunities, instead of using more expensive agency staff. Inclusion within the 'bank' can be considered a 'foot in the door' of the NHS, and as such it is hoped that all participants will sign up, with the assistance of their 'buddies.' Indeed, the HR Manager reported that the entire previous cohort had registered with the bank, and some had already received paid short-term work opportunities. The HR Manager commented that owing to the overwhelming belief in the participant's abilities, her department were publicising these people to other members of the NHS. Representation and the associated increase in applications from people with disabilities was undoubtedly impacted upon by external forces. However, a recent validation of employee's personal details has revealed an increase in representation from under 1% to around 8%. This is a considerable increase that cannot solely be attributed to the Pacesetters project. However, the increase in self-declaration is significant and can be assumed to have been influenced to some extent by the work of the HR team in providing support and education to existing employees.

6.3.5.4 Dissemination and Sharing of Experiences

As stated, at the end of each placement there was an awards ceremony held to reward the participants. This also served as a means of sharing experiences with other interested managers. Participants, their team members and managers provided honest and encouraging commentary of their time with the participant. The overwhelming sense of successful placements also resulted in the assurance from the Chief Executive Officer that funding would be found to continue the scheme. Extending from the Dis-solution scheme and addressing a longer term objective is the imminent inclusion of key lessons within the Human Resources and Equality and Diversity Strategy documents. Such actions were considered to provide the potential to sustain and extend the activities within LCCHS and beyond within the wider structure of the NHS.

Lessons learnt by the HR team as a result of the Dis-solution scheme have also been disseminated by inclusion within the Department of Health publication, 'Pacesetters; Look beneath the surface and change the way we think.' A further consequence of this scheme was the invitation for the HR Manager to present at the Health at Work conference in Birmingham and the Leading Workforce Conference for all Strategic Health Authorities (SHAs).

The sharing of experiences was considered a key criterion for the sustainability and extension of the project. The demonstration of results aligns with the explicit belief of the NHS that; 'The NHS is rich in examples of good practice and learning and we're committed to helping trusts share this information' (NHS employers, 2010; online).

6.3.6 Unintended outcomes

6.3.6.1 Learning opportunities

As well as those intended aims and outcomes, certain additional outcomes have been observed. Although improvement to front-line employees' ability to deal with patients with disabilities was stated as a desired long-term outcome, other members of staff have exhibited such traits. Members of the HR team who are acting as 'buddies' during this phase of the scheme have indicated that they are learning British Sign Language as a means of improving communication with new colleagues. Similarly, the HR Manager commented that such experiences will help to; *"give insight to own staff of the day to day challenges,"* relating to those people with disabilities.

Another learning opportunity that was discussed concerns the ability of the participant to provide assistance to existing NHS employees. The capability of one administrative assistant to use keyboard shortcuts on Microsoft has provided her line manager with (relatively small) potential efficiency improvements. The same line manager spoke passionately at the awards ceremony regarding the benefits of having the participant within her department and fully endorsed the scheme to other managers in attendance. Additionally, she commented upon personal improvements to her ability to delegate and communicate with staff, as well as having a greater understanding of others' needs.

Additionally, the HR Manager believed that the employee participation had been "quite instrumental" in creating the benefits of the scheme. The regular use of video diaries by both participants and line managers provided the opportunity for the HR team to review the process between cohorts and identify areas for improvement. This process is to be repeated for the whole process and is intended to *"make it a lean process,"* whilst not reducing the quality of the scheme.

The creation of learning opportunities for existing members of staff has been facilitated by the inclusive nature of the placements. Daily interaction between participants and employees, working together as a team has resulted in mutually beneficial results that could also benefit the patients which the NHS serves.

6.3.7 Life after the project – sustainability

The ultimate aim of the Dis-solution scheme was articulated as the increased representation of disabled people within the workforce. This will ultimately be the test of the success of this scheme.

Central to the sustainability of the scheme is the continued support of managers within the NHS Leicester City and Leicester City Community Health Service. The nature of the scheme is such that it requires managers to identify a suitable position within the organisation, and if no placement were made available, this barrier could prove a limiting factor to the success and sustainability of the initiative. Central too is the passion and commitment of those involved in the planning of the scheme. The enthusiasm and passion of the Project and HR teams has consistently been

demonstrated and in conjunction with senior management support, the focus of the Dis-solution scheme has not been lost or reduced over time. Inclusion of lessons learnt within Human Resources and Equality and Diversity Strategy documents also exhibits commitment to sustain the benefits associated with the scheme.

Furthermore, the participation and connections with numerous individuals and groups can be considered essential for the sustained benefits of the scheme. This has resulted in the sharing of experiences, which could ultimately extend and sustain the overall impact and change upon stakeholder's lives.

The Dis-solution scheme requires relatively little financial support, although without it the scheme clearly has no sustainable future. As stated, Pacesetters funding was initially granted for two years. However, the drive and passion of the HR team again ensured its continued success. Indeed, the HR Manager commented that *"commitment and passion"* were more important than funding. Clearly such a situation could have resulted in the closure of the scheme were it not for the role of the HR Management. It became the mission of the HR team to sustain their effort for the local community. Therefore, instead of simply giving up, the sustainability of the scheme has been ensured by gaining new funding as part of a Public Service Agreement (PSA) 16. This does however entail some alterations to the initiative, with a focus on mental health rather than physical disability. Therefore, the future selection of participants will attempt to target 50% of placement opportunities for those individuals with mental health or learning disability issues. Again the necessity of committed and passionate management is exemplified by such assertions.

The HR Manager sees the scheme and its approach as fundamentally in accordance with the 'fairness' that underpins the NHS as well as a desire *"maximise people's potential."* However the challenges the scheme has faced demonstrate that there can be a conflict between strategic values and operational demands.

Even with the extension to the project, it is important to consider the key themes and lessons that have been learnt in order to replicate the benefits of the scheme and reduce the potential barriers to success for this and future workforce projects. At the initial meeting in London in September 2009, the HR Manager was asked to consider the Dis-solution scheme in relation to a metaphorical vehicle. The response was the idea that it was a carnival style float. Asked to reflect upon this in July 2010, the HR Manager believed that this was still the best analogy, as it aligned with the desire to showcase and highlight people's skills and share with others at every opportunity the benefits of the scheme. However, as expected, participants' expectations have changed over time. At the initial orientation meeting (September 2009), the Project Lead created the logic tree model (Appendix C1) that identified potential barriers and challenges (acid rain) to the project. This process was repeated on the date of the last set meeting to consider how expectations have altered over time.

The initial logic tree illustrates how the external support of LCIL and other supporting agencies was considered important during the initial phase of implementation. Internal requirements of leadership, commitment and funding are considered equally significant in the creation of short, medium and long term objectives.

In July 2010 the logic tree model was repeated. Appendix C2 illustrates the reviewed diagram, with a number of alterations. Significantly, there are a number of further potential barriers and challenges that have been identified. In addition to the changing organisational structure, it was considered that the economic downturn and the resultant freeze on employment had prevented the realisation of sustainable employment for the participants within the NHS. Similarly, the restrictive IT support systems were identified as potential restrictive. Further, the idea of challenging partners is included to signify the issues the project team had with LCIL, the original external partner to the scheme. Initially it was hoped that LCIL would be an important partner in the exercise. However, early within the scheme, it was reported that they were not able, or willing to deliver what was hoped. This has been seen as a learning opportunity for the project team, who will in future be less inclined to provide finances to organisations without greater assurances. Although a somewhat negative experience, the overall experience with supporting agencies in general has been one of success. The association with groups such as Action Deafness and the RNIB has the potential to benefit the project team and wider organisation in the future. A final additional raindrop relates to the withdrawn Pacesetters funding. As highlighted this had the potential to derail the Dis-solution scheme, if it were not for alternative funding being sourced by enthused and passionate individuals and teams.

During discussions the passion and enthusiasm of the project and HR teams was emphasised as important enablers of the scheme. Both groups have therefore been included as additional sunrays to the logic tree. Furthermore, the original Pacesetters funding was also considered instrumental to enable the scheme. The Board champion has remained as an enabler, although owing to changing organisational structures, the original champion is now less involved in the scheme.

As illustrated, the relationship with the original external partner, LCIL did not result in the desired outcomes. LCIL have therefore been removed as a resource necessary for the scheme. However, the importance of the other support groups is even more significant than first envisaged.

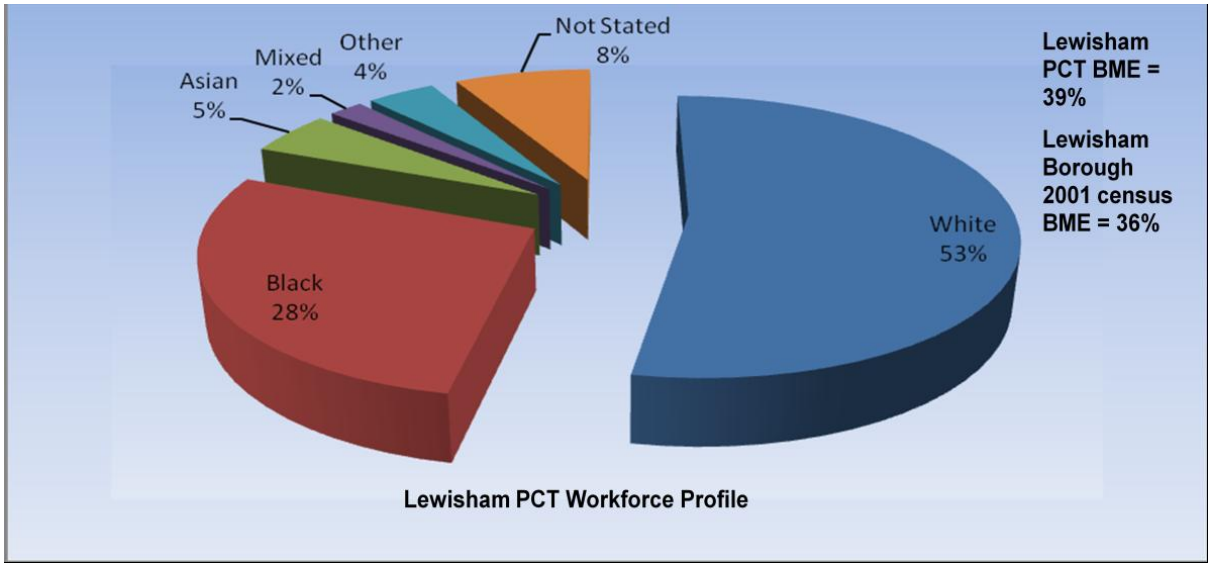
The final alteration to the logic tree resulted in the inclusion of the validation exercise as an activity (tree trunk) that is part of the scheme. This activity was essential for the realisation of increasing representation of disabled people within the workforce. The increase from under 1% to approximately 8% was revealed as a result of this undertaking. As previously highlighted, it is difficult to claim that the Dis-solution scheme is solely responsible for such a dramatic change. However, it is reasonable to assert that the scheme can be attributed with some of this change.
No alterations were made to the short term outputs or longer term outcomes. Even though objectives such as the increased representation of disabled people in the workforce and an increase in disabled applicants have been severely impacted upon by external forces, they remain long term ambitions of the HR and project teams.

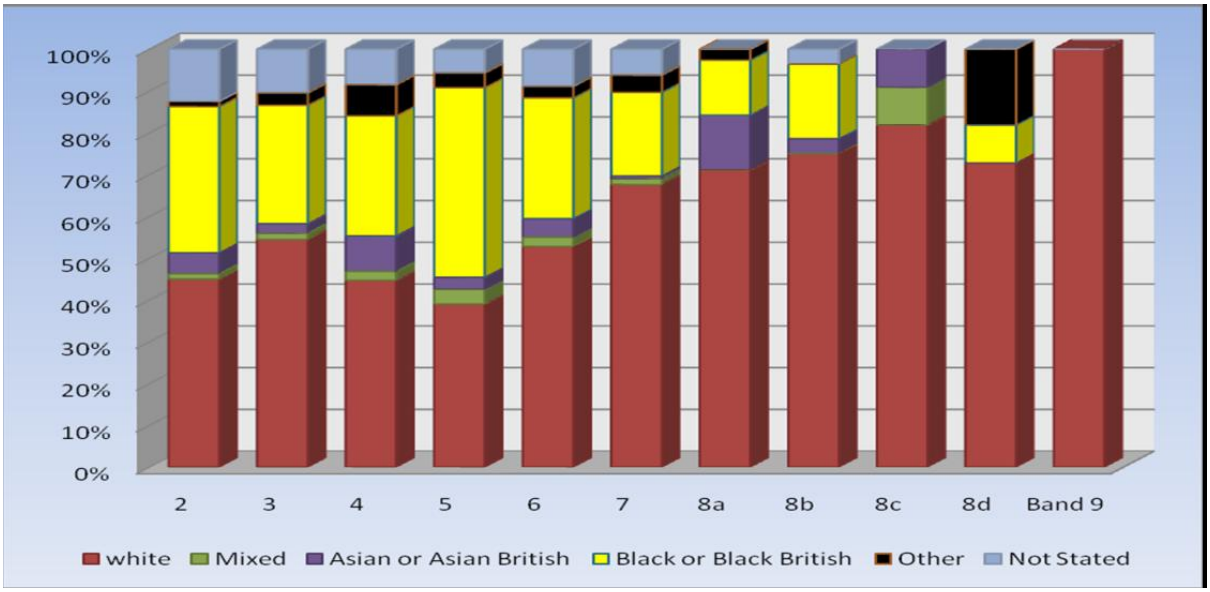
6. 4 Case Study D: Wave 2 Lewisham PCT BME Representation

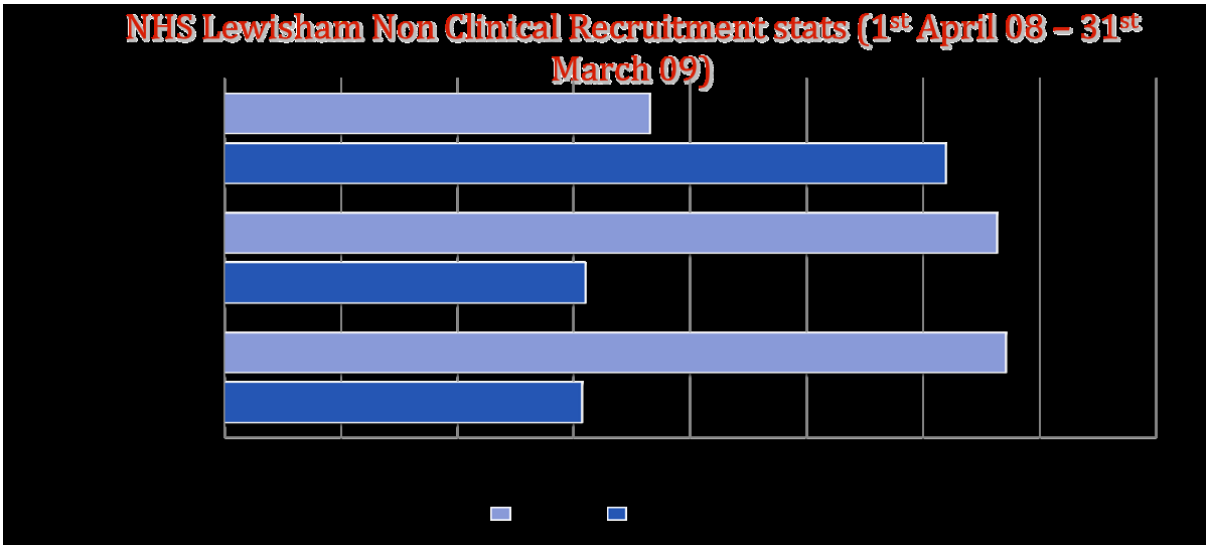
6.4.1 Context

This is a Pacesetters workforce wave 2 project addressing the problems of low representation of BME staff within Lewisham PCT, with a focus on band 7 admin and clerical (Junior management level) and above. Local baseline data was collected by the project lead who reviewed 100 recruitment files showing outcomes of interviews in 2008 in Lewisham PCT and identifying a sample of 20 as case studies for a more in depth study. The data further revealed that BME job applicants tended to score very poorly within the personal qualities scoring criteria (ability to present and communicate) in comparison to their white counterparts. It was also noted that many of the 74 other London trusts shared a similar pattern of data. This insight is revealing given the claim from one of the project stakeholders that many of these applicants would already be working in the community in Lewisham with people from BME backgrounds, possibly sharing similarities in terms of culture and language. The data indicated that whilst people from BME backgrounds were applying for jobs (internal and external) and reaching the interview stage a disproportionate number were not being appointed after interview.

This under-representation of BME staff particularly at higher levels of the organisation is also reflected in national data included in the Health Care Commissions,' 'Tackling the challenge' report', 2009 which states that, '...staff from minority ethnic groups constitute around 16% of the total workforce...but fewer than 1% of CEO's are from a similar background (p. 5). Such evidence is even more compelling taking into account Lewisham's' demographic and political context – that of a multi-racial borough of South East London with a BME population of 40% and an area which has historically been a 'pioneering Local Authority where race has always been on the agenda and on the radar of the commissioners' (Pacesetters Programme Manager). The figures below (compiled by the Pacesetters Programme Manager to share as part of a lunchtime seminar (Appendix D1) about the work of Pacesetters within Lewisham) outline local research findings.







Initial key drivers for the project can be seen within the context of Lewisham PCT's Corporate Equalities Group's commitment to promote race equality in the workforce and the desire for Lewisham PCT to be an employer reflective of the local community. One project stakeholder made the point that the Trust was 'brave' to ...'come out and admit there was a problem ....we are offering positive opportunities ...they (Lewisham) don't have to do this, certainly no other trusts are doing this....' There are clear links between this project as part of a much bigger focus around inequalities and Lewisham PCT's wider values and priorities, particularly concerning race inequality. These are reflected in the SES (Single Equalities Scheme) 'As a public body, Lewisham PCT has a duty to eliminate discrimination and promote equality across all of its functions, including the delivery of its services and its employment practices...as part of this duty, we are required to develop equality schemes - documents that outline what actions we will take to ensure that individuals, communities and staff are treated equitably.' Priorities identified within the SES as areas the PCT needs to make the most progress over the next 3 years are:

- Supporting targeted action on health inequalities

- Embedding Equality Impact Assessment
- Commissioning for equity
- Improving equalities data collection
- Ensuring equality in recruitment, retention and progression
- Building staff capacity
- Consulting and engaging our communities

6.3.1.1 Organisational structure and resources

Initial responsibility for the project lay with one of the HR managers based in Lewisham PCT who had an interest in recruitment practices and BME representation. He had been conducting some research as part of his self-funded MA dissertation around BME under-representation using Lewisham NHS as a case study. He was supported by the Pacesetters programme manager who was part of the Corporate Equalities Group and employed part-time in an equality and diversity role. She took an active involvement in the project processes and practices. Both the project lead and programme manager welcomed the flexibility and trust they were given to plan and deliver the project. The project was under the strategic remit of the overall Pacesetters lead for workforce development. Members of the BME forum (initially established to take the project work forward) provided invaluable resources in terms of ongoing support and commitment regarding the early project interventions. The BME forum had two champions from senior management who supported the work of the Forum and helped to further the project work. Further into the project 2 external consultants were responsible for resourcing a third intervention.
In April 2010 there were a number of organisational changes within Lewisham culminating in the majority of the NHS Lewisham HR department, including the project lead TUPE (transfer of undertaking and protection of employment) to Lewisham Hospital (now Lewisham Healthcare**)**. This meant that the current HR department would effectively transfer to the Hospital. The project still remained under the ownership of NHS Lewisham and under the remit of the overall Pacesetters workforce lead. The Pacesetters element was only agreed on 2nd June after an 8 week delay and an SLA was set up agreeing the level and amount of support the project lead could now provide to the project interventions. The Pacesetters project moved to become a joint commissioner and provider activity. Therefore employees (and prospective employees) from both organisations would be afforded the opportunity to access all the project interventions. The Provider was to supply administrative and professional support to the Pacesetter Project up to the initial project end due in October 2010 with the project lead taking more of a co-ordinated approach. This support was to include: the finalisation of intervention 1 - Interview gold and assistance in the co-ordination of interventions 2 - Performance Coaching (Appendix D2) and intervention 3 - interview panel behaviour (Appendix D3).

6.3.1.2 Project Aims, Objectives and intended outcomes

The aim of the project is to increase BME representation in the workforce Lewisham at all bands within admin and clerical fields, with particular emphasis to bands 7+ (management/junior management).

The key objectives were:

- To enable BME staff within the PCT to formulate interventions to promote equality in employment for BME population in Lewisham
- To ascertain the current practice within Lewisham PCT with respect to BME non clinical recruitment and selection
- To measure the effectiveness of models and frameworks available to support best practice in the field of BME recruitment and selection at the local level
- To formulate recommendations that can be implemented to proactively recruit BME non clinical applicants

In order to achieve these objectives Lewisham adopted a two pronged approach focussing on:

1. Capacity building of staff
2. Changing organisational culture

The initial focus concentrated on two interventions aimed at building capacity with both internal and external BME job applicants. This type of approach has recently been advocated in the, 'Tackling the challenge' report, 2009 with trusts being encouraged to ensure that, 'staffs from minority ethnic groups are offered opportunities for personal development to address under-representation in senior roles....and are targeted where appropriate.' (p. 29 and 30). A third intervention was introduced in the latter stages of the project focussing on organisational culture and practices. This was supported by the corporate equalities group to not, 'purely focus on doing small things and testing them' and centred on work around recruitment panels in terms of recruitment behaviours and decision making. The desire was to tackle things in the organisation on a 'wider and deeper level' which would need to include capacity building for recruitment and selection practice, as well as for line management.

6.4.2 Project mechanisms and activities

6.4.2.1 Co-design of the project and BME engagement

A key element and strength of the project was the process of co-design and staff participation. The setting up of a BME forum was one of the first project activities. BME Forum membership included both provider and commissioner staff from various bandings and professions but consisted primarily of clinical staff. Once the Forum had been established it was to be involved in active decision making regarding choice of project interventions and taking the project work forward.

At the first BME Forum meeting which the evaluator also attended the project lead presented his local research data. At this key meeting previous statistical data was

strengthened with more anecdotal qualitative evidence from BME staff attending, who shared their experiences as BME workers occupying a range of different roles/positions within the organisation. The BME forum has gone on to meet bi-monthly and has consistently participated in decision making regarding project interventions. It has been useful for the evaluator to have had the opportunity to attend 3 of these meetings in the early stages of project decision making to take account of the processes and mechanisms involved.

The forum consists currently of around 28 BME staff members. Whilst the forum is an open staff group with different staff attending each meeting there has been a consistent core group attending who have taken a more productive role.

The BME Forum soon began to grow in membership and influence locally. To some extent it has become an intervention in its own right and as time went on became a more organised self-facilitating group. Around April 2010 after the election of some Forum members to key roles a decision was made for the Project lead to withdraw from facilitating the Forum itself. The group would be involved with influencing and input into wider BME/race equality related issues within a broader context with a smaller core group making up part of the action learning set required for the ongoing evaluation of the Pacesetters project. Work has continued around locally publicising the BME Forum and project work with regular briefing pieces going out to a wide audience via a staff communications email and a staff newsletter (Appendix D4; Appendix D5). The Pacesetters Programme manager delivered an in-house seminar (Appendix D1) to inform staff about the Pacesetters programme. 21 BME Forum members have been supported to attend the national BME staff conference. Some members are now keen to link in more formally to the national forum strategies.

A key discussion point currently for the Forum is the impact of the current organisational changes in Lewisham on Forum membership, resources and priorities. Many Forum members have or are likely to move effectively to a different employer in a different location. Important decisions will need to be made as to whether the Forum should try and retain independence, be affiliated to, merge with or collaborate on certain areas with staff based at Lewisham Healthcare, the provider side of the organisation.

6.4.2.2 Co-design and evaluation

The evaluator attended three BME Forum meetings and two action learning sets. The decision was made after the first BME forum to hold action learning sets directly after the BME forum meetings. The first three meetings focused initially on decision making around project activities, review of project progress and discussions around project aims and objectives. An evaluation "tree" was partially completed on the second meeting (Appendix D6). At the third meeting decisions were still being made about project interventions and it was clear that the rising numbers of the BME forum and its unanticipated growth made it difficult to conduct action learning sets in the current format. A number of core but also different members attended each meeting and the vision had widened the focus to work outside the project remit. It was clear that newer members weren't familiar with the project remit and valuable time was lost without progress around reflections and learning being made. As a consequence of this a much

smaller and focussed action learning set was planned for subsequent meetings with key stakeholders attending including representatives from the BME Forum, the Pacesetters programme manager and project lead and external consultants delivering the third intervention. Around July and September 2010 individual interviews also took place with the Pacesetters programme manager, project lead and CEO of Lewisham PCT. Questionnaires were emailed out to BME Forum members to collect additional evidence.

6.4.2.3 Capacity building of staff - internal and external BME job applicants

As referred to previously, the key initial agreed project focus was on increasing BME job applicants' capacity and providing personal development opportunities for current BME staff at band 7. The BME Forum participated in the tendering process to identify two organisations to deliver intervention on these areas.

Intervention 1

Online interview support for internal and external BME candidates shortlisted for interview for positions at band 7 and above began in January 2010 provided by 'Interview Gold'. Fewer interviewees than originally expected have used this support due to the interruption caused by the 'job freeze' in Lewisham taking place over several months within NHS Lewisham. However, it is anticipated that all 100 licenses will be used by the project end.

Intervention 2

Performance Coaching International was selected to provide coaching to BME staff from NHS Lewisham and Lewisham Primary Care Trust Community Health Services with respect to career progression. It offered their DART programme, a '90 day coaching programme incorporating workshops, one to one coaching, email and telephone support, giving participants an opportunity to gain coaching skills to support and lead others in the workplace and experience being coached themselves.' This intervention was scheduled to be launched in March 2010 but was also postponed due to the organisational changes taking place, particularly around project lead responsibility. Initially the BME Forum voted almost unanimously to focus the intervention on their group which consisted predominantly of clinical staff. However, a decision has been made by the overall Pacesetters project lead to direct the intervention to admin and clerical staff as reflected in the original project aims. The remit was broadened to include staff at band 6 due to the initial low take up from band 7 staff. The organisational changes have also meant that staff from all areas of the organisation will have the opportunity to participate.

6.4.2.4 Tackling organisational barriers and practices: Capacity building for senior manager recruitment panels

Intervention 3 – changing organisational culture by enhancing Interviewing Practice for Equality

Further into the project a decision was made to develop a 2 pronged approach to BME workforce under-representation focussing on organisational barriers and equality and diversity issues around recruitment and selection practices. The importance of this approach to race equality is also highlighted in The 'Tackling the challenge' Report (2009) which states that, 'meeting the responsibilities of race relations legislation is not just about 'ticking the boxes,' but embedding the positive promotion of equality into a trust's culture.' It was thought that whilst Lewisham was meeting the race relations legislation in terms of minimum requirements there was a need to go further. To take these forward two external consultants were invited to an exploratory meeting in February 2010 with representatives of Lewisham PCT's Equality and Diversity section, Human Resource department, BME Forum and other stakeholders including the Equality and Diversity Lead at NHS London DH Pacesetters. Further very detailed local evidence on recruitment panels was shared by the project lead. This indicated the low take up rates of equality and diversity and recruitment selection training by recruitment panel members, inconsistent selection practices and prevailing organisational cultures being revealed in individuals' behaviours. This, despite the often diverse make-up of interview panels. Of prime concern was the potential impact interview panels were having on the recruitment profile of the organisation, in particular relation to BME staff and how recruitment behaviours could be improved to benefit individuals and the organisation.

This third intervention was agreed and consisted of a tailored programme of training and support aimed at addressing current recruitment practices by enhancing recruitment panel members' role and performance. The key objectives of this intervention were to raise awareness and improve practice in relation to:

- The challenges that recruitment and selection analysis presents
- Group practices in recruitment panels
- The behaviours, attitudes and skills that trigger unfavourable/ less favourable perceptions and evaluations of applicants' performances
- The impact of interpersonal interactions within the interview process
- Refreshed existing management and diversity approaches
- Aligning recruitment and selection practice to organisational aspirations

Training dates were circulated to 18 recruitment panel members across NHS Lewisham, The Lewisham Hospital NHS Trust Community Health Services and Lewisham Healthcare. The first training session took place in mid September 2010. The focus of the training was on those more likely to be involved in recruiting staff in the short to medium term to allow for early feedback and reflection.

One of the earlier action learning group activities had been to design an evaluation tree to pictorially specify agreed short, medium and longer term outcomes in relation to the project (Appendix D7). This was completed before the third intervention had been identified and project outcomes were reviewed and modified 9 months later in action learning set on 1st July 2010 in the light of organisational and project related changes to create an amended evaluation tree (Appendix D8). Members of the action learning set had become more ambitious in their vision for the project as the BME Forum/co-design process evolved and actions were taken leading them to identify more longer term

outcomes around increasing equality. This opportunity to reflect on the project within an action learning context was very useful...

6.4.3 Project outcomes

There were clearly a number of quick and early wins for the project during the first 18 months focussing on the identified short term outcomes including the establishment and promotion of the BME Forum in the Trust and the agreement and establishment of the first and second interventions. The organisational changes taking place within Lewisham delayed the progress of the various interventions putting things off schedule by around 8 weeks. This evaluation report reviews progress to mid September 2010 with further project work continuing to the end of October 2010 with more expected outcomes being achieved. Co-design of the project interventions has taken place in the form of continuous involvement of the BME forum in project decision making and feedback from BME Forum members has been positive. One Forum member stated, 'I think all BME staff had a good opportunity to participate and contribute to the development of the Pacesetters Project and the BME Forum.'

The Project lead has been committed to ensuring that staff participation in the co-design of this project has been reality and not rhetoric. As time went on there appeared to be more of a belief that not only changes were happening but they were being consulted and participating all the way along. One BME Forum member commented on how, after the first two meetings it was clear that they would be able to make decisions on how the project money was spent and it was the first time they believed that, 'our opinion is important'. This was an important learning point as there had been some initial (expected) hesitancy and discussion by some BME staff outside the forum at the beginning of the project that the Forum would be another 'talking shop' where words get spoken with no corresponding actions taking place. Over time an element of trust has been established as BME staff saw how their decision making had led to actions and the project was seen to be delivering. However, one BME Forum member reflected on the importance of BME staff committing to participating in these initiatives stating that, 'you can't have any influence or any opinions if you don't participate.' Another Forum member explained how, 'the democratic/participatory style of the project gave us all an opportunity to examine and select the programmes which we wanted.' This was echoed by a Forum member who stated that, 'Participation and co-design was at the heart of the focus group (BME Forum) which allowed us to discuss and debate fundamental aspects at a preliminary stage to improve equality and BME representation in recruitment.

Corporate senior managers have also been part of this and played a key role in supporting particularly the third intervention and this was seen by some BME Forum members as reassuring. Regular meetings have been well attended and the commitment and energy of the core Forum members has been very evident despite the impact of organisational changes. The will and level of support from a number of senior managers, some as project champions was very much welcomed. This was viewed as evidence of a 'willingness to embark on the change process.'

The access to open dialogue with senior managers at Forum meetings has been refreshing. One manager pointed out that, 'Some Forum members didn't have access to that sort of dialogue with other members of staff, Anthony (Anthony Berry DH), access

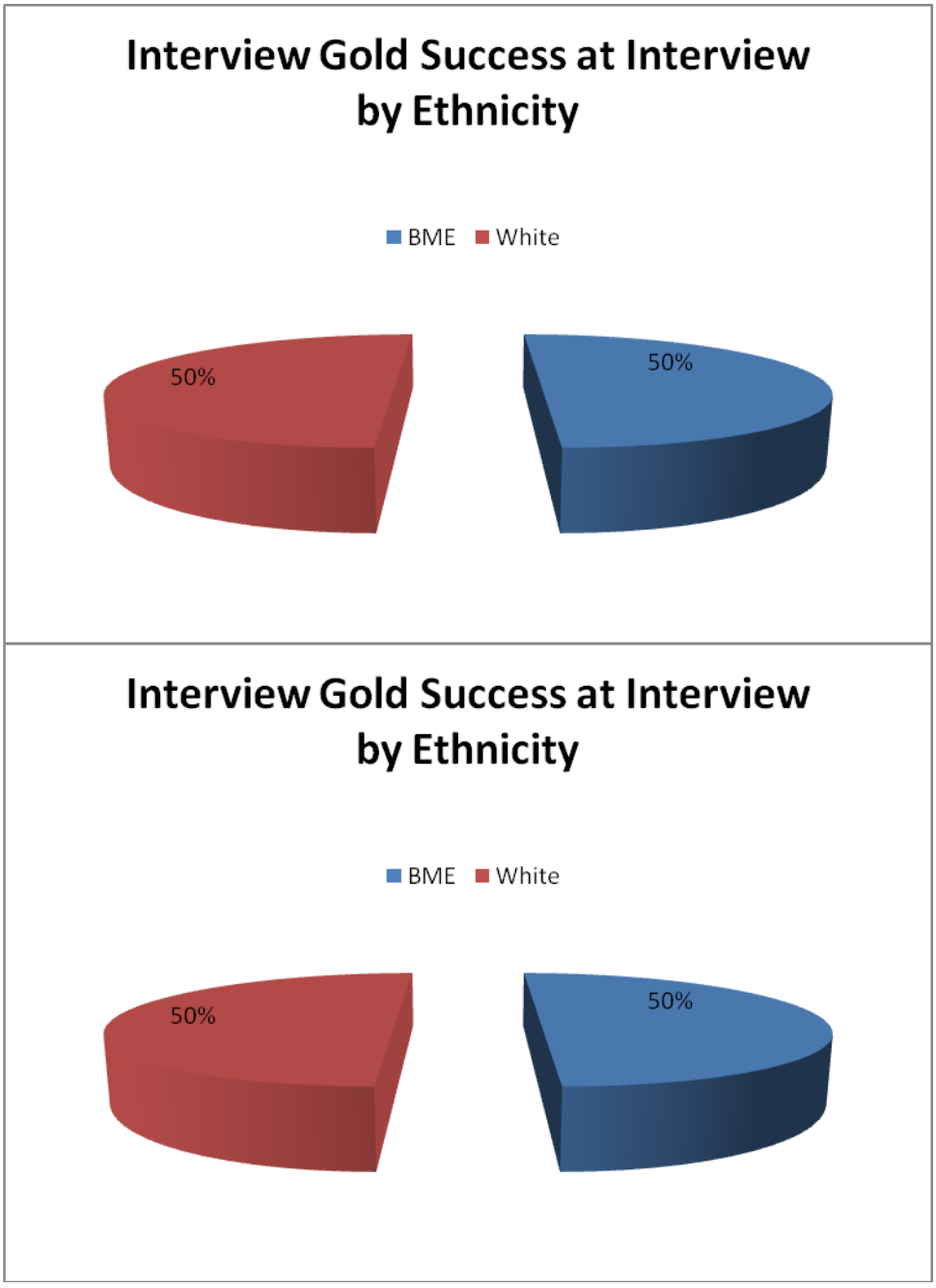
to myself and the other manager...this upset the hierarchy in a sense..For example, it's not usual for a HR manager to spend so much time with staff in a dialogical way.' This approach has been seen to be a, 'different way of doing things'. As one manger stated, 'we've never done this much engagement before.' The group has been described as 'solution focussed' by the Programme Manager and it has been thought that having a problem to tackle together as a 'dialogue of equals' through Pacesetters has worked well.'.

The relatively speedy establishment of the very first BME Forum in Lewisham PCT has been a real innovative and positive achievement for the project and should not be underestimated. The programme manager reported that membership has included staff who, 'are optimistic about their roles ...and may not have been before...has been an incredible win.' This same manager spoke about how valuable the Forum had been and described it as being 'a mirror to highlight what areas there are blockages in the organisation and being able to undo some of these..' The Forum has been seen to be powerful just by its' presence and the steady growth (10 – 15% increase in membership each month from august 2010) of it has been evidenced by the project lead appropriately withdrawing around April 2010 allowing for a self-directed staff group with access to support when necessary**.** Regular publicity has gone out to Trust employees around the Forum's activities helping to promote it and also the work of the project. Many Forum members have also promoted the BME Forum and the project work by word of mouth – an often effective method of engaging particular staff groups. This publicity in addition to information sent out regularly to staff by email and the Trust Brief staff newsletter has helped to encourage more dialogue on race issues within the Trust and specifically around BME under-representation. This has happened at corporate and other levels in the organisation with committed individuals consistently driving this.

6.4.3.1 Capacity Building of staff

It is too early to make any judgements concerning the outcomes of the on line support for those applying for jobs, both internal and external. To date there have been only 5 telephone feedback interviews with recruitment managers and members of the BME forum who had participated in the initiative. The interviewees talked about the value of the support. There was a recognition that this intervention, due to its nature, was the one more likely to produce more immediate and visible outcomes and indeed the results to date appear very positive:

- 81 of the 100 allocated Licences were issued to CHS and NHS Lewisham applicants as at 6th September 2010. There are 9 licences remaining which are expected to be used by the project end in October 2010. A decision is pending regarding the possibility of further funding to purchase additional licences.
- Early indications show positive results for those applicants allocated licences (licence used for 16 positions, 50 % of appointments were filled by BME applicants)



A full analysis will take place once all 100 licences have been distributed. The low take up rate of feedback on this intervention from participating individuals makes it difficult to gauge how effective this online interview support was. The context of individuals applying for a job where the outcome may be unsuccessful may inhibit them providing feedback even when contacted in follow up emails from project deliverers. In hindsight it would have been useful to have built feedback requirements into their online interview support package.

As referred to previously the internal mentoring scheme was much delayed. The inclusion criteria was broadened in the light of the organisational changes to include staff from both the Provider and the Client's employees. Training is due to take place on 6th, 7th, 21st and 27th October 2010. All places on the training (12) have been requested

and allocated to admin and clerical staff at bands 6 and 7 from both organisations (Lewisham Healthcare and NHS Lewisham).

6.4.3.2 Tackling organisational barriers and practices

Recruitment panels – enhancing interviewing practice for equality

These have been conducted by the two consultants. They have also spoke with key stakeholders including the CEO of Lewisham PCT and the Project lead. An observation of an interview panel in action has taken place. This involved observing 5 interviewees, the panel post-interview discussions and decision-making. Training for recruitment panel members took place on 14th September 2010 with 6 places going to CHS staff, 4 to NHS Lewisham staff and 2 going to UHL staff (out of a scheduled 14). While it is too early to pinpoint particular changes or outcomes at this stage, feedback from the consultants' initial observations are as follows:

- Recruiting managers have considerable experience of selection interviews. This considerable experience, whilst valuable, may make reduce an openness to learning for some individuals

- Participants on the programme were very receptive to the training and engaged with the content of the programme

- There appeared to be variable and inconsistent practice, for example, on whether to advertise externally when a vacancy arises. This may be important as an internal career system may favour BME staff in some instances

- There appeared to be no assessment of managers' abilities to participate on recruitment panels; individuals would only have to attend a mandatory programme and then they would be deemed ready to interview

- There was a concern that recruiting managers may be influenced or take into account applicants' non job-related factors, for example; accents, pronunciation of words, the absence of recognisable non-verbal cues, for example, gesticulation,

- Although some managers are using work-based tests to help assess performance, too many are relying on interviews only

- There appears to be a reluctance to challenge panel members when they operate inappropriately, for example; showing bias

- The recruitment of BME staff appears simply not be an issue for white managers; with 'in group' differences between BME staff appears also to be leading to subjective decision-making, for example; stereotypes about particular communities

The plans for further work in this intervention up to the project end are to track progress of the participants to ascertain whether their recruitment practice has changed or improved and what impact this has on the profile of the successful applicants. However, if the consultants are to enhance recruiting managers' practices, they will have to identify ways in which to roll out our work with panel members; this could be delivered internally to reduce costs. The consultants would want to put a number of recommendations to the client including:

1. introduce compulsory refresher training for recruiting managers

2. All new recruiting managers should be assessed and given developmental feedback at the end recruitment training; this would create opportunities for individuals who would benefit from interview practise and give recruiting managers valuable practical experience. The assessment and feedback with a 'light' touch would enable potential recruiting managers to identify areas for development

3. work with internal trainers to integrate some of the issues/sessions that we have incorporated into our programme

6.4.3.3 Unexpected project outcomes

The rapid growth of the Forum in terms of both membership and wider vision of wishing to influence other areas around race in Lewisham was unanticipated. Individuals were given the opportunity to participate in key decision making and influencing which would not have taken place without the influence of Pacesetters. The Programme Manager explained that, 'In the beginning I thought that even if only 2 members of BME staff wanted to join us it was a viable Pacesetters project which gave us the permission to try something new and test it out....' **the** learning and experiences gained from such participation could prove to be beneficial for those staff in the future.

Establishing links with the National BME Forum was very positive and a number of BME staff reported to feeling empowered by the opportunity to attend the National BME Forum conference in the early summer 2010. Lewisham as an organisation was keen to encourage membership of the network due to the groundwork achieved by Pacesetters

over the past year. Funding was provided to 21 BME Forum members to attend demonstrating a commitment to BME staff development. A comment from one of the BME Forum members illustrates how both this and the participation in the Forum impacted on their future career aspirations, '*The resources provided by the project are great building blocks on which to improve our careers*.' Another BME Forum member spoke of their change in attitude towards career progression (both their own professional confidence and their confidence in the organisation) as a result of involvement in the project, '*My personal attitude towards career prospects in the NHS has improved tremendously. I now feel that, provided I have the appropriate skills and experience, then no position is closed to me."*

One revealing outcome from the local research data was the realisation that many recruitment panel members were not following mandatory training. However, whilst this was disappointing, it was seen as something that could be changed with input from the third intervention framed around enhancing performance at recruitment panels to also reinforce the equality and diversity training staff had already undertaken. The importance of being able to present detailed, accurate local evidence very specifically related to the problem of low appointment of BME staff at band 7 after interview was enormous. Presentation of this local data pinpointed at such a micro level has been powerful, having a profound effect on both senior managers and BME staff. This data particularly has both shocked and moved a number of colleagues. Staffs' responses from seeing the data were often of, 'we've got to do something about this....' BME Forum members appreciated being presented with not only the local evidence but also the hope of a solution. The following quote from a BME Forum member helps to illustrate this, '*The data and conclusions of the application, short-listing and interview process and the work to remedy the deficiencies will always be appreciated."*

6.4.4 Challenges and Barriers

At one of the action learning sets set members spoke about the current economic and political climate which they perceived to have an impact on the project. It was deemed too early for individuals to comment on the impact of the recent change of government on the project work and wider workforce inequalities issues. One set member was of the view that the coalition government valued the patient experience and work around engagement which could provide some protection for Pacesetters. However, the drive to prioritise 'the clinical side over the workforce side' of the NHS was thought to be cause for concern. There was also a clear concern about the future possible erosion of the equalities agenda where, 'equalities is seen as a cosy extra and is stripped back and usually the first to go in these climates'. External and internal changes and pressures and the current climate of uncertainty proved to be cause for concern for set members around the momentum, outcomes and sustainability of the project.

Internal organisational changes and pressures had clearly impacted on the ability to achieve the ultimate long term goal of a more representative BME workforce particularly at manager level (from band 7) within the expected timescales and with a stripping back of current project resources. Such changes had impacted on all areas of the project affecting timescales and project management. The early recruitment freeze on jobs had meant fewer jobs being advertised than predicted resulting in less

opportunity for interviewing support for internal and external job applicants at this time.

6.4.4.1 Uncertainty around project resources

The split between the provider side (CHS) and NHS Lewisham had led to some uncertainty in the future plans of the BME Forum and there was some concern from members that the current Forum would be left in a vulnerable position with the danger of members attending meetings being problematic and the dropping off of membership. Certainly, one BME Forum member's impression was that, 'the group has fractured and there are very few of us left in this building, the latest issue with jobs is taking prominence in people's minds at the moment.'

The Pacesetters programme manager, equality and diversity was employed on a weekly temporary part-time contract at the beginning of the project and it was only during August 2010 that hours were finally agreed on a fixed term contract until March 2011. Due to the organisational changes the programme manager went on to have at least three different line managers over the duration of the project. His role changed from one of active lead to that of co-ordinator taking him more on the periphery of the project which brought with it some frustration.

A further barrier was the difficulty experienced by the consultants delivering the third intervention in obtaining organisational data to allow for a more tailored training programme arising from a local evidence base.

6.4.5 Enablers

Whilst the above impacted on activities and outcomes, the foundations set in the early part of the project around staff participation and engagement and the development of the BME Forum proved to be invaluable. Whilst the general morale of staff was lower due to the general unsettling economic climate and (uncertain) organisational changes, the core BME Forum members, Pacesetters programme manager and project lead remained positive and motivated regarding the project remit and goals. These individuals can be identified as key drivers and enablers to taking the project work forward. The programme manager was described as the, 'key initial driver and consistent driver all along'. The will and commitment of such key stakeholders was continuous as was their ability to engage with others at different levels within the organisation to participate and support the project and the BME Forum. This is illustrated in the following from a BME Forum member, *'The Project manager has managed and facilitated this process to an exceptional standard with integrity, belief and commitment to the project. Personally I felt that they have turned a potentially intimidating prospect of sharing views around a sensitive subject into a positive experience and I now feel that my workplace is a safe place of open dialogue. I have worked here for a number of years and to me, this is a huge change to the quality of working as a BME member of staff in Lewisham and invaluable progress*." In particular, the work and commitment of the project lead and programme manager were also praised by a very senior manager who referred to them as, *'doing a fantastic job leading the project and keeping everybody going.'*

A number of other senior managers were identified as both project and BME Forum champions. These individuals were described as, 'people in power championing the cause....' and 'people who shape opinions in the organisation' who were seen to provide support to the project goal at an influential level. These people were viewed as being in effective strategic positions as one BME Forum member stated, 'whatever is happening where change is being made to effect minority groups they are going to be in a position to know about those changes – we might know but they can point any of those changes in our direction ..' These individuals including the Pacesetters programme manager and project lead were viewed as ensuring the BME Forum/project had a voice and link within the corporate equalities group, *'a champ to lead us and act as a conduit to get the point over...'* this would allow the BME Forum would then be kept in the loop and part of that process of change. One BME Forum member spoke of the impact of the changing attitudes of some senior managers, '*Hearing a Director who is not a BME member of staff explaining the importance of this work and (other) equalities to other Directors has also been a great comfort and leap forward in shifting the attitudes of the senior management team. It's very comforting to know there is a powerful champion who will challenge their own and other people's preconceptions and practices.'* This element was seen as important in supporting the organisational cultural changes.

The Pacesetters programme lead also spoke about the importance of such influencing individuals having key values around equality and diversity and being able and open to reflect deeply on experiences and challenge their values. Another key enabler to the project work was the particular methodology advocated by Pacesetters reflecting the PDSA cycle that was familiar to staff in the organisation - the having a go at doing something, reflecting, learning and the emphasis on improvement rather than failing. This alleviated some pressure in thinking everything has to work well at first go. However, perhaps the current economic climate and previous experience still caused one stakeholder to report, 'I was conscious of failing – there were rumours going around of Trusts having their money taken away and you wonder why ...the fear of failing disappeared as we went quite quickly on with our interventions and they were unique.'

The will of the organisation to support the BME project in a number of ways was highlighted as a key factor in terms of project success. One stakeholder commented on how the will to apply for Pacesetters funding was there from the start, the will to choose a BME representation project from others which would feed into the other projects in Lewisham around race equality, for example, cancer and stroke projects. The PCT has demonstrated some commitment to BME representation in the will to support the project remit and particularly the more challenging intervention 3. More latterly there was seen to be a will for the organisation to continue the dialogue already initiated from the project work.

6.4.6 Making a difference

Time was taken at the very beginning of the project to prepare solid foundations to help achieve the project outcomes. The co-design and staff participation processes were a real strength to the project's success in addition to the commitment and will of both individuals as key drivers and the organisation to tackle BME staff underrepresentation.

The increased dialogue and discussion around race equality in general within the equalities group, at directorate level and with internal and external partners indicates that the project's remit has reached a wide audience. The programme manager reflected, *'People are flagging up issues and maybe thinking – what's the particular issues relating to this particular staff group?'* Subtle changes in culture to one where the environment appeared safer for issues around race to be more openly discussed was welcomed by BME Forum members with one member reporting, *'I think many staff did recognise when sitting in an AGM or any formal setting that the senior managers looking back were not representative of this very diverse borough and organisation but before pace setters it felt that people were afraid to say this out loud. It seemed that the culture of institutional racism was so pervasive yet so intangible that it could only be whispered about but never talked about freely in an open forum. The Pacesetters project has enabled us to talk openly and constructively about this and I personally feel empowered and that the oppression is lifted by uncovering, understanding and taking very real and practical steps to address the problem.'* Another BME Forum member reported that, *'The Pacesetters project has enabled us to talk openly and constructively about this and I personally feel empowered and that the oppression is lifted by uncovering, understanding and taking very real and practical steps to address the problem.'*

One stakeholder commenting on the wide reach of the project reported, '*We've reached so many .external and internal candidates with capacity building.'* Another likened the project processes to that of a journey for BME staff with support at all stages of that journey – from external and internal job applicants with interview Gold support, recruitment panel training focussing on equality and diversity ensuring greater equality at interview and finally with the opportunity for mentoring support and coaching once employed in the organisation to help with progression. The programme manager strongly believed that it was important for organisations to be able to answer the question – what is the journey for BME people within our organisation (given the issue of under-representation). She also highlighted how this approach to BME under-representation developed in Lewisham primarily aimed at BME staff could also be used in other equality and diversity areas suggesting how any equality strand could be overlaid with this approach.

There was some disappointment felt by a number of stakeholders that the full sense of how the project had made a difference had got a little lost given the impact of organisational changes and the much delayed timescales. It was felt that many staff had other priorities within the current climate and as one BME Forum member stated, *'people's main focus is job security and people say, make a difference but they just want to have a job...'* One stakeholder commented that by this stage of the project (September 2010) they would have liked to have seen much more demonstrable visible changes on a larger scale as had been anticipated to the interruptions had led to some frustration with this. However, it was envisaged that such changes would be demonstrated over the next few months and hoped that the good work in terms of laying down the foundations in place could continue. This certainly was viewed as having an impact with one BME Forum member speaking about their experience.

6.4.7 Reflections on learning

A key message from the programme manger was how the strength of the project work had been, *'having a big vision and doing something towards it is brilliant but if you loose sight of the vision ...that's not good.'*

Central to this was the ability and willingness to bring in other people to champion and progress the project work. In Lewisham this had been, 'having a group of allies for race equality.' It was also noted that Pacesetters had come with a relative small amount of funding and this project has 'proved' you can do a lot with a small amount of funding if the will is there. The project was seen as quite cost effective costing £20000 over 2 years and producing some key outcomes including a good tested working model to help address BME staff under-representation. The main cost for the project was said to have been staff time. This was particularly true for the project lead and programme manager. Reflecting on this the programme manager pointed out that setting something up usually takes more time initially and that is the investment.

6.4.8 Sustain and spread

Commitment from the PCT to fit into the Pacesetters Programme was valuable. Sharing the learning with other London trusts particularly in the light of the organisational changes was strong and various seminars and events have taken place within London to give project stakeholders the opportunity to share and disseminate learning and learn from each other. The project manager has delivered internal seminars about Pacesetters and this particular project to colleagues.

The organisational changes leading to the merge with UHL has meant that a more diverse group of staff will potentially benefit from the project work in regards to all 3 interventions. This is particularly the case in intervention 3 allowing recruitment panel staff from UHL to be incorporated into the training programme.

There is a desire for the pilot project to be rolled out to other areas of Lewisham. Due to the organisational changes taking place there will now be the opportunity for the mentoring/coaching element to spread to Lewisham Healthcare to benefit these staff. Dialogue around the project work has already reached the hospital. Certainly, the Pacesetters Programme lead is very committed to intervention 3 being thoroughly tested and rolled out nationwide as an effective way of changing organisational practices within recruitment and wider.

It was seen as very important to share the learning from this work with others, 'We have a responsibility to share this...Trusts may be interested in learning what we have been through ..'

6.4.9 The future

A commitment to further funding is required to enable this innovative project to meet its' more longer term outcomes. There is a sense of commitment from senior management to invest in such priorities once the uncertainty of funding is clarified. The CEO, Lewisham PCT has spoken very positively about the project and has indicated commitment to the project aims and objectives. Whilst mindful of the forthcoming public sector cuts and the need to reduce costs she has stated she would like to see the

progression of the project, '*We have got to find a way to keep it....*' With the Equalities Act high on the agenda the organisation is hoping to gain funding for further work to keep things going. More specifically it was thought that the project interventions were very useful in the light of the impending time of transition set to come about in the organisation. As many staff will find themselves in the position of applying for their own/other jobs, a sense of fairness, equality and best practice being in place with the same opportunities afforded to all staff was viewed to be very important and reflected some of the objectives of the project.

Reflections on the future developments by a selection of project stakeholders are as follows:

'Improvement and expansion of BME Forums system-wide to encourage the exchange of ideas and information and to present a stronger voice. A recognition and acceptance of responsibility by BME people that it is not just our responsibility, but our duty, to do all that we can to help ourselves.' (BME Forum member).

'*I would like to hear everyone including the Chief Executive and all senior managers, and the HR lead for NHS Lewisham acknowledging and talking about how equality, EIAs and BME workforce under-representation will be factored into the HR framework and delivery of cutting 50% management posts over the next year and for the future transition from PCT to consortiums. I would like the whole organisation to be informed of the purpose of BME forum and the importance of the Pacesetters project. If line managers are to release staff for a number of hours, they may be more understanding if they understand the value and scale of this work.'* (BME Forum member)

Whilst the future remains uncertain for the public sector and the area of equality and diversity it is clear that the Lewisham project has introduced some innovative interventions, focussing on both individual and organisational change within a climate of co-design and participatory working. It is hoped that such processes and outcomes can be supported for future development to strengthen the longer term goal of increasing BME representation in the workforce

6. 5 Case Study E: Wave 2 United Lincolnshire Hospitals (ULH) NHS Trust and Lincolnshire PCT Improving Access to Employment for Disabled People Project

6.5.1 Context

Within the East Midlands SHA, NHS services are delivered by primary care trusts (PCTs), hospital trusts, mental health trusts, independent sector treatment centres (ISTCs) and the East Midlands Ambulance Service. There are a total of nine Primary Care Trusts, nine Hospital Trusts, one Ambulance Trust and eight ISTCs. The important point to emphasise here is the geography of the region. East Midlands is the fourth largest region in England in geographic terms. It is home to 4.4 million people (ONS 2008) and has a polycentric spatial structure with its population distributed amongst the urban areas of Nottingham, Leicester, Derby, Lincoln and Northampton, smaller sub-regional centres and market towns. The East Midlands is a relatively rural region, with about 40 per cent of its population living in towns and villages with populations of less than 10,000.

Examination of ONS key statistics data for the East Midlands at face value hides some significant sub-regional socio-economic variations that should be highlighted .ONS data reveals that the East Midlands regions has a population living at a density of 284 people per sq km compared to the English average of 395. However this regional population density average masks marked variations between the counties that make up the region with Nottinghamshire's population density significantly in excess of the regional average whereas Lincolnshire's is way below (118 people per sq km).

Another notable spatial disparity is presented by the Standard Mortality Ratio (SMR)[9] . There are pockets of multiple deprivations within the region and some SMRs are on a par with the most deprived former coal mining centres in South Wales such as Blaenau Gwent and Merthyr Tydfil. This pattern of dispersed population distribution and socio-economic disparity is hidden if the demographics of the East Midlands region is taken at face value whilst at the same time generating significant challenges when it comes to the delivery of NHS services. These contextual features of the region also give an important insight into the backdrop to this particular Pacesetters project which is in a rural area. The project is one of only three staff-related Pacesetters project out of a total of ten in the East Midlands region that are based outside of the Leicester based Trusts. The other two projects are based in Nottingham and within the East Midlands Ambulance Service. On the patient-side, two of the twelve projects are based in Lincolnshire. The distribution of the remainder sees seven projects based within the Leicester trusts, one within the ambulance service and two within the Nottingham based trusts.

This workforce related wave 2 project focused upon workforce representation of disabled people and in this case, people with hearing impairments. Within this disability related project, the project leads have cemented relationships that both NHS Lincolnshire PCT and United Lincolnshire Hospitals Trust have with Deaf Lincs, a

[9] The Standard Mortality Ratio (SMR) is the ratio of observed deaths to those expected by applying a standard death rate to the regional population

Lincolnshire based charity providing support and advice to deaf, deafened and hard of hearing people within the county. NHS Lincolnshire has a service level agreement with Deaf Lincs. The project aims to find out what the experiences are for deaf people who work for United Lincolnshire Hospitals Trust and NHS Lincolnshire. This overarching aim echoes the words of the SHA's Director of Inclusion in his vision statement *"make regional NHS organisations the best NHS commissioner and providers within the United Kingdom and beyond, by proactively including individuals and groups that may feel, or are being, excluded from the services and employment opportunities provided by NHS organisations within the East Midlands."*

The need for a project in this topic area is highlighted by real and anecdotal evidence of deaf applicants being advised that they cannot work for one of the organisations because the disability support is not in place in the workplace. Both organisations want to look at ways of enhancing its image as a model employer and for hearing impaired people to see the organisation in this positive way. They are also keen to see that staff receiving poor treatment, can complain effectively about that treatment and that disability support is provided at an appropriate level in the workplace. Whilst on the face of it, this sound like a grand statement of intent, the equality and diversity team supported by the recruitment team strongly believe that the small incremental differences that they have made are key steps towards achieving these goals.

In 2007, NHS Lincolnshire carried out an audit of it's Out of Hours service in conjunction with the Royal National Institute for Deaf People (RNID). This audit was instigated following concerns expressed by a patient on whether communication devices were keeping pace with technological changes and public preferences. Following a full walk through of the Out of Hours service, the RNID produced a ten point plan for service improvement in order for NHS Lincolnshire to secure the RNID Charter Mark (Louder than Words). This service improvement plan only referred to the Out of Hours service, however NHS Lincolnshire's Equality and Diversity Manager was keen to go further and look at how to roll out this action plan across the whole Trust and provide support to not only deaf, deafened and hard of hearing patients, but also employees too. This wave 2 Pacesetters project has its foundations in this initiative and built upon the service improvements that have been introduced.

The project collected data from facilitated workshops and focus groups with deaf, deafened and hard of hearing people and worked with DEAF Lincs to deliver a programme of training on deaf awareness and communication tactics. This Pacesetters project has a strong association with the Pacesetters project entitled *Improving Workforce Monitoring: 'Out at Work'*. The aim of this project is to improve the disclosure levels and quality of equality data that is being held. This is being achieved via a range of initiatives such as a LGBT staff network, working with Bradford University to develop a programme of reverse mentoring for Executive Teams, data cleansing exercises and attendance at community events such as Lincoln Pride.

Nationally, the ethos of the Pacesetters programme puts great emphasis on working in partnership. Locally, this has been achieved through partnership between the human resources departments in the two trusts. Pacesetters has fostered a different approach to thinking about partnerships. Working with Deaf Lincs on NHS staff related issues is a key part of this different approach because working with a community organisation is a

more common occurrence when addressing patient issues. Pacesetters also has facilitated the discussion of hearing impairments *per se* and this has made in the words of the Diversity Manager "*a massive difference*".

6. 5.1.1 Aims and objectives

The fundamental aim of this project is:

- To improve access to employment, promotion and training for disabled people, especially for deaf, deafened and hard of hearing staff and potential applicants.

This overall aim can be broken down into a series of sub-aims with more detail attached:

- To highlight the barriers deaf and hard of hearing people face when applying for jobs within the NHS
- To examine ways of ameliorating these barriers
- Promote and encourage applications, offering a choice to deaf people, get deaf people to seriously consider the NHS as a model employer. This project and its related objectives around supporting staff, recruiting from a diverse pool of people and retaining staff all contributes to the goal of ULH Trust to be a model employer.
- To raise awareness of support mechanisms available to deaf and hard of hearing employees (e.g. such as specialist equipment available in their job)
- To increase the number of people able/comfortable in declaring a disability in the staff survey Low level of disclosure of disabilities. In most recent staff feedback survey only c. 24 staff members disclosed a disability. Clearly this is a significant underestimate. This is tied in with a general fear that disclosure may put one's job at risk. It may also mean that an individual has to prove his or herself above and beyond everyone else as a result.

6.5.2 Project Mechanisms

6.5.2.1 Focus groups

Focus groups have been held with two groups of deaf/hard of hearing NHS staff and two groups in the community composed of younger and older adults. These focus groups were facilitated by Deaf Lincs between August and November 2009.

6.5.2.2 Conclusions from focus groups

There were many issues raised during the focus groups by the members and it was interesting to establish that the themes ran mainly in common across the diverse groups. Positive and negative issues were raised and the key points are summarised below:

- Consideration of the support levels for staff with a hearing impairment by colleagues and management.

- An improved working knowledge of use of assisted devices and their effective use for people with a hearing impairment.

- Stigma felt by people with a hearing impairment regarding communication issues including those with colleagues. Additionally the reluctance of people with a hearing impairment to ask for recognition of the condition by management.

- Prejudice exists against people with a hearing impairment; this should be recognised and tackled by all of us.

- A significant change in the understanding and the use of Access to Work should be contemplated and acted upon. It is recognised that many of the people involved in the focus groups were fully aware of this and made use of it, however due to the stigma issue some did not and this could be replicated elsewhere due to the reluctance to disclose.

- Consideration should be given to highlighting the positive use of role models with hearing impairment within publications internally and externally. This could tackle both stigma and discrimination.

- The issue of the use of telephones and the difficulties faced by those people with a hearing impairment was raised throughout the focus groups. A range of amplified equipment could be explored as a solution.

- A planned awareness raising campaign, regarding hearing impairment, through training would assist in the reduction of barriers.

- Organizations sometimes only see the negative side of hearing impairment – focus should be placed on the positives too.

- Recruitment procedures should be reviewed to ensure they are compatible with equality for people with a hearing impairment including those who are sign language users.

6.5.2.3 Focus groups and general consultations

The discussion groups appear to have progressed well. The findings were written up and fed back to the participants at a meeting in Sleaford on the 24th February.

Discussions about the focus groups and findings during the action learning set meeting in December 2009 led to a number of issues being raised.

The findings generally represented no surprise to Deaf Lincs but nonetheless it was good, from a consistency standpoint, to hear the same problems being identified. There was lots of useful learning for the E&D staff involved and the participants too. For example, the NHS staff participants didn't realise on the whole that specialist support equipment was available to support them in their jobs such as amplified telephones. The main comment from participants in all focus groups was centred on life/work experiences of deaf people generally. Participants talked about their isolation as a deaf person but were warmed by the fact that other deaf participants had similar concerns:

"Didn't know other people felt the same… I thought it was just me"

Another interesting finding was that participating NHS staff wanted a staff support network for deaf and hard of hearing colleagues. The AL set discussed the pros and cons of a more generalised disability network before agreeing that where such entities have developed in the past, they've tended to be dominated by the more vocal disability lobbies at the expense of marginalising those with other disabilities. The discussion then developed onto the merits of a more general network of deaf and hard of hearing people involving NHS staff but also people in the wider community. In this way, there is potential to break down the entrenched cultures of the NHS and the 'same old..' by exposing the NHS staff to 'other cultures' that might challenge what is perhaps taken as fixed and rigid.

The focus groups confirmed the significant differences that one needs to be aware of when talking about deaf people. There are those who are deaf, those who are hard of hearing and those who are profoundly deaf and use BSL as a first language. Lincolnshire's agricultural economy has meant that the region has attracted a significant number of Polish and Lithuanian migrants. Some of these migrants took part in the young person's focus group which introduced a further dimension to communication because sign language has many forms whilst effective lip reading partly depends upon your command of English.

The project leads also talked about the possibility of a video clip being made available on NHS Jobs. NHS Jobs is the only way to apply for jobs in the NHS. Hence if you are partially sighted, have a disability that requires you to use a wheelchair, deaf/hard of hearing, dread ICT etc you could have great difficulties even accessing the system. It is the only way to apply for NHS jobs but it is clearly not serving its customers. The video clip would enable potential deaf or hard of hearing job applicants to get help finding their way through this complex system by launching a signing facility to explain the process.

A general finding from the consultative work done by the E&D team more generally is that NHS staff (without a hearing disability) wanted more training on dealing with and communicating with deaf and hard of hearing colleagues and customers.

The key findings can be summarised as follows:

- Consideration of the support levels for staff with a hearing impairment by colleagues and management

- An improved working knowledge of use of assisted devices and their effective use for people with a hearing impairment

- Stigma felt by people with a hearing impairment regarding communication issues including those with colleagues. Additionally the reluctance of people with a hearing impairment to ask for recognition of the condition by management

- Prejudice exists against people with a hearing impairment, this should be recognised and tackled by all of us

- A significant change in the understanding and the use of Access to Work should be contemplated and acted upon. It is recognised that many of the people involved in the focus groups were fully aware of this and made use of it, however due to the stigma issue some did not and this could be replicated elsewhere due to the reluctance to disclose

- Consideration should be given to highlighting the positive use of role models with hearing impairment within publications internally and externally. This could tackle both stigma and discrimination

- The issue of the use of telephones and the difficulties faced by those people with a hearing impairment was raised throughout the focus groups. A range of amplified equipment could be explored as a solution

- A planned awareness raising campaign, regarding hearing impairment, through training would assist in the reduction of barriers

- Organizations sometimes only see the negative side of hearing impairment – focus should be made on the positives

- NHS staff would like a staff support network for deaf and hard of hearing colleagues

6.5.3 Project Outcomes

6.5.3.1 Staff network for deaf, deafened and hard of hearing staff

As a direct response to requests coming out of the focus groups with NHS staff, the staff network was launched on the 30 April 2010 (please see Appendix E1). The launch provided an invaluable forum for hearing impaired staff, some of whom are seldom heard in the workplace, to air their views in a supportive and enabling environment.

The whole event was hosted by Steve Day, one of the UK's only deaf stand-up comedians.
"Compared to other organisations, I think stuff like today is superb, it's a start, at least people are talking about it, in other places they wouldn't even consider it" [Steve Day].
Other comments from the launch attendees were equally supportive and positive:
"I think staff network is absolutely essential because there are a number of staff out there who aren't aware of the services that are available and it's really interesting to see the turn out of staff from across the NHS, people seem to be getting an awful lot out of it, people who have never understood can see that it is not a disease to be deaf " [Staff network Member].
"Today I have been able to learn about different people who are deaf and hard of hearing and think about ideas for the future... I hope it improves for the future" [Staff network member].
"My understanding is that this is a first, so well done Lincolnshire! You're actually embarking on something that is very important and good practice..." [Maqsood Ahmad, Director of Inclusion for East Midlands SHA]

The project leads recognised some of the main problems associated with staff networks around hierarchies of disabilities and the power differential this engenders but they have not detected these problems in the discussions they have had with staff. The network is seen as a forum to share ideas and information. Anecdotally, one nurse mentioned that she had a special stethoscope to help her in her job and that she had found it very easy to obtain. This was news to another nurse who did not know of this and had in fact held back on promotion for three years because she did not know of the availability of specialist equipment to help her in her job.

The network launch was used to sign people up to the network. Flyers and posters about the network launch were to be made available at all staff induction events. Information about the network launch was made available on 26/2/10. By 1/3/2010, the project leads already had 20 delegates. At the launch event itself, 54 people signed up to the network. This figure is a major achievement in itself given that in the latest NHS Lincolnshire staff survey only 24 staff declared a disability of any type. The pacesetter project leads also managed to attract some key speakers such as Maqsood Ahmad, Director of Inclusion for the East Midlands SHA. During his presentation, Mr Ahmad made some very encouraging noises about the potential for spread of this network initiative. Rather than seeing it merely as a Lincolnshire based entity, Mr Ahmad was keen to see it take on a regional focus. Similarly, the Director of Inclusion was also keen to see the use of deaf awareness and communications tactics training spread throughout the East Midlands region and would provide funding and support to facilitate these things happening. As yet, this spread initiative is still to be rolled-out so these statements may be mere rhetoric.

The launch also responded to feedback from profoundly deaf staff who said it would be nice if colleagues etc could sign some basics such as 'hello' and 'how are you' etc. Non-hearing impaired staff members had also expressed a wish to communicate with hearing impaired staff and patients. Consequently a fun and interactive sign language session was arranged as part of the network launch. United Lincolnshire Hospitals Trust is also planning to hold a number of 'Learn to Sign in Your Lunch Break' sessions for staff across the different hospital sites.

An unexpected outcome of the project is the fledgling plan to create a patient group. This follows on from potential applicants, Deaf Lincs staff and volunteers who had lots of experiences in accessing healthcare and wanted the project organisers to adopt a similar approach to setting up a patient group as was followed for the staff network. Establishing the patient group is still at the planning stage but Deaf Lincs will facilitate the meetings and it hopes to engage with about 5- 8 deaf people to set the group up before going out to the wider community for their experiences of what needs to change in terms of service delivery.

6.5.3.2 Deaf awareness and communications tactics training

Between March and August 2010, ULH and NHS Lincolnshire in partnership with Deaf Lincs ran a series of well attended deaf awareness and communications tactics training sessions. These sessions were open to all staff working within the two Trust and Lincolnshire Community Health Services. As of June 2010, forty staff had completed the deaf awareness training and thirty employees had undertaken training in communication tactics. There were three courses remaining with fifteen spaces on each. Where there is spare capacity on the deaf awareness training course, this was offered to staff from the Mental Health Partnership Trust despite them not being a part of Pacesetters. A related but unexpected outcome of this training and its discussion at the network launch is the plan by one of the general managers at Grantham Hospital to introduce meeting etiquette training amongst the staff at that hospital.

6.5.3.3 Easy-Read application form

In recognition that some profoundly deaf people with limited use of English as a second language find Easy Read more accessible (pictorial language sometimes used for people with learning difficulties), an Easy Read job application (see Appendix E2) has been designed and this will sit alongside a more traditional paper copy of application forms: *"We may be bucking a trend and going against what the rest of the NHS is doing but hey!"*

This is a significant step forward from telling a deaf person to go away when they apply for a job in NHS Lincs. This Easy Read form is a small part of the wider work being done by the newly restructured recruitment department since the beginning of February 2010. The recruitment team at ULH NHS Trust has been working on a series of projects including developing and producing effective branding literature on the Trust and Lincolnshire to attract candidates and attending recruitment fairs around the county.

6.5.3.4 Recruitment strategies

Deaf Lincs held an open day on 6 March 2010. Lincolnshire NHS/ULHT piggy-backed on this event. Significant work had been invested in the previous few months in designing literature and branding to display and hand out. A laptop was set up to demo the ease of

accessing NHS jobs website and allay some of the fears about its complexity. The open day in March 2010 was viewed as the first in a series of events where the recruitment team partnership working between NHS Lincolnshire and ULHT will seek to tap into the networks and population groups associated with the community partner, Deaf Lincs.

6.5.3.5 Qualitative outcomes

There is already evidence of change working. Five or six staff, for example, got in contact to say they could not make the launch but were very interested in it. Staff members were coming forward just because they saw something related to 'deafness'. Set members believed what they were witnessing was a positive shift in confidence away from deafness as a stigma to something more positive as people 'come out' wanting to talk about deafness:

> *"a member of staff said at the end of the event on the 30th April (staff network launch) that she had always felt embarrassed about being deaf and that after that day she felt really empowered and she was going to go back into the workplace and not be embarrassed about asking for things that she needed and I just thought that whole thing was just worth it for that one person ... it changed the way she thought about herself actually, in focus groups she kind of felt it was a weakness and she's not applied for promotion because she needed bits of equipment and translated that to not being able to do the job"*

Two out of three members of staff who agreed to speak at the network launch had previously 'covered up' their hearing impairments. Anecdotally, people who work in reasonable proximity to each other and know each other in the workplace were surprised to find their colleagues at the launch and knew nothing about their relative hearing impairments because it was covered up in the workplace. This represents a significant change from the start of the project and it is doubtful this would have happened without this pilot initiative.

On reflection, Strong and effective partnership working is also an outcome of this project. Partnership working has brought together the human resources teams in both ULH and NHS Lincolnshire. Moreover the added ingredient of Deaf Lincs makes this partnership working unique and this relationship has gone from strength to strength. It is possible that these organisations might have possibly come together to respond to something related to patient issues but to come together effectively on matters related to staff is a radical thing. Testimony to this strong partnership working, ULH has applied for the NHS Leadership Awards (NHS Partnership Award of the Year 2010) for the project.

6.5.4 Logic tree diagrams and vehicle analogies

At the start of the evaluation in September 2009, the project leads were asked to visualise their project using a logic tree diagram which seeks to identify and get stakeholders to reflect upon particular factors such as enabling tools (sunshine/sunrays), challenges and barriers (black acid rain drops) and long term outcomes (slices of apple pie) . As a participatory creation, the diagram below highlights the crucial role that the community partner Deaf Lincs plays in virtually all aspects of the project process. Partnership working between ULH and NHS Lincs is also highlighted as an important enabling factor (see Appendix E 3).

The tree diagram was reviewed in a set meeting in early March 2010 (see Appendix E 4). The most significant change was the greying-out of the acid rain drop relating to the lack of open and fair recruitment. The group felt that progress was being made in this area. The group felt it prudent to question whether open and fair recruitment was a reality via all managers. Whilst quality assurance can be carried out, human resources cannot sit on every recruitment panel. Nonetheless, the group felt that it was very interesting to see the logic diagram and recruitment that was seen as a real difficulty/challenge is now an enabler and this was in no small way down to the recruitment team.

An additional acid rain drop was included and this relates to funding for the staff network to drive it forward and make it sustainable when the project leads walk away. A perceived lack of understanding/empathy by leadership was reinforced in the discussion. This raises questions about awareness of the project detail at Executive Trust Board level but perhaps more seriously, awareness of what being a model employer involves. But even without the desired top management buy-in, it was felt that individuals and teams could still make a positive difference. Significantly and symbolically an important delegate and champion of the project at the network launch event was the Director of Human Resources. Nonetheless this raise issues with regard to the sustainability and continued development of this initiative without management understanding and commitment.

The pressure on staff time was emphasised in discussion. Lincolnshire has four Pacesetter projects on the go. The project leads highlighted that they are still expected to do all the other parts of their job despite the Pacesetters work. This equates to working evening and weekends at home to catch up on e-mail etc. The leads felt that there was never a time when they could put Pacesetters to one side for 2 weeks because it would lose momentum and focus. In sum, the workload was manageable when compared to the work required by wave one sites but because of particular circumstances, it had been difficult.

At the September orientation meeting in London for the selected projects, the project leads were asked to compare their projects to a vehicle. The following comparisons were made:

> *"National Express Coach because it's good for longish journeys but uncomfortable at times but hopefully everyone is onboard for the full destination. Sometimes it's like a rickshaw in which I'm doing all the physical work".*

"A flat back lorry because it has stamina. It would be red in colour, capable of carrying lots of ideas but open back to see the bigger picture. Slow and steady".

Asked to reflect on these comparisons in March, yielded the following response. The analogy of a rickshaw had been dropped but the coach idea has been retained though the engine is considered more powerful than first thought but it still requires people to sell and distribute tickets, agree on the overall route, timetable, stops etc.

In June 2010, the analogy of the coach had been dropped in favour of a 'motorbike'. This reflected the slimmed down staffing available to the project following the end of the secondment of one of the project leads, the increased pressure on the remaining staff time, questions over future funding and sustainability and consequently the increased vulnerability of the project in terms of forward momentum. The project is in a transition phase at the moment in which the planned launch has taken place and a meeting needs to be arranged for network members at which issues of sustainability (creating a steering group, terms of reference, identifying the funders of interpretation services etc) need to be established. Currently, five members of the network have expressed an interest in forming the steering group. It is anticipated that the first post-launch meeting will take place by late September and a fledgling steering group will be in place. The development of the network will continue to be supported and coordinated by the ULH Diversity Manager. But what is the best means of communication for the network members scattered across a predominately rural county? Is e-mail the best tool or is face to face communication? Will staff be given time allowances to participate in network events? Some important logistical issues need to be resolved for the network to move forward on a firm footing. In addition, the project lead is lacking some basic information which is required for forward planning. This information includes budgeting information for 2010-11. In this instance, among the many positives of partnership working espoused in this report in that monies must reside within an organisation's budget and if it is sitting in an organisation which has no staff working on Pacesetters, this provides a significant stumbling block to moving forward and project sustainability.

The tree diagram was reviewed again in early June 2010 (see Appendix E 5). The most significant changes were the emphasis on partnership working from the outset in the roots of the tree. This is reflected in the change from 'project coordinator' to project group which included DEAF Lincs. The project championing and positive support of senior managers led to the greying out (situation less of a concern that previously) of the acid rain drop 'lack of understanding/empathy by leadership. Computer systems had also been re-examined in a similar light in the belief that it should not be a significant barrier to anything the project wishes to achieve. One major omission from the tree diagram below compared to March 2010 was the disappearance of staff-side support. Without explanation and despite confirmation of attendance, the Royal College of Nursing (RCN) and the public services trade union (UNISON), did not attend the network launch. This lack of support represented a significant disappointment to the organisers.

6.5. 5 Concluding remarks

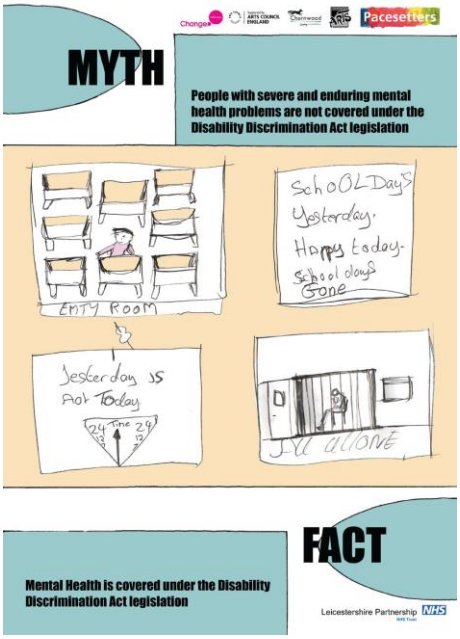
The development and origins of this project date back to 2007. Back then, collaboration between Lincolnshire PCT and the RNID was at the core of this change initiative. The evolution of the project continues to place a critical emphasis on collaborative working and partnership between ULH, Lincolnshire PCT, NHS staff and DEAF Lincs. It is clearly apparent that without the proactive input and co-operation of DEAF Lincs, the project would fall. The new staff network also requires the continued support of DEAF Lincs but it also needs to develop an energy of its own which will allow it to consolidate and survive. Having had its launch, the network has entered the difficult phase which all fledgling projects and ideas have to face. Now that the dust has settled what happens next? How might the network build a momentum of its own and move towards drawing up terms of reference and facilitating meaningful engagement between network members. What will be the communication tools for that engagement given the pressure on staff time and the related difficulties of face to face meeting time when network members are scattered across a predominately rural county? How will the network be resourced and whilst the involvement of the regional SHA might be a positive development in terms of spreading the network and providing resources, its equally important that the local does not become lost in any spread initiative.

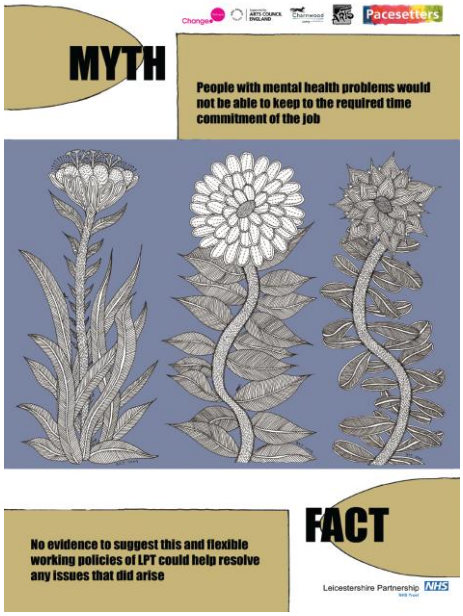
The short and medium term outcomes of this project are clearly being achieved. Encouraging people to talk openly about disability, appear at forum events and disclose their disability is no mean feat given the secrecy and perceived stigma attached to disclosure. Hand in hand with encouraging disclosure, the project leaders in conjunction with DEAF Lincs have supported and fostered the development of a staff network for sharing ideas and experiences. In due course, representative members of the Deaf staff network will sit on the Trust wide Diversity Group, which is a strategic Trust wide group, chaired by the Director of HR.

The longer term outcome of whether the network and all that it stands for can be sustained is a difficult question to answer at this stage. The central government fiscal deficit will undoubtedly have local implications in terms of resource allocation and availability and it is whether some initiatives related to equality and diversity such as this will fall into the 'essentials camp' or the 'it would be a nice things to do but... camp'. Encouragingly, having a project champion at SHA level, where Pacesetters sits, can do no harm in helping to ensure that the former rather than the latter scenario is the outcome for this Pacesetters initiative. Though the most recent central government announcements about the future of SHAs means support from SHA level may be short-lived.

6.6 Case Study F: Wave 2 Leicestershire Partnership Trust (LPT) NHS Trust: An awareness campaign around employment of people with lived experience of mental ill health.

MINDFUL EMPLOYER





6.1 Introduction

This report provides an analysis of the process of development and a record of the outcomes which have occurred during a specific Pacesetters project. This project, at Leicestershire Partnership NHS Trust (LPT), was an awareness campaign around employment of people with lived experience of mental health. The campaign was a wave 2 project and was designed to run from March 2009 to March 2010. The project was one of three Pacesetter projects undertaken by LPT. In the spirit of participatory evaluation this report integrates local data collection and analysis undertaken by the project team with material collected by the evaluation team during the period June 2009 – September 2010; these time scales for evaluation were determined by the Department of Health (DH). This report has been discussed with the key stakeholders. It has been constructed by the LJMU evaluator and adds an external perspective to the internal reflections of those involved. This would not have been possible without the openness and commitment of the people involved.

6.2 National Context and LPT Context

Pacesetters as a DH initiative involved a three year programme running from April 2007 – March 2010. The aim was to embark on: *'a shared journey between health*

organizations and local communities, to understand the inequalities and develop innovative ways to improve health care'.

This LPT project comes within the Socially Excluded Adults Public Service Agreement (PSA 16) and is situated within a national policy context where the previous government set out overarching ambitions for mental health and employment: 'Working our way to better mental health: a framework for action'. The government commissioned an independent review led by Rachel Perkins: 'realising ambitions: Better employment support for people with a mental health condition'. The Perkins Review highlighted the benefits of work for people's health and argued that helping more people return to work would help reduce the costs of managing mental health services to the economy. The government responded to the review's recommendations and set out specific actions for the Government and regional and local stakeholders in 'Work, Recovery and Inclusion' (HM Government 2009). The joint ministerial foreword for this Best Practice Guidance states:

> '*Our vision is one is where having a mental health condition is no longer stigmatising nor a barrier to full and equal participation in our society. We must rethink how we work and challenge negative assumptions about mental health conditions*'. (HM Government, 2009: 3).

This project specifically focused on challenging negative assumptions about mental health and the project leads demonstrated an up to date and in depth knowledge of key policy drivers which they identified as:

- HM Government (2009) Work, Recovery and Inclusion
- Mind / Rethink (2008) "Time To Change" Campaign http://www.time-to-change.org.uk/
- NHS Employers (2010) "Open Your Mind" Campaign http://www.time-to-change.org.uk/news/time-change-welcomes-launch-openyour-mind
- Perkins, R; Farmer P & Litchfield P (2009) Realising Ambitions: Better Employment Support for people with a Mental Health Condition

A stated rationale for this specific project was that:

> 'People with severe mental illness recover better when employment is retained (NHS Employers 2008; Robdale 2008; East Midlands Public Health Report 2006.) Despite this people with mental health problems have the lowest rate of employment for all disabled groups. In the East Midlands the figures cited are around 18 - 27% (East Midlands Regional Employment Team 2008) compared to almost 80% of the adult population as a whole (Shaw Trust 2007.)' (Appendix F1)

The project was situated within CORIIN, an LPT delivery mechanism to ensure engagement with local communities and the promotion of inclusive practice. A key principle of Pacesetters is that there should be strong and genuine engagement with community and patient groups. Therefore, it was planned that service users would be involved throughout the entire project. Six service users were recruited and a project focus group was formed with these individuals and representation from other priority

stakeholders: Breaking the Barriers, an organisation which helps people with a disability into employment; LPTs Equality and Human Rights Lead; key clinical; Human Resources and service user employees of LPT.

The project was led by two Employment Facilitators who were employed by LPT to review current workforce policies and to consider access to jobs within the Trust and the support available to those employed with mental health problems. The project fitted within their remit and was part of LPT's Workforce project which aims to:

- Develop capacity and capability to support and promote employment opportunities for mental health service users
- Review the support systems and policies which are in place for all staff

The campaign coincided with LPT signing up to the Mindful Employer charter www.mindfulemployer.net. The campaign booklet explains that this illustrates LPT's:

> *Commitment to improving the working lives of our staff by showing a positive and enabling attitude to employees and job applicants with mental health issues. It also shows our pledge to not make assumptions about a person with mental ill-health or a learning disability in relation to their work performance* (Project booklet page 5)

This questioning of taken-for-granted assumptions is a key driver for many pacesetter projects and underpins the participatory evaluation approach adapted by the LJMU evaluation team.

6.6.3 Evaluation approach

The LJMU evaluation team were commissioned by the DH in June 2009. When the two project leads attended an orientation event in August 2009 they were five months into the project. During this event the evaluation approach was explained, namely that the LJMU evaluator would work with the internal evaluation processes in order to produce a local report. Appendix F2 is the final report produced by the project leads and this has been informed by the action learning methodology adapted by the LJMU evaluator.

This methodology is compatible with Pacesetters ethos as it focuses on engagement with a core group at each case study site. Four action learning set meetings with key informants (including service users) and four individual interviews enabled further exploration and clarification of the learning and action which emerged during the project. Data has also been collected using local data including monthly update reports which have provided details of planned and actual progress and pre- and post questionnaires.

6.6.4 Resources

As discussed, this particular project was led by two project leads; both had lived experience of mental ill health. The project leads are full time employees of LPT and are employed as Employment Facilitators; the success and learning which has arisen from this project can be attributed to their enthusiasm and the support they have received

and developed within LPT. Unfortunately, one of the project leads was absent from September to March, this impacted on the roll out of the campaign. The remaining project lead commented: '*what was designed as a two person project has become a one person project*'. Therefore the roll out of the campaign was staggered though it had initially been planned as a three month campaign.

The Equality and Human Rights Lead has been fully supportive of the project and this evaluation. Indeed, a key feature of the project has been the involvement of a range of stakeholders in the design, implementation and evaluation stages. Stakeholders involved were:

- Service users and representatives from local service user forums (open assembly and people forum)
- Leicestershire and Leicester PCT Commissioners
- LPT staff who have experience of mental health services as a user or carer
- Occupational Therapy
- Occupational Health
- Human Resources
- Job Centre Plus and local employment agency (breaking the barriers)

In addition to the above time resources have been invested by others within LPT, other resources include the use of facilities and materials.

6.6.5 Initial aims and intended outcomes

At the initial evaluation meeting in August 2009 the project leads articulated the project aims and outcomes as:

Aim: To have an impact on staff's attitudes about people who have suffered mental ill health.

Outcomes:

Short term: Raised awareness around the issues of mental ill health and dispelling some of the myths; LPT more supportive of employees who are currently, or have been, service users.

Medium term: Change in staff attitudes and behaviours; increased disclosure of mental health issues; increased employment within LPT for people with mental health concerns; a workforce representative of the national population with regard to mental health issues.

Long term: Service user applicants for all positions; continued support for service users within LPT and the establishment of a team of experts to support employee service users.

The above have been captured in a logic tree model which was completed during the orientation event in August 2009, see appendix F3. Appendix F4 shows an updated logic

tree which was completed in June 2010 when the project had been completed. It is interesting to note how the process of evaluation enabled a clearer articulation and representation of the project. At the initial stage of the project long term objectives (apple pies), medium term objectives (apples) and short term objectives (leaves) were clearly articulated. However, these altered as the project progressed. The logic tree also shows barriers (acid rain) and enablers (sun); the trunk and roots show support for the project. During the process of evaluation, specifically the action learning set meetings, these became more clearly articulated as a shared understanding of the project developed and the project team enacted a plan do, study, act (PDSA) cycle.

The project was initially planned as a poster campaign with a pre and post evaluation questionnaire; initially to 'prove' that the campaign had positively impacted on staff's attitudes regarding people who have suffered mental ill health. Implementation followed a different course reflecting local circumstances and reflection processes.

6.6.6 Project Mechanisms and activities

Key activities were:

Service users and key stakeholders were involved from the start of the project (April 2009) in the initial design of the campaign; including the design of the questionnaire, the booklet and the poster campaign.

An equality impact assessment (EIA) day was held with key stakeholders (including service user volunteers) on 23rd April 2009 to impact assess the key HR policies which were pertinent to the objectives of this project; policies included were: Recruitment, Access to Work, Equality and Diversity, and Dignity at Work .

A poster campaign on myths and facts regarding attitudes to working alongside service users was designed by a service user artist. The project leads designed the myths and facts using their own experience as service users. The artwork for the posters was supplied by service users. Proof posters were displayed around LPT for comments during August 2009 and this resulted in slight amendments to wording and logos. Posters were received in September 2009 and started to be displayed in October 2009.

A project booklet was produced to support the poster campaign. The booklet was impact assessed by the project focus group in August; amendments were made and taken back to the group. The second draft of the booklet was sent out for consultation in October 2009. The booklet was distributed in January 2010.

A pre and post poster campaign evaluation questionnaire was designed by the project leads and service user volunteers. The questionnaire was piloted on 25 staff, the service user's forum and LPT disability staff group. Project leads received good feedback on the trial questionnaire and it was sent out early June 2009 to 500 LPT staff. A total of 192 questionnaires were returned, 6 were not completed so a total of 186 questionnaires were analysed by the audit department. A second questionnaire was distributed in January 2010 with a return date of 1st March 2010. A total of 146 questionnaires were returned, 5 were not completed and 2 were returned late. A total of 139 questionnaires were analysed by the audit department. The results to baseline audit were discussed at the action learning set on the 25th March 2010 in order to explore the issues underlying

the quantitative data. Please see Appendix F2 for the results of the pre and post evaluation questionnaire.

Promoting and integrating the project

In addition to the above key aspects of the project other actions have been taken to ensure the success of the project and it's alignment with other pacesetter initiatives and LPT processes. These include:

- Publicity of the project at events across the Trust, e.g. listening and Working events.
- Opportunities identified to generate qualitative data from service users.
- Participatory evaluation 'way of working' adapted for Peoples Forum

The above outline of project activities highlights the time investment required by the project leads and other stakeholders. Undoubtedly the requirement for extensive stakeholder involvement slowed down the process. However, this involvement has led to the achievement, refinement and future sustainability of project outcomes.

6.6.7 Project outcomes: evaluation and refining

Project outcomes have been reviewed on an ongoing basis facilitated by the use of the action learning sets and follow up interviews with key informants on the 24th June: two HR personnel, one of the project leads and the Equality and Human Rights Lead. During set meetings and the follow up interviews the initial logic model was reviewed and updated, Appendix F4 shows the final logic tree. Comparing this logic tree to the one originally completed in August 2009, Appendix F3, it is clear that the project team identified more enabling factors (sun) but also more barriers (acid rain). The final interviews enabled a further discussion around short, medium and long term outcomes and this proved extremely useful in further focusing and developing a shared understanding of the stated outcomes and a judgement on the extent to which each outcome had been achieved. The discussion also resulted in further clarification and refinement of some of the stated outcomes. Key aspects are summarised below.

The first short term objective was to raise awareness around issues of mental ill health and to dispel some of the myths. The poster campaign was viewed as a success as the Equality and Human Rights Lead commented: '*The posters have caused a lot of discussion'*. This was reinforced by one of the HR practitioners who commented: '*they are so striking, the one with the head in the hands, we can all feel like that some days'.* However, the need to continually raise awareness was identified as an ongoing challenge.

The second short objective was to ensure LPT was more supportive of employees who are currently, or have been, service users. This was considered a success as evidenced by an increase from 3% to 15% of employees who are now on a Care Programme Approach (CPA). A CPA provides support for those with lived experience of ill mental health and this support programme had previously not been available to employees.

The first medium term outcome was to change staff attitudes and behaviours regarding perceptions of people with mental ill health. This was identified as an ongoing and longer term outcome. The pre evaluation survey indicated a 'reasonably positive' attitude among those who responded which may indicate that those who responded were aware of the issues. This interpretation is supported by many of the qualitative comments, for example:

> *'There is a vast array of mental illnesses from which create so many different issues therefore, I find the above questions very difficult to answer; with different degrees of severity in mental health problems''.*

The post evaluation survey also indicated a reasonably positive attitude and the pre and post results were discussed at an action learning set meeting on the 25th March 2010. The set supported the interpretation that those who had replied were more aware of the issues. However, the set also discussed their lived experience, negative media reports and national statistics around employment and discrimination. They concluded that there was an ongoing need to continually challenge staff attitudes and behaviours. These 'conversations for understanding' were a key feature of the set meetings and resulted in facilitating the plan, do, study, act (PDSA) process inherent in the project. This is evidenced later within the final section of this report which discusses the re-focused objectives.

The second medium term outcome was to achieve an increased disclosure of mental health issues. Anecdotal evidence indicates that during the period of the project disclosure figures have improved. At the time of writing this report survey data was not available to support or contradict this view. However, key informants were aware of the complexity underpinning disclosure and possible reasons for non-disclosure including individuals' fear that *'it would be used against them'* or '*they would not be employed*'.

The third medium term outcome was to achieve increased employment within LPT for people with mental health concerns. LPT had been successful in bidding for funding under the Future Jobs Fund initiative and the Making Time to Care initiative. This has resulted in additional posts. However, these sources of funding no longer exist and this presents a new challenge for LPT. This is discussed later.

The fourth medium term outcome was to achieve a workforce representative of the national population with regard to mental health issues. Key informants discussed what this figure should be and the possibility of 25% was discussed. Most of the key informants thought this figure was too high. However, this led to a discussion concerning the constitution of the representation, the need for a '*skilled workforce',* and questioning whether service user representation could be achievable in all job roles. The informants agreed that this was a longer term outcome which was negatively impacted by the current recession and emerging government policies.

The first long term outcome was to achieve service user applicants for all positions. This is a particularly challenging outcome and was discussed by the key informants as highlighted above. This is also discussed further with regard to barriers.

The second long term outcome was to provide continued support for service users within LPT and the establishment of a team of experts to support employee service

users. To some extent this has been achieved as the project leads are full time employees and they have developed expertise during the project. The project leads have also identified a master's course on vocational rehabilitation and are currently discussing the possibility of attendance at this course for themselves and other key post holders.

The refining of the project outcomes provides some evidence of the sustainability of the project and its potential to spread. The project outputs will support this spread.

6.6.7 Project Outputs: sustain and spread

Two outputs will be key in enabling further sustain and spread of this project.

Posters and booklets
Some of the posters have been framed so that they can be displayed permanently within LPT. In addition, several other Trusts have requested copies of the posters and the booklets. The funding received from the other Trusts will be used to fund Art Space.

EQA on HR policies and impact on service users
The writing of the policies has been delayed due to competing pressures of work. However, dedicated time has now been given for HR staff involvement and work is now progressing, currently 20 policies are being reviewed and rewritten. All job descriptions and person specifications positively encourage service users or those with empathy to service users. Some posts include service user experience as essential criteria, for example the two project leads are employed as Service User Development workers.

The ongoing evaluation of the project has ensured that longer term outcomes and sustainability needs were the focus of the project agenda rather than an over emphasis on project activities and delivery. Key informants identified the main barriers and possible future barriers to sustainability.

6.6.8 Challenges and barriers

The recession was viewed as the key barrier. In March £4 billion had been cut from NHS budgets and at the time of writing future cuts and re-structuring were causes for uncertainty. The Future Jobs fund, a major contributor enabling people to gain employment, had been cut. The potential contradictions within the emerging policies of the new coalition government were viewed as cause for concern. In particular the proposals which may require people to work longer appear to contradict policies which support employment for service users. As one informant stated: '*if people work for longer where do the jobs come from? Jobs for anyone, not just service users'.*

On several occasions key informants discussed the '*benefits trap'* and the need for *'joined up thinking and joined up services'.*

Also, and as discussed above, the problems underlying disclosure and individuals fear of '*being labelled'* were also identified as barriers.

Restructuring at LPT had also resulted in uncertain reporting structures. For example, the project leads had '*four different bosses in eighteen months*'.

Despite the above challenges several key enablers have contributed to the success of this project.

6.6.9 Enablers

The key enabler was undoubtedly the will and commitment of the people involved in the design, implementation and ongoing evaluation of this project. Key informants were aware of the complexities involved and open to questioning taken for granted assumptions. They embraced the participatory evaluation design and took action to improve or learn from the project during the evaluation period.

Some aspects of the organisational structure proved to be key enablers and this included the Communication Rights and Inclusion Committee (CRIC) which reports directly to the Trust Board. The Equality and Human Rights Lead is a member of this Board and reports to the Director of Communities, Rights and Inclusion. This reporting structure, and the active participation of the Equality and Human Rights Lead, ensured that Pacesetters projects remained on the Trusts agenda.

At the time of writing LPT were seeking Key Foundation Trust Status and this was identified as a key driver in securing resources to update HR policies.

6.6.10 Learning and what happens now

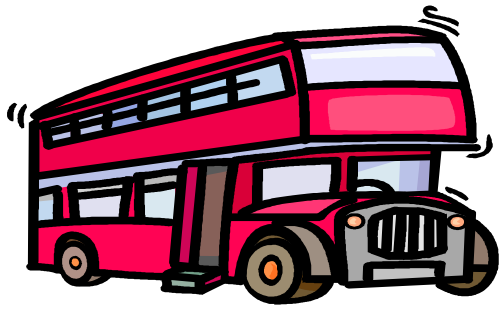
Wider issues around the project have been freely discussed using the set as a 'safe place'. This has enabled the project team to articulate the links between these projects and to identify future research / key stakeholders.

Based on the analysis of the survey data and discussion at the action learning set meetings LPT have identified three myths which will provide the focus for further work:

- People with mental illness take a lot of time off sick.
- People with severe and enduring mental illness are not covered under the Disability Discrimination Act Legislation.
- LPT does not have the structure in place to employ people with mental health problems.

Work to dispel these myths will continue within LPT around PSA 16 and the Mindful Employer initiative.

At the orientation event held in August 2009 the project leads were asked to describe the project as a vehicle, they described:



'*A big red promotional bus that moves around and gathers interest as it goes*'.

This illustrates the promotional aspect of the initial project and the planned campaign.

In March 2010 they described the project as:

'*A racing car stuck behind a tractor. The tractor is full of hay and the hay keeps falling on to the road so the racing car can't get past.'*

This illustrates the frustrations they were experiencing at this time with regard to the roll out of the campaign and organisational barriers as discussed above.

At the end of the project the project leads produced a report for wider dissemination; see Appendix F2. This articulated two broad aims for the project:

<u>Re-focused aims:</u>

- To engage mental health service users in reviewing the Trust's capacity and capability to better promote and develop employment opportunities within the Trust for service users.
- To review current policies and support practices in place for employees with experience of a mental health condition.

At the end of the project the project leads produced a presentation, and the scope of the project was articulated as:

<u>Re-focused objectives:</u>

- To build up the service user engagement with the project so that their chances of employment either within the Trust or with other employers are enhanced.
- To review current policies and support practices in place for employees with experience of ill mental health, across all levels of the Trust, including ensuring that staff with lived experience have the opportunity to influence policy and practice.

- To review the Trusts capacity and capability to better promote and develop employment opportunities within the Trust for service users.
- To identify and work towards developing the systems to support these employment initiatives.

This clearer articulation of project aims and objectives provides some evidence of the learning that had taken place during the evaluation period. It also provides some insight into the sustainability and potential for spread which continues to emerge from this Pacesetters project.

The project was designed to fit into the wider agenda and was recognised as a small but vital area to tackle. As the project evolved it has been re-iterated that the campaign alone cannot deal with everything. The set identified that stigma in the workplace and HR policies can hinder service users in seeking work. However, set meetings also provided a 'safe place' to grapple with and identify research in other areas. This included the 'benefits trap' the role of Occupational Health as gate keepers and concerns about being 'labelled'. A key concern remains the apparent contradictions in government policies, the complexity of the issues they are facing and the uncertainty.

Despite such complexities and uncertainties there is evidence that this project has been a success and the project leads have been inventive in refocusing the project as it evolved and they encountered difficulties. This refocusing has ensured that the project succeeded but also that it can be sustained and embedded with LPT and other Trusts.

The external evaluator was impressed by the enthusiasm and openness of those who participated in this evaluation; in particular their willingness to question taken-for-granted assumptions during set meetings. There was evidence that this 'action-learning way of working' had impacted on other equality initiatives and the Equality and Human Rights Lead has agreed to a follow up meeting with the evaluator to explore this aspect further.

6.7 Case Study G: Wave 2 South East Coast Ambulance Service: BME recruitment and employment

6.7.1 Context

This is a workforce related project and a wave 2 initiative. It centres on enhancing BME recruitment to SECAmb with retention as an added value. In a nutshell, the project under the auspices of the Equality and Diversity Head is about the development and delivery, through a user-led process of advertorial materials in a range of formats and communication media. The ambulance service specific advertorial material is targeted at BME communities. The pilot project tests the feasibility, effectiveness and best value of the dissemination tools which include:

1. Full colour advertorial in the Voice newspaper detailing thee work of the Trust, staff, roles and career routes;
2. A series of professional vox-pop tapes for radio play using either narrative or advertorial targeting BME communities. Use of Rokker Radio will enable the media to reach gypsy and traveller groups;
3. Investigation into appropriate web-based approaches for disseminating information to BME communities that are seldom heard and who remain underrepresented in the recruitment process.

The geographical focus for this pilot project is the Surrey Travel to Work Area (TTWA).The advertorial campaign featuring the publication of 'life interest' stories from selected current BME employees is organised in conjunction with The 'Voice' which is a weekly tabloid newspaper aimed at the UK African–Caribbean communities.

The need for a project in this area is highlighted by data from the national ambulance service which revealed the poor representation of BME people in this sector. More generally, the Race Equality Foundation's Briefing Paper (2007) on the recruitment and retention of BME staff in the NHS focuses on the disproportionate distribution of BME staff in the NHS through the lens of grades and occupations (see http://www.better-health.org.uk/files/health/health-brief4.pdf). Locally, SECAmb has a 7 percent BME client base in its operational area but its BME employee percentage does not come near this figure.

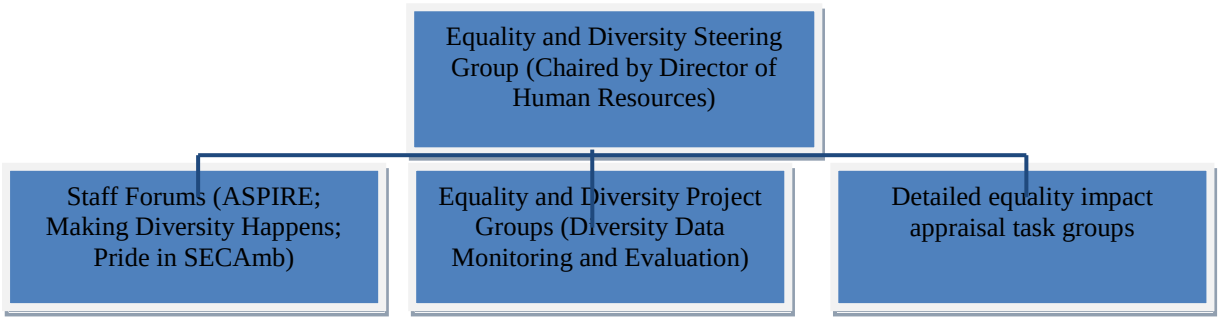
The South East Coast Ambulance Service NHS Trust (SECAmb) responds to 999 calls from the public and urgent calls from healthcare professionals such as GPs. The Trust also provides non-emergency patient transport services to and from healthcare facilities. The Trust's geographical remit covers Kent, Surrey, Sussex and parts of North Hampshire.
Over the past few years, SECAmb has embarked on an intensive programme of work around equality and diversity issues. Some of the key actions include:

- Assisting staff to set up workplace forums to support diversity;

- Review and development of internal equality, diversity and human rights training programme;
- Undertake work to identify barriers in recruitment and employment and promote equality of opportunity for all in accordance with SECAmb's Single Equalities Scheme.

By way of delivering on this work schedule, SECAmb appointed two specialist staff whose remit covered equality and diversity (PPI Manager for Equality and Diversity; and an Equality and Diversity Lead). The structure chart below provides an insight into how equality and diversity issues are handled in a collaborative way.

Equality and Diversity Structures at SECAmb



A supplementary activity of this Pacesetters project is a skills and training needs audit. This has been coordinated by SECAmb's BME and minority faith staff network, ASPIRE. The idea of BME networks was developed in the context of recruiting and retaining BME workers and represents a key component of the overall diversity and equality strategy within the NHS (Department of Health, 2001). Launched in October 2008, ASPIRE provides a collective voice to promote equality and diversity throughout the Trust and is open to all staff. It also works with SECAmb to support the recruitment and retention of people from BME backgrounds and helps to identify the impact the Trust's work has on BME people and communities. ASPIRE is not an innovative idea. In fact, the SECAmb entity is a relatively late arrival on staff network scene. In Liverpool, for example, the Liverpool NHS Black and Minority Ethnic Staff Network has been operating for over 12 years, providing expert advice and information to BME staff and professionals working within nine local NHS Trusts.

As an outcome of the SECAmb audit, 8 BME staff have received accredited training as Equality and Diversity Facilitators. Two of these staff have also undertaken a related Training-the Trainer programme in order to build sustainability into the programme. Other complementary activities include a system of buddies/mentors for new BME starters who request peer support.

6. 7.1.1 Aims and objectives

Alongside the Voice advertorial, the overall aims of this project were:

- To increase the number of non-white BME staff at all grades employed by the Trust from the most recent published figure of less than 1.5% to a figure that is closer to the demographic profile of SECAmb's operational area 7%.

- To increase the profile of the Trust as an employer of choice amongst BME communities across Surrey, Sussex and Kent.

- To work with local BME communities to promote the Trust as an employer of choice.

- To work with adjacent Ambulance Trusts and through the NHS Confederation, to increase awareness of roles and employment opportunities within the NHS Ambulance Service for BME communities in our travel to work area.

6.7.2 Project Mechanisms

6.7.2.1 Workshops and focus groups

As part of this Pacesetters project, a workshop with 18 Black and Minority Ethnic led community and faith groups in the Banstead, Surrey travel-to-work area were held. Through focus group type discussions, a range of barriers to recruitment, based on perceptions and attitudes were identified. These included:

1. Lack of awareness around the role and function of the service in relation to the NHS.

2. Misconception around the professional and clinical roles and complexity of some work within the ambulance service – some participants viewed working for the Ambulance service as 'lowly'.

3. Lack of awareness around non-clinical career routes in the service.

4. Perception from some participants that a degree or at least A-level standard qualifications would be required for most, if not all roles.

5. Lack of clarity around pay and benefits.

6. Questions over the lack of representation of BME people in existing corporate information and whether Ambulance Services are welcoming of BME candidates.

6.7.2 2 Epsom Conference

SECAmb organised a highly successful conference in October 2009 on equality and diversity in the emergency care sector. The conference was attended, amongst other, by Ambulance Trusts from across England with key note speeches and prominent roles at the conference from the top tiers of the Trust management and the Pacesetters programme (see Appendix G 1 for the conference programme). What became apparent from the conference was that the project lead had secured the all important senior management buy-in for the project. The importance of horizontal and vertical buy-in can not be under emphasised if the project is to be sustainable. The Voice advertorial was formally launched and distributed widely at this event.

6.7.3 Project Outcomes

6.7.3.1 The Voice advertorial

As mentioned previously, this is a print based tool, targeted at local BME communities. It seeks to address the issues raised in the workshops through the use of 'advertorial material'. This material, forms part of a stand-alone insert and incorporate articles and images, aimed at tackling some of the issues and concerns raised by BME participants (see section 2i). The advertorial contains a series of real life stories of real career progression for BME staff members that the general public might readily encounter on their local high street. This is a key strength of this advertorial. The publication also demonstrates potential opportunities and the diversity of career paths (see Appendix G2).

6.7.3.2 Vox-pop for radio and other web-based dissemination tools

The Voice advertorial has been made available on The Voice website and can be accessed at http://www.voice-online.co.uk/sec_ambulance/index.html. At this stage it is unclear as to the extent to which other forms of media communication have been explored for reasons that are detailed in section 4 below.

6.7.4 Challenges and barriers

In the view of SECAmb's Equality and Diversity Lead, the Epsom conference marked an important watershed. In the two months up to October, difficulties had been experienced in involving Directors. People continued to commit verbal support, but not time. Epsom provided a turning point and the challenge from October onwards was to retain involvement and goodwill. It is further hoped that the evaluation training workshops which were in negotiation (training to be provided by LJMU) was to be

promoted as a 'development opportunity' for staff across the business to enable buy-in from senior staff, who would ordinarily not wish to become involved in the evaluation process, but do have influence over Directors and are also budget holders. In the event this did not take place.

The challenges and barriers to the success of the project are also captured in the acid rain items in the logic tree diagram (Appendix G3). Having said all that, this project was highlighted as a beacon of good practice at the Epsom conference by the then DH Pacesetters Programme Director.

In a figurative sense, an 'acid rain thunderstorm' has subsequently hit the project. In March 2010, the Equality and Diversity Lead for SECAmb was seconded for six months to a post within the South East Coast SHA. The hand-over process for Pacesetters was complicated by a financial and organisational restructure which meant the E& D Lead's post was not backfilled. Pacesetters and equality and diversity matters simply became part of the burgeoning portfolio of responsibilities for another department. The loss of the key agent of change for this project has had a dramatic effect on the project's progress. In truth, it would not be unfair to say that the project has now stalled and whilst there are some efforts to pick up the threads, we are yet to see if this will be decisive in re-energising this Pacesetters project. This latest and most severe setback for this workforce change idea followed on from a period of project downtime caused by the Trust's need to activate its REAP 4 policy due to operational pressures during the coldest winter for 31 years and the lingering concerns about the swine flu pandemic. Consequently, operational staff could not be released to attend training or meetings. The outcomes and consequences of the secondment of the E&D Lead raises questions about the depth and sustainability of the top-management buy-in which was manifest in a positive light at the October 2009 conference.

Another key challenge is the current public sector fiscal crisis which has led to a recruitment freeze on non- operational roles. This creates undoubted difficulties given the feedback from BME groups who are more likely to apply for non-operational roles.

6.7.5 What has worked and what is not working?

Evidence from Monthly Monitoring Status Reports (MMRs) reveals that by the end of November 2009, the project status was rated 3 by the Equality and Diversity Lead. This equates to a 'modest improvement' and that successful tests of changes had been completed (1 PDSA cycle minimum). Some small scale implementations had been done, anecdotal evidence of improvement is available and project goals were 20% complete. By January 2010, the project status rating had risen to 3.5 indicative of improvement and that testing and implementation continues and additional improvement in project measures towards goals has been seen. Key milestones achieved were the completion of a Certificate in Facilitating Diversity by the first wave of staff, including staff involved in recruitment and retention of BME staff and the provision of support for an ASPIRE workshop on leadership which links in with the retention strand. Discussions will follow with the Certificate in Facilitating Diversity cohort about how to sustain their involvement and use their project ideas within this Pacesetters BME representation project.

SECAmb had also received support from national BME Committee of the Ambulance Service Network during this time. The Equality and Diversity Lead had also seen an increase in requests from staff, as well as members of ASPIRE to be included in workshops held with ASPIRE on retention and leadership related training and events.

During the action learning set discussions, it was suggested that the evaluation of this change idea might focus on the following evaluation tools:

1. The published *advertorial insert* will be taken back to the original 18 BME led groups, drawn from the Surrey travel to work area, in a workshop format. The aim would be to test responses and to elicit feedback in the light of their earlier concerns and issues.

2. The published advertorial insert will include a tear our response form, which will enable the geographical distribution to be tracked, as well as preliminary interest, though costs of the freepost would need to be investigated.

3. The PDF would need to be included on the Voice website – with a link being made known and available to all Ambulance Trusts. T his would be to enable other Trusts to provide comment on the content and format as a BME targeted recruitment tool.

4. Enlarged story boards of the Advertorial PDF would be on display with a Talking Wall to enable seminar delegates to post comments.

5. From October 2009 onwards, NHS Jobs, the dedicated on-line recruitment portal for NHS Trusts in England and Wales, would need to include specific reference to whether an applicant had heard of the Trust via the advertorial insert.

Evaluation depends on the cooperation of the key agents delivering the project. The removal of the key lead at a crucial phase of the project coincided with the final evaluation phase and has had an impact on the ability of the evaluation team to ascertain progress due to a break down in communication following the handover referred to above. Thus the external evaluation team has currently no way of ascertaining if the any of these evaluation tools have been actioned. The key champion who was a key driver of this initiative also saw value in capacity building for evaluation and its value in informing change. The evaluation process was dependant on partnership working between local actors and the evaluation team. However the current apparent lack of meaningful local evaluation makes it difficult to gauge the impact of this workforce idea beyond the initial activity. In addition, references to the dissemination of this workforce change idea among gypsy and traveller communities appears to have been dropped. The reason behind this could be because BBC Three Counties, which is responsible for Rokker Radio, has not broadcast a programme since January 2009 and has no programmes scheduled in the near future.

6.7.6 Conclusion

After an initial thrust the processes underpinning this initiative stalled in no small part due to the failure of the Trust to use the money provided by Pacesetters to back fill the post while it was temporarily vacated for six months by the project lead. With the absence of any leadership or change agent taking the initiative forward the process faltered in its early stage in part because there had been insufficient time to embed ownership beyond the project lead, making it vulnerable to such changes. This raises questions as to the real organisational ownership of the initiative despite the high profile early on since the project was over dependent on one key person. This is a lesson for all projects.

6.8 Case Study H: Wave 2 Cornwall and Scilly Isles: Representation: Employment of People with learning disabilities

Jess on work experience with CIOS PCT colleagues

6.8.1 Context & Rationale

CIOS PCT is involved with 4 Pacesetters projects in total. Two are better health initiatives concerning stroke rehabilitation and raising the awareness of testicular cancer and one is a data change project. This evaluation concerns a Wave 2 project seeking to increase the representation of people with learning disabilities within the workforce. The project team consists of a variety of NHS staff and partners including an

Equality & Diversity Manager, a Human Resources Advisor, a project Co-ordinator and a Nurse Consultant for people with Learning disabilities. Together they are accountable to the Pacesetters Steering Group which reports to the Equality & Diversity sub-committee. People with learning disabilities are also represented on the project steering group and participated in many aspects this evaluation – including 'set' meetings.

The original innovation in this project was to increase the representation of individuals with learning disabilities within the workforce through short-term (12 week) work experience placements. By incorporating a team of CHAMPS (Cornwall Health and Making Partnerships) from another externally managed project, however, the initiative has broadened its scope and reach. CHAMPS is a team of 9 people with learning disabilities who are now employed on substantive NHS contracts to advise and develop accessible services for others. These initiatives have been supported with advice from *Cornwall Learning Disability Partnership Board* (which provides advocacy and information for carers) and *Cornwall Works for Learning Disabilities* (which aims to provide a pathway to sustainable employment for people with learning disabilities). The initiatives have also benefitted from strong support from the Board of Directors and, together, everyone has worked hard to develop the projects *with* people with learning disabilities rather than simply *for* them.

Research has shown that, as with the wider population, providing employment to people with learning disabilities leads to greater longevity and fulfilment in life – enhancing self-esteem, skills and social integration[10]. Yet, less than 10% of people with learning disabilities have jobs. Even within the public sector only a small minority employ people with learning disabilities on substantive contracts. One of the key policy aims of the (previous) Government was **'To enable more people with learning disabilities to participate in all forms of employment, wherever possible in paid work, and to make a valued contribution to the world of work'**[11]**.** The Department of Health is therefore committed to widening opportunities for employing people with learning disabilities in the NHS. Unlike many equality initiatives, however, the CIOS PCT innovation is not just driven by policy but by passion and belief in what learning disabled people can both accomplish for themselves and contribute to others if given the opportunity.

6.8.2 Aims & Objectives

This project seeks to increase the representation of individuals with learning disabilities within the workforce by identifying appropriate employment opportunities, training managers and tailoring recruitment processes. The original statement of intent was:

> **The Trust will work...finding work placements for people with learning disabilities, training will be provided to help managers deal with their preconceptions and include how to support and mentor people with learning disabilities in the workplace. Job Coaches will be provided and mentors chosen within the workplace who can support and nurture these**

[10] Jenkins, R. (2002). Value of employment to people with learning disabilities. British Journal of Nursing 11(1), 38-45.
[11] Department of Health (2001) *Valuing People: A New Strategy for Learning Disability for the 21st Century.* The Stationery Office, London

individuals. The project will require innovations in the recruitment process e.g. in job design, easy read formats for job descriptions etc. It is hoped that individuals will begin to be placed with the Trust by the autumn of 2009. The placements will last 12 weeks during which time the students will gain experience in a variety of departments and disciplines dependent upon their skills. The sites identified to accommodate these placements are Camborne, Sedgemoor and Saltash.

In a short period of time the PCT has not only created 3 Work Experience placements for people with learning disabilities but also established the necessary support and supervision structures to ensure their success. After a successful pilot, moreover, 9 Health Champs now also work in the public health team providing advice and support on disability issues and developing more appropriate services for people with learning disabilities. Other innovations are at various stages of development and include 'easy read' information packs, job carving and exploring alternative ways of recruiting, training and retaining a diverse workforce.

As a result of this initiative, there are in fact now two routes to increasing the representation of people with learning disabilities within the PCT. The first (and original Pacesetters innovation) is through Work Experience by which people with learning disabilities are provided with short-term placements within the Trust to learn new skills, increase confidence and contribute to the needs of the workplace. The second is through the CHAMPS project through which people with learning disabilities are employed on substantive NHS contracts to advise and support Trust staff, for example, training practitioners and managers in working with people with learning disabilities and checking that services are accessible.

6.8.3 Evaluation Method

With an assumed baseline of zero, it is not particularly meaningful to make comparisons between 'before' and 'after' the intervention. The cultural change required throughout the organisation is also difficult to quantify so a soft qualitative approach focussing on the views and experiences of evaluation 'set' members has therefore been adopted. The Action Learning Set met every 2 months over about a year. It had a stable core of 4 people: a senior manager, Health Champs Co-ordinator, HR advisor and the external evaluator. Other partners also attended and a Health Champ was also present at each meeting. The views and opinions of those involved in the Work Experience Pilot, other Health Champs and their colleagues were also considered. CIOS PCT covers a huge area which is difficult travel, for logistical reasons it was therefore impossible to meet employees in person but a telephone interview was undertaken with one person on Work Experience. A questionnaire was also specially developed to capture the employees' experience of working in the Trust and was administered by her workplace supervisor (See Appendix H1). In addition to attending the bi-monthly evaluation meetings Health Champs worked together to produce a story board charting their journey through the employment process so far (Appendix H2).

6.8.4 Project Mechanisms

According to the Director of Workforce Development at CIOS PCT, **'We want to make the NHS more accessible to people with learning difficulties, both as an employer and a service provider'** (See Appendix H3). To achieve this, the Trust must understand and adapt. The innovation in the project has therefore focused on changing attitudes through *training* and changing habits through *tailoring* policies and procedures so that they are more sensitive to the needs and strengths of people learning disabilities. However, what became clear during this evaluation, is that the most effective agents of change has been people with learning disabilities themselves as they work with pride and challenge prejudice.

Tailoring

Before entering employment with the Trust, all Health Champs needed to be interviewed. This is a stressful experience for anybody to go through but for people with learning disabilities is potentially alienating and confusing. A lot of preparation therefore went into planning the interviews as a 'fun day' for Team Building and included activities such as beach combing. This was highly successful resulting in all interviewees being offered employment. According to one Champ it was not stressful at all but **'really good'** and everybody got through it successfully and with minimal support. This, perhaps more than anything else, bears testimony to the progress made during the pilot period of the project. When Champs had their original interviews last summer they had job coaches to support them through the process. However, although they were offered the same service for the new NHS job interviews only one person asked for the support of a job coach and then did not even use her to answer the questions!

While the interview process could be tailored, however, the team had to work with existing documents such as job descriptions, CRBs, occupational health forms and so on. The Health Champs therefore needed a lot of support with this aspect of the appointment process – including help from two Liaison Nurses. Rather than singling out people with learning disabilities, the team shares the conviction that 'easy to read' forms should be mainstream and would benefit everybody and not just those with literacy difficulties. There are therefore on-going efforts to ensure that appropriate changes are made so that recruitment, retention and career development for people with learning difficulties become embedded in the Trust. This is a slow and difficult process as 'easy reads' need to cover every legal requirement but in a way that is understandable to a wide range of abilities. The team is also trying to influence national policy because it is expected that managers will resist change if they have to produce two job descriptions: one complex enough to go through the evaluation process and one easy enough for the people with learning disabilities to understand. To address this, the team is also trying to influence the Agenda for Change to see how easy read job descriptions can become mainstream so that managers will only need to provide one in the future. One team member has already had a meeting in London about the issue and will prepare a paper for the Agenda for Change evaluation group.

There are, of course, many other ways of enabling people with learning disabilities in the workplace that do not require complex procedural change. The Work Experience employee is, for example, provided with a pictorial schedule in the mornings and was guided through health & Safety in pictorial form which she found very helpful (See Appendix H4&5). Health Champs too benefited from a tailored induction programme which was broken down into manageable chunks and focussed only on that which was relevant - **'I loved it'** one Champ insisted.

Training

The first round of training focussed on how to support and mentor people with learning disabilities in the workplace and was provided by an external partner with expertise in these issues. Three workshops with senior managers were undertaken and underlined the need to challenge assumptions and provide additional training – particularly regarding communication with people with learning disabilities. The workshops' key suggestions are summarised below:

Inputs required	Expected Outcomes	Perceived Benefits	Perceived Threats	Outputs
People wanting to participate. Identify suitable role profiles. Work trials. Contact with job coaches. Education. Awareness training. Publicity. Training. Education. Training for client and NHS.	An inclusive workforce Staff working as a team to support person. Accessible information Knowledge and understanding. Work experience placements. Recruiting people with LD becomes routine. Culture change. Understanding, acceptance and integration. Options for paid employment	Willingness. Enthusiasm. External Funding. Tailored job descriptions. Establishing if parts of jobs could be separated. Right information given out. Culture change.	Pre-conceived ideas. Bureaucracy Time limitations. People don't see it as a priority. Budget Space – not enough in many rooms. Employers unwilling to employ people with learning difficulties. Not being honest with existing staff.	Long-term employment. Accessible information. Good communication at the right cognitive level. Informed, adapted work environment. Use of pictures, text and staff training.

The second round of training took place in May 2010 and consisted of 3 one day sessions for managers and 3 for prospective Buddies. Training was provided by an outside expert and Health Champs provided additional support through role play which highlighted the impact of labelling people with learning disabilities. Other issues that have been addressed include 'job carving' and 'interview by trial' and a pilot 'rotational programme' in which different roles can be tried and tested to inform future planning.

While both rounds of training were well-received, the project team has come to realise that they actually possess the skills and expertise to provide it themselves in future and this would, additionally, be more cost-effective. Perhaps even more important than this, is the self-advocacy of employees with learning disabilities. Whether on work experience or substantive contracts they have self-evidently demonstrated their value and worth as workers in the Trust.

Training and development is on-going and progress is slow. Old habits have been difficult to break. Managers do not job carve routinely, for example, because it is easier not to. In the current economic climate, however, this could be a cost-effective way of generating lower band roles from higher band work. While the (previous) Government suggests making a 'business case' for employing people with learning disabilities[12], and it is clearly possible to do so, project team members felt that managers should not be motivated by money: **'We need to say, 'do this and you'll get a really motivated workforce, your absence rates are going to plummet, colleagues will be really motivated to work with them and you MAY save some money'.** The emphasis in training and development has therefore started to focus on the (many) benefits that result from working with people who have learning disabilities. Over time, this will **'help managers to change their HR practices and the way they manage people, so that the new methods will eventually become par for the course'** (Appendix H3).

6.8.5 Outcomes

Photo: CIOS PCT Health Champs Team

[12] Department of Health (2009 p.88) *Valuing People Now: a new three year strategy for people with learning disabilities.* The Stationery Office, London

As already noted, a major milestone has been the employment of Champs on substantive NHS contracts. These 9 employees were previously employed through a well known agency with expertise in learning disabilities but due to the complex sub-contracting arrangement, communication was sometimes slow and accountability was unclear. At one point the situation became so strained that Health Champs were in danger of losing their jobs. Swift action by team members along with careful negotiations with the external partner meant that the crisis was successfully resolved to the satisfaction of all. The main reason for the successful outcome, however, was due to the Health Champs themselves, who through their infectious enthusiasm had already won the hearts and minds of CIOS PCT Board members. **'When we told senior managers the Health Champs didn't have jobs from March'** one set member stated, **'they were horrified...It's an enabling force, leap-frogging us into a complete sign up in 24 hours. If we hadn't had those difficulties, we would have probably just carried on as we were but, now we are now bringing them in on substantive contracts'**. This change of employment has had an enormous impact, **'they pay you on time for a start'**, and one Health Champ joked. The most important difference, however, is the sense of achievement, **'I can actually say 'I'm employed by the NHS and be proud that I am. My whole family is so proud of me''**.

Health Champs are employed in a variety of roles and can road test both public health and workplace initiatives. They will, for example, help pilot a 'rotational programme' in collaboration with the Trust's *Skills For Life* lead in which each month a different role can be trialled for suitability and informed career planning. **'Doing the work experience rotational programme will be fantastic, opening the door for everyone else'**, one set member stated, **'It gives people more of a feel about what it's all about rather than just consulting and training'.** During the period of this evaluation they have also contributed to 'easy reads' on public health issues, including a booklet which guides people with learning disabilities through all of the services available locally. They have also provided advice on the use of jargon in the Trust and have even helped to produce some DVDs, including one for clinicians on hospital discharge for someone with learning disabilities. **'They've helped us to take account of who we're engaging with'**. Indeed, as a direct result of their work with Primary Care Liaison Nurses, there has also been an increase in annual health checks and dental appointments among the learning disabled community locally.

Work Experience: a vignette

Jess at work

So far there have been 3 people who have participated in the Work Experience Pilot (one has just started and another just finished). Jess is 24 and likes computers, watching TV and listening to music. She also enjoys line dancing. Before coming to CIOS PCT she had worked on the till in a charity shop and for an Optician putting glasses in to cases. She has learnt many office skills at the Trust including laminating, faxing, binding and franking post all of which require a good deal of dexterity. She really enjoys doing these jobs but especially likes the people with whom she works. The only difficulty Jess has had at work, she joked, is **'reaching things'** because of her diminutive stature.

Feedback from both employee and employer have been very positive. The employee herself enjoys working for the Trust and described the staff around her as friendly and helpful (Appendix H1). Her manager, states that she is **'a complete joy to work with'** while another observer adds, **'Our student has exceeded our expectations in terms of her skills and what she can achieve'**. Colleagues too have reported that Jess works really hard and is a quick learner. **'I'll show her how to do something and then easily walk away knowing that she'll do a very good job of it'** one stated**.** Jess was however very shy when she first started but now, her line manager stated, **'she has really grown in confidence, is bubbly and has me in stitches'.** Another manager similarly stated:

> **The first day Jess turned up she was a quiet little mouse. Slowly she built confidence so we could just say, 'Jess could you just go off and do this' and she was confident enough to go on her own without someone going with her. She spent her first 6 weeks with me and her confidence really did grow. We buddied her up with someone and she got on really well. She loved sitting there and having lunch with him...Jess was saying that she became one of the team. It was very good for my team, actually, to work**

with Jess and look at things from a completely different perspective. It's done them the world of good as well actually...It's been a real joy having Jess with us.

6.8.6 Challenges and barriers

There have been many challenges over the period of this project – some of which have been impossible to overcome. Building refurbishment has, for example, delayed the recruitment of people for Work Experience because of health and safety issues. Several different partners have been used with varying degrees of success. In one instance this slowed down progress, jeopardised outcomes and ultimately led to the decommissioning of services. Despite these difficulties, however, barriers to progress often became an enabling force, as one team member stated, **'If we hadn't had those difficulties, we would have probably just carried on as we were but now we are now bringing them in on substantive contracts'.** Other challenges and difficult barriers, of course, remain and include:

- *Attitudes and preconceptions*: While there is no suggestion of overt prejudice or discrimination against people with learning workers in CIOS PCT. Some staff clearly do not always feel comfortable with 'difference'. Often people may, for example, query how they should react or talk to Health Champs. If more comfortable, banter or humour may be used. Although self-advocacy has been highly effective in destigmatising people with learning disabilities in the workforce, this also has its drawbacks. Involving Health Champs in management training has, for example, led to suggestions that they are being 'paraded'.

- *Bureaucracy*: Recruitment processes in particular are complex and difficult to simplify to the satisfaction of all. Changes have therefore been slow and often need to be agreed by various stakeholders who may lack understanding. When Band 2 job evaluations were re-written in easy read format, for example, they were re-graded as band 1 even though the job itself had not changed!

- *Old Habits*. Trying to get managers on board remains problematic, not because of their unwillingness but because they do not have the capacity. This has affected attendance at training sessions but also impacts on potential job creation. When looking at carving jobs up, as already noted, they tend not to take time to think about whether someone with a learning disability can fulfil certain aspects of a position. Working under pressure, managers tend to do the easiest, quickest and 'safest' thing and replace like for like.

6.8.7 Sustainability

Addressing cultural, structural and organisational issues means that the project team has had to work tirelessly to gain 'approval' from the Board of Directors to the grass roots for the innovation. This has broadly been achieved and the success is due in no small part to the **'infectious enthusiasm'** and self-advocacy skills of Health Champs themselves (and other colleagues) who demonstrated their value to all and challenged

preconceptions without fear and with total disregard for status. The following is only one example of many such stories that were told during set meetings:

> **We had an assessment day last year and the Champs helped out and I think the Board was totally smitten and asked two of them to come up to the Health Service Journal Award Night in London.** [Health Champ] **challenged someone from the SHA in front of the Chief Exec & Directors and asked him 'what are you doing to make sure everyone is employing people with learning difficulties, like us in Cornwall?'.**

Team members, including Health Champs, have also attended various national and regional events to raise awareness of the projects at CIOS PCT. This has generated interest from the press, social services and other NHS organisations and led to further opportunities to share their learning. The team has, for example, made a DVD about employing people with learning disabilities which they will also present at a Pacesetters celebration later this year. All of this will no doubt raise the profile of this project and, hopefully, inspire others to follow suit. However, the real legacy is the lives that have been changed as 3 Health Champs make clear:

'it's nice to meet other people with learning disabilities; this job has really increased my confidence.'

'I love my job and earning my own money so I can save up for things on my own.'

'The job is very good, I love to be out and about helping people and raising awareness about having learning disabilities'

It is not just about changing lives of people with learning disabilities, however, it is about transforming and enriching the workplace. What this innovation demonstrates above everything else is that everybody gains something from a more diverse workforce. This requires action through training and tailoring but without truly participatory values at the heart these will come to nothing. People with learning disabilities are *themselves* **'the best advert for employing people with learning disabilities',** one set member observed and their employment will almost certainly lead to more opportunities for others in CIOS PCT and beyond.

6.8.8 Conclusion

With the (total) employment of 12 new people with learning disabilities the core objective of this innovation has clearly been met. However, some important processes such as staff training, easy reads and 'job carving' are still at various stages of development despite the hard work of the project team. Most importantly, obstacles to progress have been creatively overcome leading to even more innovation and positive outcomes.

Lives have been enriched by this project and CIOS PCT is a more diverse and dynamic workplace as a result. Above all, however, it demonstrates what can be achieved when

humanistic values drive what is done rather than mechanistic criteria individual and collective lives are improved. In summary, it is an excellent example of all the elements of a true Pacesetter initiative – with real co-design and collaboration at its heart and producing real change.

7. Final Observations on the Case Studies as a whole

Passion is a word that has been repeated again and again by participants in both the online survey and the case studies. But passion alone does not change things. For those initiatives that are change ideas based on in-depth analysis, which are supported and owned by the community of interest, and which are embedded in different ways within the organisations involved, either in new employment practices or in heightened awareness of the issues by managers, the change stands more chance of being developed sustained and spread. Resilience in the light of challenges comes from good relationship building. It also requires real ownership by key managers beyond lip service or rhetoric. Innovations can be characterised as either add-ons – competing for resources, or add-ins – competing for attention, power, influence and survival in the system. In system terms, any disturbance in the intervened system causes resistance as well as new opportunities. The problem is primarily how to make such interventions robust and accepted. Most interventions need commitment, good planning, persistence and the intervened system must be prepared, as there must be readiness for change in the system.[13] Bringing about change means learning and adopting new attitudes and practices. Getting people to do things differently is inherently difficult, as habits and beliefs developed over a long period of time get reinforced. Much has been written about evidence based practice; however, it is through trying things out and experiencing the difference that new ways of doing things can be encouraged. The key is getting a balance between "hard" evidence and "soft" relationships. The PDSA cycle implies a reflective and analytical approach to change, but this needs to be combined with the humanistic. Involving the community and a range of stakeholders directly in the whole process of understanding the issue, deciding what to do, trying it out and then actively reflecting together through dialogue on the outcome provide the necessary glue to make it work.

[13] Durlak, J A and Du Pre, EP (2008) Implementation matters: A review of research on the influence of implementation on Program Outcomes and the Factors affecting implementation AmJ Community Psychology 41 327-350

APPENDICES

Appendix A 1

Bristol BME Representation Logic Model

Inputs	Outputs		Outcomes		
What has been invested?	What we do!	Who we Reach!	Short	Medium	Long
Funding Staff Participation Manager/Project lead half time fixed term contract finished Feb 2010- also worked on other areas disability and LGBT **Time Support and partnership** Chair of BME Forum HR personnel Bristol Community Trust Equalities Officer Health promotion/improvement specialists **Time :** Bullying and Harassment helpline staff volunteers **Evidence** from local and national NHS staff surveys indicates that BME staff experience more bullying and harassment than their colleagues	Revival of Old Scheme established 2003 Meetings with current bullying and harassment staff helpline volunteers Collection of baseline data from recent NHS staff survey regarding extent of bullying and harassment Mapping exercise undertaken Information and support meetings with staff helpline volunteer Meetings Publicity leaflets to recruit helpline	BME personnel experiencing bullying and Harassment Volunteers	Recruitment drive to increase the diversity of helpline staff Engagement with BME forum to support recruitment of BME staff to the bullying and harassment helpline	Infrastructure developed to support the bullying and harassment scheme Newly recruited helpline volunteer trained	To increase the diversity of staff volunteers to the bullying and harassment staff helpline focusing on BME employees

	volunteers printed and distributed New publicity to advertise the helpline developed The Bullying and Harassment scheme presented at a BME network meeting				
Enablers: Enthusiasm of volunteers or newly appointed BME lead. **Barriers**: Geographical spread and work patterns making engagement of front line staff difficult, for example, meeting attendance and email. No further investment or capacity to cope with increased demand. Lack of Capacity of HR department. No formal supervision of volunteers. Service demands and shifting priorities, for example, floods and swine flu					

Appendix A2


NHS
Bath and North East Somerset
Bristol
North Somerset
South Gloucestershire
Bristol Community Health
bullying and harassment advice service*
*for PCT staff
24 hour voicemail
0117 900 3447
Confidential advice and support if you think you are experiencing bullying and harassment in the workplace.

Appendix A3

Outline of Pacesetters Programme Bristol PCT Workforce Project Seminar Slides

Staff Participation Development Manager Post

18 Month Fixed Term Post
August 2008 - February 2010
18.75 hours per week
NHS Band 5
Managed through BCH HR Department

Workforce Project Remits
Development of a lesbian, gay and bisexual staff network
Improve the uptake of flexible working options for disabled members of staff
Recruitment of a more diverse range of advisors to the Bullying and Harassment scheme that would reflect better the profile of the organisation, by initially focusing on Black and Minority Ethnic Employees
Main Achievements
SO HEARD Staff Survey (in collaboration with Clive Gray and WHAL)
LGBT Staff Network set up
Recruitment of new Bullying and Harassment Volunteers (in collaboration with HR team)
Staff disability forum questionnaire (in collaboration with Staff Disability Forum)
Liaison with BME network established leading to closer working with Bullying and Harassment Scheme (in collaboration with BME Network)
Flexible Working Options on-line audit with full monitoring across the 6 strands completed as a baseline

Rationale for Workforce remit
Research shows that BME staff are more likely to have experienced Bullying and Harassment than their colleagues

NHS Staff Survey 2008 – Reporting of experiences of Bullying and Harassment from a manager or team leader

- 10% of BME staff.
- 7% of White staff

In the UK it is reported that 44% of LGB Staff have experienced discrimination in the workplace
Department of Health Briefings – Reducing health inequalities for lesbian, gay, bisexual and trans people 2007

Providing Flexible Working Options enables Bristol PCT to employ and benefit from the contribution of a diverse range of staff that may not be able to adhere to traditional work patterns
Supplementary Statistics

There are currently 1.3 million disabled people in the UK who are available for and want to work
Only half of disabled people of working age are in work (50%), compared with 80% of non disabled people
Employment rates vary greatly according to the type of impairment a person has; only 20% of people with mental health problems are in employment

Source: Office for National Statistics Labour Force Survey, Jan - March 2009

Key Operational People
Mel Byrne, Chair for Staff Disability Forum
Amanda Chappell, Chair for BME Staff Network
Clive Gray, Senior Health Promotion Specialist, NHS Bristol, Chair of SO and Health Stakeholder Group
Claire Gunningham, HR Advisor, BCH
Sarah Shather, Health Improvement Officer, BCH
Lesha Wilson, Equalities Officer, NHS Bristol
Key Stakeholder Groups
Sexual Orientation and Health Stakeholder Group
Human Resources Operational Team
Black and Minority Ethnic Staff Network
Staff Disability Forum
BME Development Group
Bullying and Harassment Volunteers

Barriers to Progress
Geographical Spread of 50 Bases
Provider/Commissioner Split
Human Resource Department Capacity
Absence of formal policy for staff network participation and protected time
Service Demands
Low declaration of disability

Related Work Activities being undertaken within BCH and NHS Bristol

BCH/NHS Bristol HR department developing a Staff Network Policy to formally embed staff network activities
BME Staff Network re-launched and actively involved in BME Development Work
Internal Staff Communications Project
Human Resource Team Delivery of Bullying and Harassment Training for Managers
Training Department Development and Implementation of Mentoring Policy

Next steps

Present Final Report and Recommendations to the BCH/NHS Bristol Human Resources Operational Team
Questions?
Contact Details : Louise Gethin Louise.gethin@nhs.net

Appendix B 1

Hastings and Rother Theatre& Full Report

Project Objectives

Objectives:

Theatre& delivered four days of Bullying and Harassment Workshops on 15th July 2009, 30th September 2009 5th November 2009 and 17th February 2010.

The objectives of the workshop were:

- To understand the impact of bullying, harassment and exclusion on the workplace
- To understand the personal and organisational consequences that can arise from inappropriate behaviour
- To explore the differences between banter and harassment
- To understand the difference between bullying and effective performance management
- To explore how we manage and challenge inappropriate behaviour in the workplace

Using drama and interactivity to enhance learning, **Theatre&** are able to create a setting where delegates benefit from a safe, non-confrontational learning environment which allows them the opportunity to challenge their own boundaries in an effective, engaging setting.

Key Outcomes

Key Outcomes:

Number of Delegates:

Pre Evaluations 94

Post Evaluations 95

- ✓ The overall post evaluation results demonstrate how the training has developed knowledge, confidence and understanding against the key objectives set out for this training programme
- ✓ The style of delivery and interactive participation has clearly been beneficial and enjoyable for delegates. **94%** of attendees rated the *overall workshop* in our top two categories (scale of 1-5 37%=4 57%=5). **97%** rated the *trainers knowledge* in our top two categories (scale of 1-5 33%=4 64%=5). **96%** rated the *training style* in our two top categories (scale of 1-5 25%=4 71%=5)
- ✓ One of the key objectives for this training programme was to highlight the consequences of Bullying, Harassment and Exclusion in the workplace, for an individual and for an organisation. Pre training there was a **43%** confidence level recorded in our top two categories, post training this has risen to **96%**
- ✓ One of the aims in this workshop was to take in to account perspectives from both staff and managers. Part of the workshop was involved in understanding the difference between bullying and performance management. Pre training **34%** of delegates scored in our top two categories (measured on a 1 - 5 low to high scale), post training this has risen to **87%**
- ✓ Instilling a new confidence in recognising inappropriate behaviour in the workplace we have developed confidence in actually being able to challenge this behaviour. Pre training there was a **33%** confidence level recorded in our top two categories, post training this has risen to **76%**
- ✓ The final part of our workshop looked at building confidence in asking for support and also where to go to get support. Pre training there was a **32%** confidence level recorded in our top two categories, post training this has risen to **66%**
- ✓ The comments from question 5 (looking at what delegates are going to now do differently) are very encouraging to read, two examples are *'Think before tackling sensitive subjects. Be more aware that what I find acceptable is not always the same for others'* and *'Tackle some of the joke telling/banter within my team, not by stopping it but by making people aware of its potential impact on individuals'*
- ✓ The written feedback from the training has been very positive. Comments have included *'Excellent workshop, really well presented. I will go back to the office and recommend that all my colleagues attend'* and *'I really enjoyed the workshop and think it is a very positive high impact way of delivering training'*

Recommendations

- It is a recommendation that our Bullying and Harassment training becomes an ongoing programme. We have worked with organisations to support them in improving working cultures on a long term basis, allowing delegates to express their anxieties and fully explore resolutions through workshops and focus groups. In the long term we can see positive business case results, such as a decrease in staff absence and less grievance proceedings

- We are currently running a large scale project in Bedfordshire for the NHS looking at Stress Management, Staff Engagement and Wellbeing. This training has been getting some very positive results. It would be a further recommendation to look at providing this kind of training to all staff as we have found that instances of inappropriate behaviour, bullying and harassment can arise from not managing or understanding signs of stress

- We have also run NHS specific (with an understanding of the KSF) Management Development training for Team leaders, Managers and Senior Managers. This kind of training ties in to Bullying and Harassment, because we look at managing difficult conversations and situations in the workplace, building confidence in using effective body language and interpersonal skill to better manage a typically very diverse range of individuals and personalities

Contact:

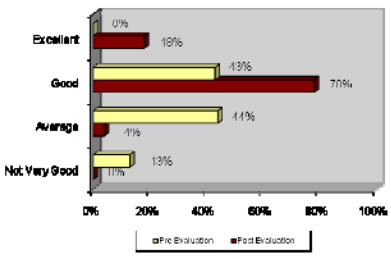
Matt Brown

Business Development Consultant

01484 532967/07917 518712

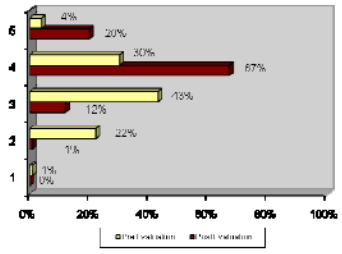
Comparative Analysis

Q1. To what extent would you gauge your understanding of the consequences of Bullying, Harassment and Exclusion in the workplace?



There has been a general increase in the level of understanding of the consequences of Bullying, Harassment and Exclusion in the workplace after attending the workshops. The most significant changes are the **18%** increase in the Excellent category and the **35%** increase in the Good category.

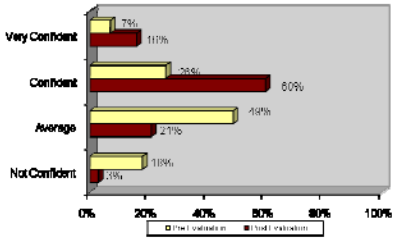
Q2. How would you gauge your understanding of the behavioral difference between Bullying and Performance Management? (with 1 as low and 5 as high)



These results demonstrate a general movement upwards in the understanding of the behavioral difference between Bullying and Performance Management. This is shown by the **53%** increase in the top two categories.

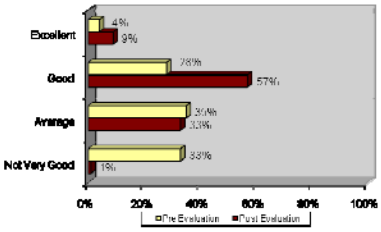
Comparative Analysis

Q3. How confident do you feel in challenging unacceptable, inappropriate behaviour in the workplace?



Prior to the sessions **33%** of those attending felt Very Confident or Confident in challenging unacceptable, inappropriate behaviour in the workplace. Following the training this had risen to **76%.** This measure shows a **43%** rise in confidence.

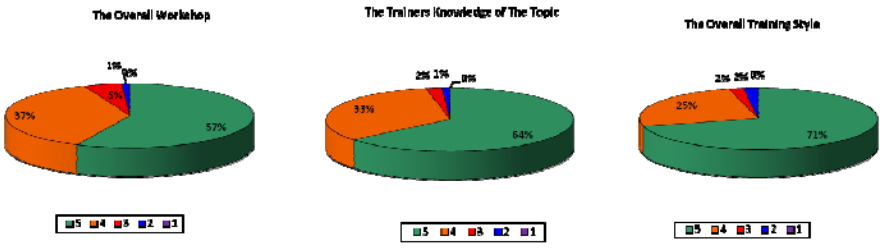
Q4. How would you gauge your understanding of the internal Bullying and Harassment support procedures?



Responses to this measure show a rise of **34%** of attendees who felt they were now more understanding of the internal Bullying and Harassment support procedures after taking part in the training. **66%** scored themselves in the top two categories after the sessions contrasting to **32%** prior to the workshops.

Post Evaluation

Q5. Please identify on a scale of 1-5 (with 1 as low and 5 as high) the quality of:



The overall results of the questionnaires show that delegates demonstrated an extremely positive shift in their own key learning throughout the session.

In addition, when gauging the overall quality of the workshop, the training style and the facilitator's knowledge, no less than **96%** of the delegates scored within the top two categories.

Post Evaluation

Q6. What will you do differently after attending this workshop? *(*NB this is a selection of answers, a full list is available on request)*

- I am currently managing an investigation into bullying and harassment and do feel this session has helped my perception of the accuser
- I now know that bullying is not always visible. I will be sensitive to people and respectful and not be judgemental
- Be more aware of my comments to others and how they react
- Think before tackling sensitive subjects. Be more aware that what I find acceptable is not always the same for others
- Check and monitor my own behaviour on a regular basis
- Reinforced how important communication is. Talking things through. If any problems in the workplace
- Tackle some of the joke telling/banter within my team, not by stopping it but by making people aware of its potential impact on individuals
- Think about my personal behaviour
- Look at my behaviour towards others
- Try to be more aware and identify things when happening
- Not feel afraid to challenge colleagues behaviour and body language
- Listen more carefully to colleagues
- Be more aware of bullying and take appropriate action to rectify. And know the difference between this and harassment
- Be more aware of when this is taking place
- More aware of 3rd hand harassment
- I think I will be more aware of banter and bullying

Post Evaluation

Q7. Any further comments? *(*NB this is a selection of answers, a full list is available on request)*

- I was initially very cynical about this training but found it both enjoyable and helpful
- Very good fun course highly recommended. Thought the acting was excellent. I liked the fact that you could be involved without the actual acting
- Excellent workshop, really well presented. I will go back to the office and recommend that all my colleagues attend
- Excellent workshop – a lot taken on board
- An excellent course. Started with the more obvious scenarios then moved on to the more discrete and less obvious and ended with a real like scenario which was challenging and difficult to deal with. Well done!
- Wonder if some people may be offended by the swearing
- I enjoyed it. Love it to be presented to the whole team working together on some day (away days)
- Feedback to my own team
- Really good course enjoyed it very muck thank you
- Humour is a great therapy
- Very enjoyable way of learning (no role play yippee)
- Excellent workshop
- Change of time at short notice was difficult due to prior arranged commitments
- This type of training is memorable. Use participation rather than the dreaded role play, feels a lot more comfortable thank you very much
- Refreshing change to watching slide show, enjoyed!
- Thank you well done
- Loved the theatre workshop style
- I really enjoyed the workshop and think it is a very positive high impact way of delivering training

Appendix B2: Workshop Attendance

Table 1a

Total number of attendees, withdrawals and non-attendance from combined PCTs.

Total Numbers	
Total Attendance	177
Total Withdrawn	17
Total Did Not Attend	42
Total	236

Table 1b

Percentages	
Percentage Attended	75
Percentage Withdrawn	7.2
Percentage Did Not Attend	17.8

Table 2a

Summary of attendance against Staff Pay bands. (numerical)

Staff Grade Total Attendance				
Staff Band/Attendance Status	Attended	Withdrawn	Did Not Attend	Combined Non-Attendance
Bands 1 -4	74	0	5	5
Bands 5 - 7	85	1	5	6
Bands 8 - 9	29	0	9	9
Executive	8	0	1	1
Unknown	8	0	1	1

Table 3a

The table below shows the attendance status of staff by pay band bracket who attended, withdraw or did not attend as a percentage of those who booked.
For example, 36.27% of attendees were from bands 1-4, compared to 3.92% of attendees from executive pay bracket.
The combined column shows all those who did not attend and withdrew.

Staff Band Percentages - overall				
	Attended	Withdrawn	Did Not Attend	Combined Non-Attendance
Bands 1 - 4	36.27	0.00	23.81	22.73
Bands 5 - 7	41.67	100.00	23.81	27.27
Bands 8 - 9	14.22	0.00	42.86	40.91
Executive	3.92	0.00	4.76	4.55
Unknown	3.92	0.00	4.76	4.55

Table3b

The table below shows the breakdown within each pay band bracket of the percentage who attended, withdrew and did not attend.
For example, we can see that 93.67% of bands 1-4 attended, where 6.33% did not attend.
The combined column shows all those who did not attend and withdrew

Staff Band Breakdown Percentages				
	Attended	Withdrawn	Did Not Attend	Combined Non-Attendance
Bands 1 - 4	93.67	0.00	6.33	6.33
Bands 5 - 7	93.41	1.10	5.49	6.59
Bands 8 - 9	76.32	0.00	23.68	23.68
Executive	88.89	0.00	11.11	11.11
Unknown	88.89	0.00	11.11	11.11

For consideration: These tables show the staff in the pay bands brackets they are currently in. There is no way of showing the pay bands they were in at the time of completing the course. Staff may have changed job roles, therefore changing pay bands. Also, some staff did not pull through in the pay band report due to their banding not being recorded on the reporting system.

Table 4a

Summary of attendance by directorate.

Directorate Total Attendance				
Directorate/Attendance Status	Attended	Withdrawn	Did Not Attend	Combined Non-Attendance
Commissioning and Primary Care	13	2	2	4
Community Services	73	6	30	36
Finance	10	2	1	3
Human Resources	34	2	1	3

Corporate Affairs	11	1	0	1
Public Health and Medical	35	4	7	11
Executive	1	0	1	1

Table 4b

The table below shows the percentage of the workforce by directorate who attended, withdrew, or did not attend.
For example, 7.3% of attendees came from the Commissioning and Primary Care directorate.
The combined column shows all those who did not attend and withdrew.

Directorate Percentages - overall				
	Attended	**Withdrawn**	**Did Not Attend**	**Combined Non-Attendance**
Commissioning and Primary Care	7.3	11.8	4.8	6.78
Community Services	41.2	35.3	71.4	61.02
Finance	5.6	11.8	2.4	5.08
Human Resources	19.2	11.8	2.4	5.08
Corporate Affairs	6.2	5.9	0.0	1.69
Public Health and Medical	19.8	23.5	16.7	18.64
Executive	0.6	0.0	2.4	1.69

Table 4c

The table below show the percentage of staff within each directorate who attended, withdrew and did not attend.
For example, 67% of Community Services attended, where 27.5% of Community services did not attend.
The combined column shows all those who did not attend and withdrew.

Directorate Percentages				
	Attended	**Withdrawn**	**Did Not Attend**	**Combined Non-Attendance**
Commissioning and Primary Care	76.5	11.8	11.8	23.53
Community Services	67.0	5.5	27.5	33.03
Finance	76.9	15.4	7.7	23.08
Human Resources	91.9	5.4	2.7	8.11
Patient and Public Engagement	91.7	8.3	0.0	8.33
Public Health and Medical	76.1	8.7	15.2	23.91
Executive	50.0	0.0	50.0	50.00

Summary of Commissioning / Provider attendance.

Table 4d

Commissioning/Provider Total Attendance				
Department/ Attendance Status	**Attended**	**Withdrawn**	**Did Not Attend**	**Combined Non-Attendance**
Commissioning	74	8	7	15
Provider Services	103	9	35	44

The table below shows the percentage of attendees, withdrawals and non-attendees coming from either Commissioning or Provider Services.
For example, 41.8% of attendees were from Commissioning.
The combined column shows all those who did not attend and withdrew.

Table 4e

Commissioning/Provider Percentages - overall				
	Attended	**Withdrawn**	**Did Not Attend**	**Combined Non-Attendance**
Commissioning	41.8	47.1	16.7	15
Provider Services	58.2	52.9	83.3	74.6

The table below shows the percentage of Commissiong and Provider Services who attended, withdrew and did not attend.
For example, 83.1% of Commissioning staff attended the training.
The combined column shows all those who did not attend and withdrew.

Table 4f

Commissioning/Provider Percentages				
	Attended	**Withdrawn**	**Did Not Attend**	**Combined Non-Attendance**
Commissioning	83.1	9.0	7.9	16.85
Provider Services	70.1	6.1	23.8	29.93

Please note:
These reports have been conducted using ESR (Electronic Staff Records) therefore this data is constantly changing with staff. These records therefore show staff in their current post which may have changed from when they did the training, so staff may have changed band since the training.Some staff may also have left the trust, which means their information is no longer available, therefore they may not have been included in the Staff Band tables.

Appendix B3:

Summary of key findings from first internal questionnaire (IQI)[14]

Reasons why bullying and harassment goes unreported

Reason	Reported by	Exemplar
Seniority of perpetrator	6	'There seems little point. One of them is my Manager. Have discussed problems previously – no change.
Fear of reprisals	9	'I raised the issues (verified by colleagues) but requested no action for fear of more bullying'
Lack of support	7	'Because I did not believe my Line Manager would help me'
Victim's choice	3	'Happened to a colleague who asked me not to pass on this information'
Miscellaneous	6	

The impact of incidents of bullying & harassment on staff

Impact	Reported by	Exemplar
Moving (or wishing to) – either victim or perpetrator	8	'I have had to move out of premises as I cannot cope with being in same building as feel unsafe'
Demotivation (individual)	7	'Indifference towards colleagues/clinical team'
Stress & sickness	7	'Feeling generally unwell, very unwell'
Low morale (team)	7	'Poor team work effects on patient care and staff are unable to perform their duties due to lack of support and guidance'
Avoidance	3	'very wary of person and avoid where possible'
Miscellaneous	2	

[14] These figures are based on 52 victims who, on occasion, reported multiple issues. It is therefore not possible to record percentages.

Suggested solutions to bullying and harassment.

Suggestion	Reported by	Exemplar
Cannot be changed (e.g. personality, culture, complexity)	6	'Bullying is in some people's characters - they do not know they are bullies - these people tend to have powerful support networks at staff level and complaining about them can seriously rebound. You have to change people in a profound way and I don't know if an employer can do this'
Provide training (e.g. interpersonal skills, awareness raising)	7	'Managers need more training in how to communicate to staff and should be disciplined when this behaviour becomes personal'
Improving communication (e.g. generate dialogue, openness, informal reporting procedures)	8	'Management need to listen to staff and staff need a forum in work to inform management of how we feel. There is no opportunity to feed back to management our concerns'
Modelling by managers (e.g. valuing workforce, managing stress)	2	'Managers need to act as role models demonstrating interpersonal skills which make people feel valued and supported'
Miscellaneous	6	

Appendix B4:

Summary of key findings from second internal questionnaire (IQ2)

Data showing responses supplied in the Bullying and Harassment questionnaires sent out in June 2010.

Q1 - During the year April 2009 to April 2010 have you been bullied or harassed by a work colleague?

	Yes	No
As total	13	30
As percentage	30	70

Frequency answering YES for ethnic minority, gender, full time or part time, age groups, sexual orientation and religion:

Ethnic Origin	Total	Percentage
British	8	61.5
Any other white background	4	30.8
Do not wish to disclose	1	7.7

No other options selected so these have been omitted from the table.

Gender	Total	Percentage
Male	4	30.8
Female	7	53.8
No response	2	15.4

Full Time/Part Time	Total	Percentage
Full Time	7	53.8
Part Time	3	23.1
No response	3	23.1

Age group	Total	Percentage
16-19	0	0.0
20-24	0	0.0
25-29	2	15.4
30-34	2	15.4
35-39	1	7.7
40-44	1	7.7
45-49	3	23.1
50-54	3	23.1
55-59	0	0.0
60-64	1	7.7
65 or over	0	0.0

Sexual Orientation	Total	Percentage
Lesbian	0	0.0
Gay	0	0.0
Bisexual	1	7.7
Heterosexual	11	84.6
Do not wish to disclose	1	7.7

Religious Belief	Total	Percentage
Christianity	8	61.5
Other	2	15.4
Do not wish to disclose	2	15.4
No response	1	7.7

No other options selected so these have been omitted from the table.

The following information shows percentages against the number of people answering yes to Q1.

Q2 - If YES was that colleague employed by PCT

	Yes	No
As total	12	1
As percentage	92	8

Q3 - Was the person who bullied or harassed you…

	Senior to you	Same level as you	Junior to you
As total	9	4	1
As perecentage	64	29	7

Q4 - Did the inicident/s occur in the workplace?

	Yes	No
As total	12	1
As percentage	92	8

Q5 - What form did this bullying or harassing behaviour take?

In rank order:	Rank	Number selected
Humiliation	1	11
Undermining	1	11
Verbal	3	10
Overwork	4	6
Destabilisation	5	4
Written	5	4
Isolation	5	4
Other - as stated	8	2

Sexual	9	1
Physical	10	0

Other includes:
Insitutional bullying by management
Threat of removal from department
Rumours
Hostility
Avoidance in the workplace

Q6 - Have you taken any action against the person who bullied or harassed you?

	Yes	**No**
As total	4	9
As percentage	31	69

Q7 - Has being subjected to this behaviour resulted in you being away from work?

	Yes	**No**
As total	4	9
As percentage	31	69

Q8 - Have you sought medical/psychological support because of this behaviour?

	Yes	**No**
As total	2	11
As percentage	15	85

The following information shows percentages against the number of people responding in total including those who responded with 'No' to Q1.

Q9 - Were you aware of the Theatreand 'Ban Bullying' workshops held between March 09 and March 10?

	Yes	**No**	**No response**
As total	9	6	27
As percentage	21	14	64

Q10 - Were you interested in attending one of the workshops?

	Yes	**No**	**No response**
As total	12	16	4
As percentage	38	50	13

The following information shows percentages against the number of people responding 'Yes' to Q10.

Q11a - Did you book a place on a workshop?

	Yes	No	No response
As total	18	12	11
As percentage	44	29	27

Q11b - If you answered 'No' to Q11a, please tell us why you did not book a place

Reasons listed:
Unaware course was running/ who course was aimed at
Of no interest
Unable to take time out of office
Unsatisfied by previous outcomes of bullying/harassment situations and question benefit of course
Consider course irrelevant due to not suffering bullying/harassment
Already attended a course
Considered irrelevant
Manager did not book staff member on to course

The following information shows percentages against the number of people responding 'Yes' to Q11a.

Q11c - If you answered 'Yes' to Q11a, did you attend?

	Yes	No	No response
As total	15	3	1
As percentage	79	16	5

Q11d - If you answered 'No' to Q11c, please tell us why you did not attend?

Reasons listed:
Not enough staff to cover
Cancelled course
Assumed was aimed at managers only
On waiting list

Q12 - If you attended a workshop do you think similar training should continue to be offered to staff?

	Yes	No	No response
As total	16	1	23
As percentage	40	3	58

Q12b - Please tell us the reason(s) for your answer

Supporting answers:
Benefits at all levels
Good style
Useful and enjoyable
Raises awareness

Helps to identify/define Bullying and Harassment
Refreshingly different

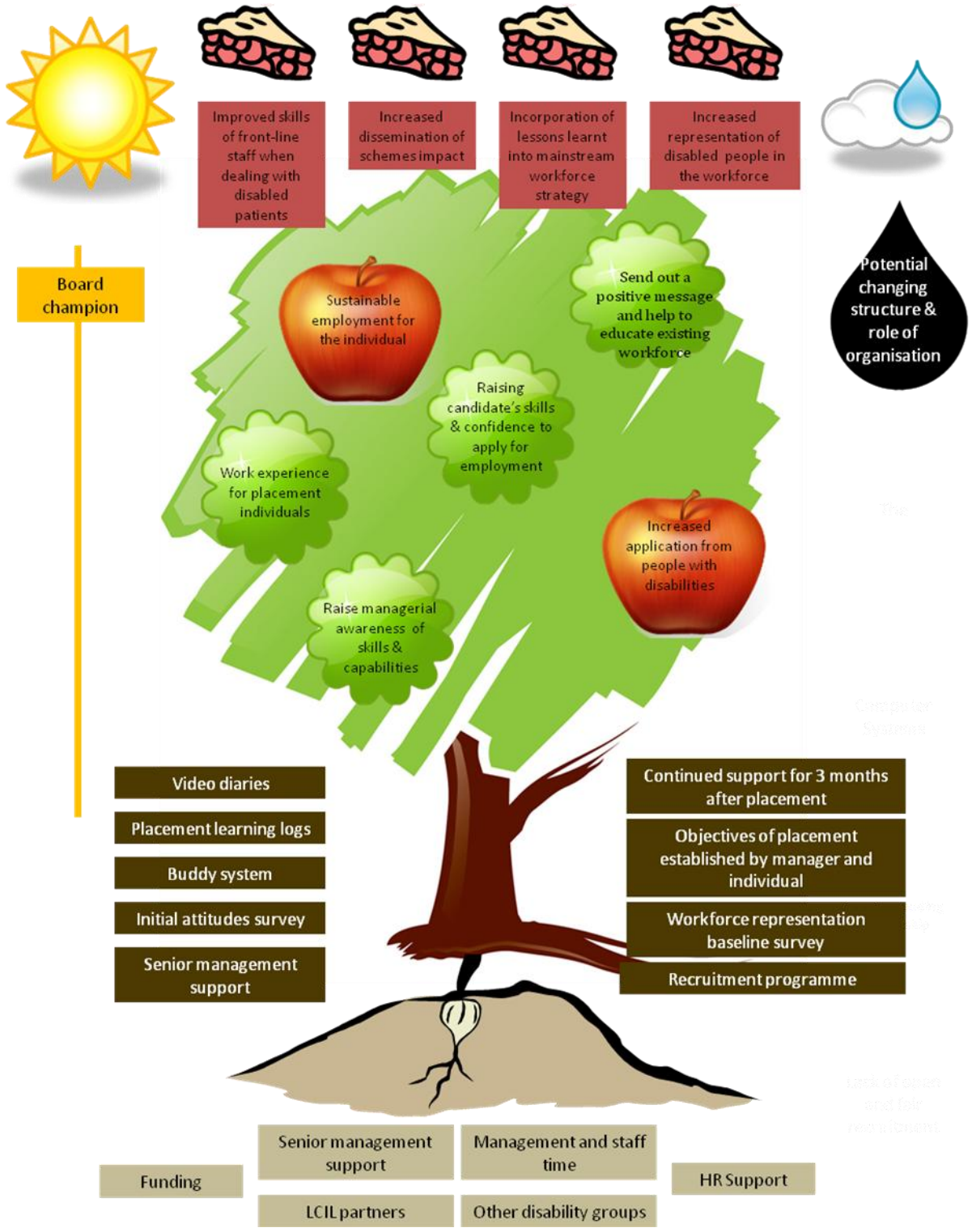
Unsupporting answers:
Lack of training and punishment available
Workshops did not offer any new knowledge
Expensive option for raising awareness
Offered little advice on overcoming bullying - limited to raising awareness
Disliked being 'forced' to attend by management
Should be essential for managers and supervisors

Q13 - What is the one thing you think the organisation should best do to reduce bullying and harassment at work?

Listed as:
Train management
Act upon complaints quicker
Raise issue in supervision
Improve communication and listening skills
Make staff feel valued
Senior staff to be aware of when they may come across as bullying
Make bullying training mandatory for all staff at all levels
Identify and define terms
Continue training courses
Reduce hierarchy of staff
Monitor workload to prevent overwork
More 1:1 time to prevent build up of bullying
Make clear guidance more available
Stronger disciplinary procedures
Regular supervision

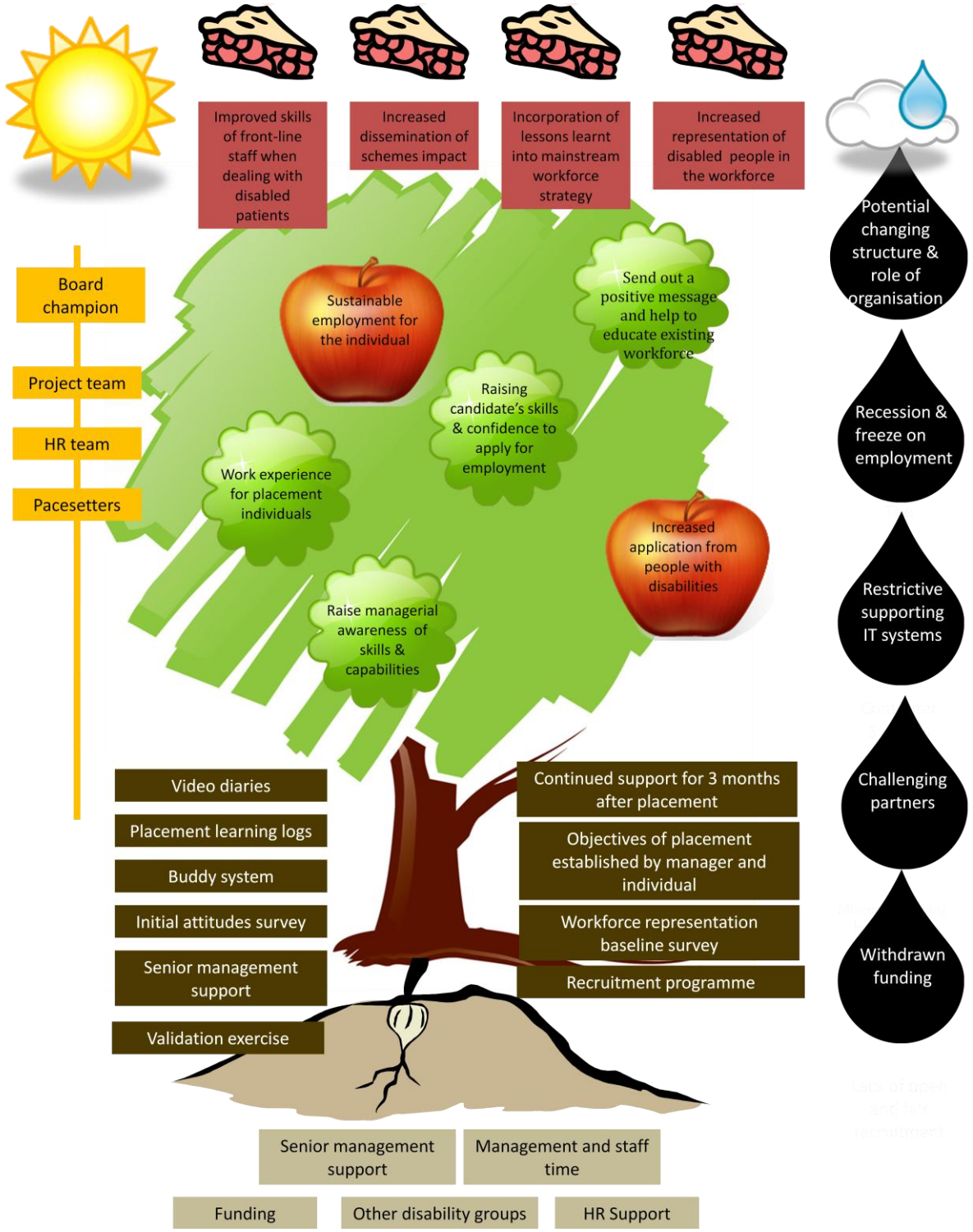
Appendix C1

Logic Tree September 2009 - NHS Leicester City and Leicester City Community Health Service – Dis-solution scheme



Appendix C2

Logic Tree July 2010 - NHS Leicester City and Leicester City Community Health Service – Dis-solution scheme



Appendix D 1

Lewisham: Pacesetters Lunchtime seminar. Notes from Slides

Equality & Diversity Council
SEC member: Fiona Edwards Chief Executive
Surrey & Borders Partnership NHS Foundation Trust

"To achieve high quality and personalisation, the NHS will need to be innovative and ambitious in the way it manages and uses delivery systems and processes. It will need to change established mindsets, cultures and behaviours and to think differently about how it engages with its communities and staff, responding with innovation and by embracing change."

" To embed a progressive approach to equality and diversity in the NHS, we also need to inspire excellence in leadership and throughout our workforce."

Introduction to Lewisham Projects

Pacesetters Programme:
Pacesetters is a programme to deliver equality & diversity improvements & innovations resulting in:

- Reduced health inequalities for patients and service users
- Working environments that are fair and free of discrimination

The programme works with 37 trusts and 6 SHA's on a range of projects across six equality strands

We successfully bid to participate in the programme and began work in November 2008

National Pacesetter projects
Wave 1 - Three local projects to challenge, stretch, sustain and spread good practice

Wave 2 – Two local projects to focus on three clinical areas: cancer, CVD and stroke, diabetes

Workforce projects: bullying & harassment, flexible working and representation

Improving data collection of workforce and patients, related to local project

Yorkshire and The Humber

Leeds Partnerships NHS Foundation Trust
NHS Sheffield
Yorkshire Ambulance Service NHS Trust
NHS Leeds

Bradford & Airedale Teaching PCT
NHS Doncaster

Service Improvement methodology
Opportunity to try something new and capture all learning
Small scale testing (PDSA cycles)
Evidence base leading and underpinning work
Using engagement to design and test innovations
PDSA cycle
Key Questions:
The 'Innovation Funnel' outcomes

Pacesetters Programme

The programme is underpinned by guiding principles in the NHS Constitution:

The NHS provides a comprehensive service, available to all
NHS services must reflect the needs and preferences of patients, their families and their carers
The NHS works across organisational boundaries and in partnership with other organisations in the interest of patients, local communities and their carers
The NS is committed to providing best value for taxpayer's money and the most effective and fair use of finite resources
The NHS is accountable to the public, communities and patients it serves

And staff rights include:

Good working environment with flexible working opportunities
Safe working conditions-free from harassment, bullying and violence
Involvement and representation in the workforce
Fair and equal treatment that is free from discrimination
A process of complaint / redress if it is felt a right has not been upheld

Why Lewisham?
Lewisham is a Spearhead local authority area

We recognise we could do better in tackling health equalities, particularly in the area of race (see Single Equality Scheme for more info)

Lewisham is ethnically diverse with 60% white and 40% BME population (school age population is 40% white and 60% BME)

The "Spearhead Group"
Public Service Agreement target to address geographical inequalities in life expectancy, cancer, heart disease, stroke and related diseases.

The targets aim to see faster progress compared to the average in the "fifth of areas with
the worst health and deprivation indicators".

Achievement of the targets will be assessed on the outcomes for this Group in 2010.

The Spearhead Group is made up of 70 Local authorities and 88 Primary Care Trusts,
based upon the Local Authority areas that are in the bottom fifth nationally for 3 or more of the following 5 indicators:

Male life expectancy at birth
Female life expectancy at birth
Cancer mortality rate in under 75s
Cardio Vascular Disease mortality rate in under 75s
Index of Multiple Deprivation 2004 (Local Authority Summary), average score

NHS Lewisham projects
Increasing representation in the workforce for BME staff
Increasing uptake of breast cancer screening by BME women
Improving experience of rehabilitation after stroke for the BME community

Why focus on racial inequalities?
NHS Lewisham commissions services as a representative of the local population and is committed to reducing all health inequalities

NHS Lewisham recognises that the history of the NHS and race equality is inadequate and is committed to be active at changing this at the local level

Introduction to Pacesetters Programme
Workforce project

Lewisham PCT workforce Pacesetters overall aim is to:' **To increase BME representation in the workforce at all bands within admin and clerical fields, with particular emphasis to bands 7+ (management / junior management)'**

A BME forum was established (current membership 28) to deliver this aim. The forum consists of both provider and commissioner staff from various bandings and professions.

BME forum membership has increased at a rate of 5-10% per month since its introduction in August 2009.

Although the Pacesetters team support the forum in identifying potential equalities, the BME forum themselves are the key stakeholders in agreeing the interventions proposed.

The project started out with the following main objectives:

To enable BME staff within the PCT to formulate interventions that will promote equality in employment for BME population in Lewisham

To ascertain the current practice within Lewisham PCT with respect to BME non clinical recruitment and selection.

To measure the effectiveness of models and frameworks available to support best practice in the field of BME recruitment and selection at the local level

To formulate recommendations that can be implemented to proactively recruit BME non clinical applicants.
PCT Workforce Profile (April 09)
As you can see the PCT like most NHS London Trusts meet the minimum requirements of the Race Relations Act in the sense that the organisation is representative of the community in which they serve.
However on closer inspection
NHS Lewisham Non Clinical Recruitment stats (1st April 08 – 31st March 09)

Workforce Pacesetters Interventions
Two pronged approach via 3 interventions:

Capacity Building of staff
Changing organisational culture
Intervention 1 Online interview support
Intervention 2 – Internal BME Staff Performance Coaching
Intervention 3 – Enhancing Recruitment Interview Panel Performances
Progress and Learning to date
What is going well?
Pacesetters Programme has supported the development of the forum – ensuring the learning/feedback is embedded within the organisation.
Management support for staff to attend and focus on key issues affecting staff in the workforce at all bands within admin and clerical fields, with particular emphasis to bands 7+ (management/junior management)
Focussing on the interview stage of the recruitment process
Interview Gold established for the use of BME staff applying for positions within the PCT
Leading in terms of actually doing something and not focussing on recruitment statistics
Corporate Equalities Group – asking how we are doing/support for the forum.
Department of Health evaluation has been positive and illustrates our progression.
Commitment from Chief Executive
What has been challenging?

Recruitment to the forum – due to staff commitments and work schedules.
Publicity – promoting the BME forum within the Trust.
Future of the BME Forum – (CHS integration with Local Acute Trust 01.04.10).
Equality to BME at all levels from Band 2-9.
Action learning has been difficult given continuous growth of the BME forum
Time commitment from both HR & stakeholders
Keeping the momentum – not just being a "talking shop"
Recruitment freeze made testing / starting interventions virtually impossible.

Next Steps

Maintaining the commitment already shown by members.
Increasing BME membership and BME Network agenda.
A BME forum member on the Corporate Equalities Group.
Rolling out the BME pilot across Lewisham Health Sector.
Testing of further inventions and evaluation of the 3 Pacesetters interventions – noting that outcome is long term
15 BME forum members joining NHS BME network

Commissioner:

"…. how for a small amount of money, Pacesetters projects by design evidences how you have to plan, implement and commission difference. Otherwise, commissioning stays with what it knows and sometimes that is more of the same "

Our Challenge as commissioners
Scrutinise our practices, look at our evidence
Have we commissioned for difference?
Are the changes we're thinking about *Improvements?*
Continue to be committed to dismantle institutional and cultural barriers
"Use a pull model with strivers not a push model with drivers"
Be creative – doing things the same way is not an option
Commission for difference with innovation, confidence & leadership
Incorporate one new project that meets our requirements to deliver improved quality and the NHS Constitution. (from DH)

Further information:

Swarnjit Singh	Programme Manager
NHS London	
Swarnjit.Singh@london.nhs.net	
Lewisham Programme Manager	Gemma Novis
Equality & Diversity Co-ordinator	Gemma.novis@lewishampct.nhs.uk

Appendix D2

Integrated Coaching for Performance and DART Coaching programme

Prepared for

Lewisham PCT BME forum

How the Programme Would Work

This 90 day coaching programme incorporating workshops, 121 coaching, email and telephone support, gives participants an opportunity to gain coaching skills to support and lead others in the workplace and experience being coached themselves.

Day 1 – The first 6 delegates each receive a 121 DART Coaching session

Day 2 - the second 6 delegates each receive a 121 DART . coaching session

Day 3 to 30 – Email and telephone support from the lead Coach

Day 31 and 32 – Coaching for Performance two day workshop – all delegates attend.

Day 33-59
Knowledge Development – Again, you have unlimited access to the coach during these days via phone and email with a range of articles, models, techniques and relevant information will be emailed.

Day 60 The first 6 delegates each receive a 121 DART Coaching session

Day 61 The second 6 delegates each receive a 121 DART Coaching session

Day 62 to 90 – Email and telephone support from the lead Coach

The DART Coaching™ part of the programme

Two one to one Coaching sessions for each delegate, an opportunity to develop your skills, improve performance or enhance their career.

DART stands for the opportunity to:
Detect the challenge or issue
Analyse the root cause
Re-energise and refocus
Transform performance

What can you focus on in a coaching session?

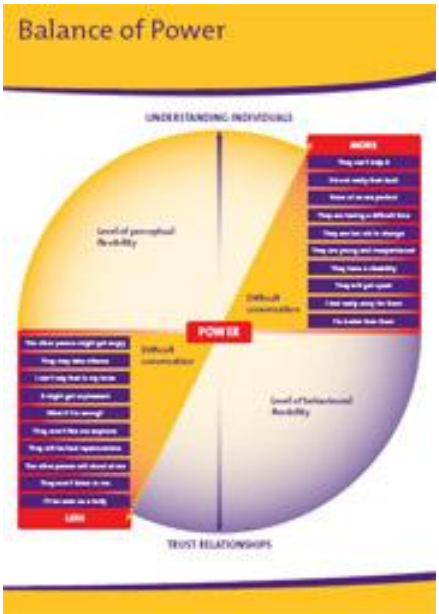
- ✓ Inspiring and motivating others
- ✓ Strategic influencing and stakeholder management
- ✓ Resolving relationship issues and turning conflict to advantage
- ✓ Sounding out new ideas
- ✓ Challenging your thinking and decision-making, giving new perspectives and above all encouragement and support
- ✓ Further enhancing your stature and credibility in the eyes of others
- ✓ Increasing your opportunities to make a valuable contribution and a real difference to the business
- ✓ Building and enhancing a broad range of business and personal skills including, communicating, influencing and negotiating
- ✓ Developing resilience and a proactive mindset
- ✓ Overcoming a phobia of public speaking or further developing your presentation skills
- ✓ Receiving Feedback - an executive coach can speak frankly and highlight blind spots to enhance your performance
- ✓ Further developing your leadership style
- ✓ Creating a compelling vision and strategy
- ✓ Maintaining or creating work/life balance
- ✓ Managing perceptions, reviewing your personal style and being clear on your strengths
- ✓ Increasing your ability to leverage time, prioritising key initiatives and increasing productivity.
- ✓ Increasing confidence and making sustainable behavioural change
- ✓ Overcoming stress, anxiety, frustration and procrastination

- ✓ Enjoying change and managing change
- ✓ Planning for future career development and vision
- ✓ Gaining a greater understanding of the politics at the new level, balancing management and leadership, managing key stakeholders and the keys to success, especially during the critical first 100-day period of a new job or role.

Workshop: Coaching for Performance - an intensive two-day workshop

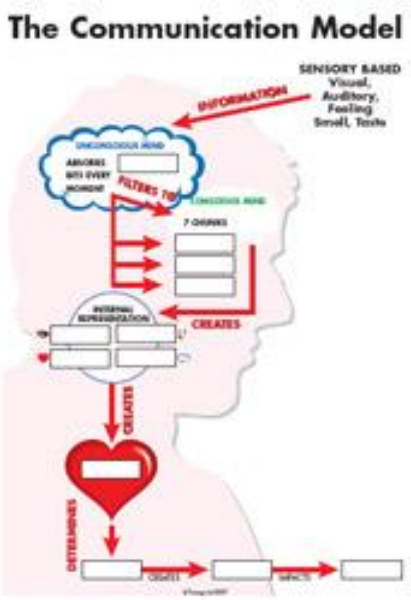
The actual content will be dependant upon and tailored to the needs and level of the group, but will include:

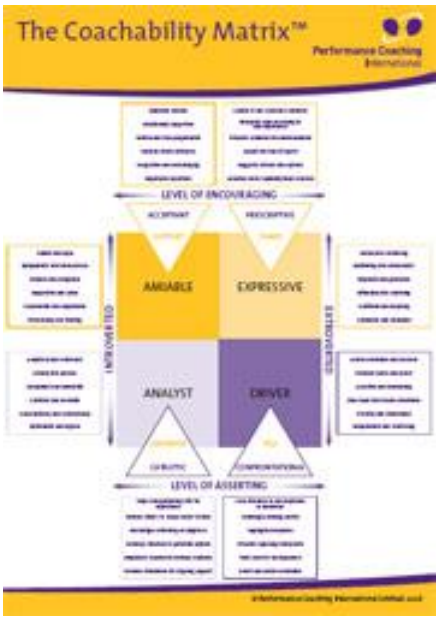
- ❑ The coaching culture and the coaching mindset
- ❑ Leadership & Coaching: style & substance
- ❑ Coaching for motivation and inspiration
- ❑ Coaching and developing others
- ❑ Coaching the key to empowerment and delegation
- ❑ .The Art of Questions: "Sometimes the best gift you can give someone is the right question"
- ❑ Coaching analysis tool – 30 ways to quickly understand others.
- ❑ What to pay attention to & how
- ❑ Identifying & analysing needs, patterns, internal obstacles and strategies
- ❑ Creativity, flexibility and adaptability
- ❑ Use multiple perspectives
- ❑ Feedback, feed-forward, & challenge
- ❑ Models & techniques for use in coaching
- ❑ Decision making and problem solving
- ❑ Developing others – getting them to take responsibility
- ❑ Goal & objective setting & measuring



Our Creative  **style**


SMART OUTCOMES


The Communication Model
SENSORY BASED
Visual,
Auditory,
Feeling
Smell, Taste
INFORMATION
UNCONSCIOUS MIND
ABSORBS BITS EVERY MOMENT
FILTERS TO
CONSCIOUS MIND
7 CHUNKS
CREATES
INTERNAL REPRESENTATION
CREATES
DETERMINES
CREATES
RESULTS


The Coachability Matrix™
Performance Coaching International
LEVEL OF ENCOURAGING
AMIABLE
EXPRESSIVE
ANALYST
DRIVER
LEVEL OF ASSERTING

Appendix D 3

Enhancing Recruitment Interview Panel Performances: Increasing BME representation in the workforce project

Background

Methodology
We propose undertaking this work in phases using varied methods.

Phase I: Data gathering and analysis
We propose

- a speedy evidence review of numbers applying for advertised posts, interview results by appointment, demographic drivers for business performance, clarifying explanations for disproportionate or variable recruitment outcomes
- case studies of the panel behaviours that might provide scope for improvements
- analysis of the applicant appointment profiles within the PCT
- demography breakdown by ethnicity and disability of reasons why applicants may not be getting through
- prepare some basic questions [for example, regarding prior learning] for e-mail circulation to 10 managers identified to participate in this pilot project

We propose seeking broader background organisational information in order to:

- assess the levels of BME presence within the Trust
- interview a small number of selected individuals from the BME Forum who may have gone through the Trust's recruitment process in order to incorporate their perspectives on improving performance overall
- collate key stakeholder perspectives on indicative trends, if any, and available employment data
- identify different approaches to diversity monitoring.

Phase 2: Stakeholder meetings

Meet with cohort managers for an initial group meeting to further clarify individual needs and ways of working and scope and 'test out' proposed interventions

BME Forum Half Day
As part of this phase we propose a half day for providing development support to the BME Forum, subject to further discussion, and agreement of objectives. We would offer a facilitated group session leaving room open for agreeing potential actions.

Participation in Action Learning Set Evaluation Half Day
We anticipate our involvement as enabling a broader perspective that will add value to this project.

Phase 3: Design and Delivery One day

We propose to cover

- equality and diversity in recruitment
- meeting fair practice requirements and reducing bias in the process
- evaluating interviewee performance: processing information and attributing performance
- exploring what panels want [the ideal interviewee /response]: how panel perception may undervalue performance of particular groups
- the impact of individual and group behaviour in influencing the process, e.g. making the decision [or not] to ask a supplementary question; demonstrating by non-verbal cues that the answer is what the panel is seeking
- practise in assessing performance
- the provision of feedback (self/peer/facilitator) regarding strengths and areas for development.

Phase 4: Support and review

Following participation in the training we propose that

- participants' experiences and decisions are tracked in their real-time participation in recruitment panels over a period of 2/3 months.
- participants' identification of any additional benefits in their managerial routines, for example, in conducting appraisals is monitored. Such monitoring could provide assurance to the Trust regarding meet their statutory race equality obligations, in employment and other areas.

Appendix D4

May 2010

May 2010

Trust Brief

Distributed on: **Tuesday 4 May 2010**
Feedback required by: **Friday 21 May 2010**

Briefing items for all staff

May 50/2010 Work to reduce inequalities recognized with award

Congratulations and thank you to staff working on the Pacesetters programme to tackle health inequalities and strengthen partnerships with local communities. The Department of Health and NHS London have recognised this with an award.

The aim of the Pacesetters programme is to deliver equality and diversity improvements resulting in greater engagement around service design, and reduced health inequalities for patients, and striving to ensure working environments are fair and free from discrimination.

Within NHS Lewisham, staff have been driving forward objectives of the programme in a variety of ways. Improvements to workforce training and recruitment processes have been made through the introduction of a package that provides support to existing and potential staff when preparing for interviews.

Another element has been increasing representation of BME community members and staff at focus groups for stroke and breast screening projects.

The award was presented yesterday by Lynda Brookes, Director of Pacesetters, DH at the Pacesetters: Commissioning for Difference event held in Westminster.

There are lots of exciting plans to continue the work including the launch of a BME forum, and the exceptional efforts of staff are making this possible.

Any staff who would like more information on the BME forum can contact Jackie Keizer on 020 7206 3236 jackie.keizer@nhs.net

Appendix D5

July 2010

Trust Brief

NHS Lewisham

Distributed on: *Monday 5 July 2010*

Feedback required by: *Friday 23 July 2010*

Briefing items for all staff

July 72/2010 BME Staff Forum

Developments in support for black, minority and ethnic staff – The BME Forum is born

A decade after the Stephen Lawrence Report there is clear evidence that the NHS is not delivering on its Race Equality duties.

Last summer the start of some decisive action to tackle the issue saw the very first national BME Conference take place. Professionals, NHS senior managers and other key figures came together to provide an open forum to share ideas on real solutions to the problem.

18 staff from NHS Lewisham, Community Health Services and University Hospital Lewisham attended and here's some of the feedback…

> *"This was the most productive one day conference I think I have attended in 30 years in the NHS. My personal challenge as a white, middle aged, middle class manager was to get my head around the concepts of "whiteness" and "the invisible knapsack". I felt very proud of my PCT colleagues who have been building our own BME forum and I'm really optimistic about what we could achieve if we use the talents, experience and insights of our staff – I'm*

sure this is key to reducing the health inequalities that exist for Lewisham residents."

Senior Manager, Lewisham

"I really hope more BME staff would become members and join forces to make the voice of change louder. I am now on a recruitment drive to get more staff to engage."

Manager, Lewisham

"I believe the seeds that were planted at this launch conference will grow into mighty trees in the future. The eye opening information and ideas that were discussed included very useful data on the consequences of cultural and racial differences as well as potential solutions to avoid future conflicts."

BME Forum member, Lewisham

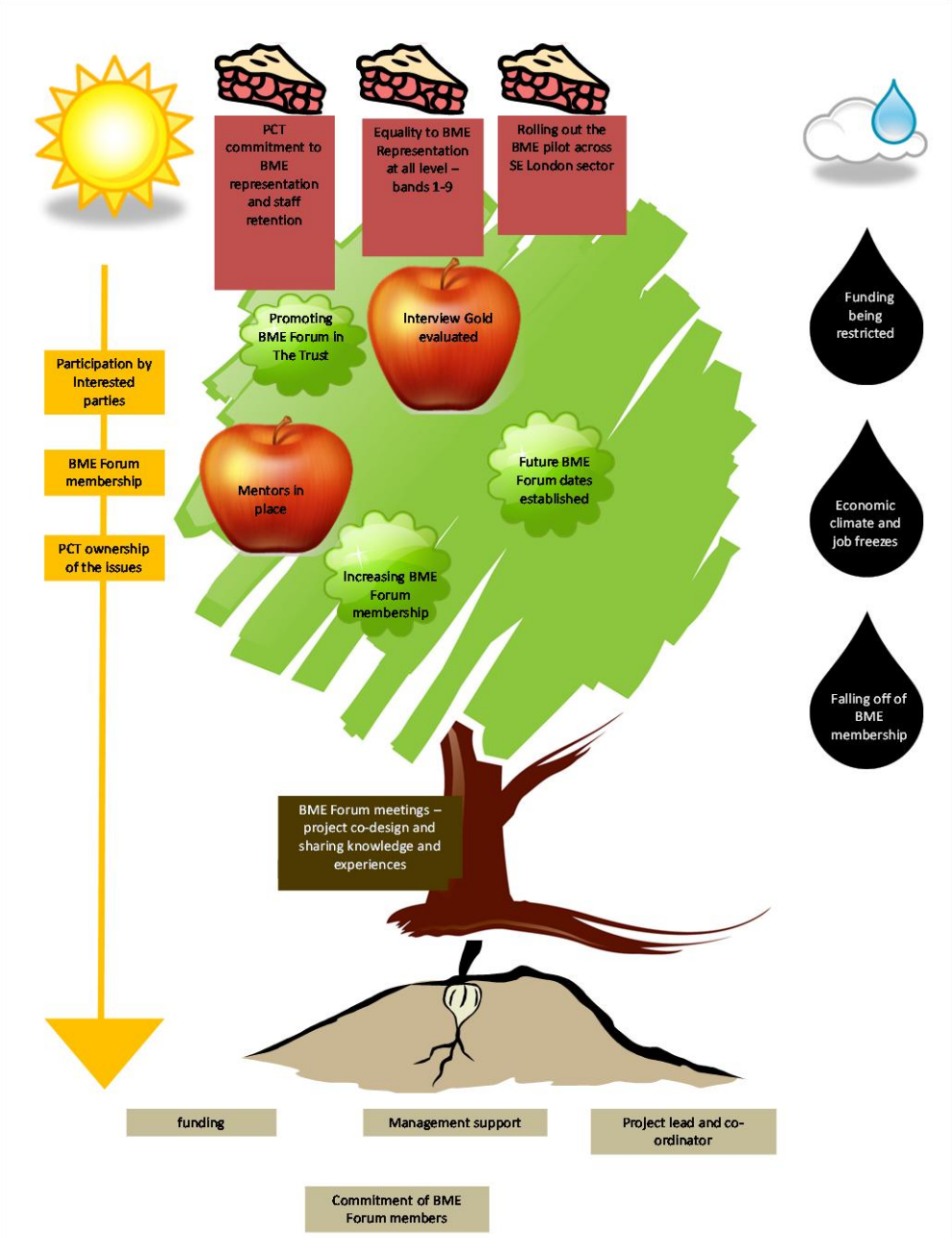
The local staff BME Forum will feed into the objectives of the national network and right now is a great time to get involved. The forum are putting together their plans and looking at key issues they want to tackle.

Keep an eye on the intranet for updates on the work of the forum.

If you're interested in being part of the forum contact Jackie Keizer on 020 7206 3236 or jackie.keizer@nhs.net

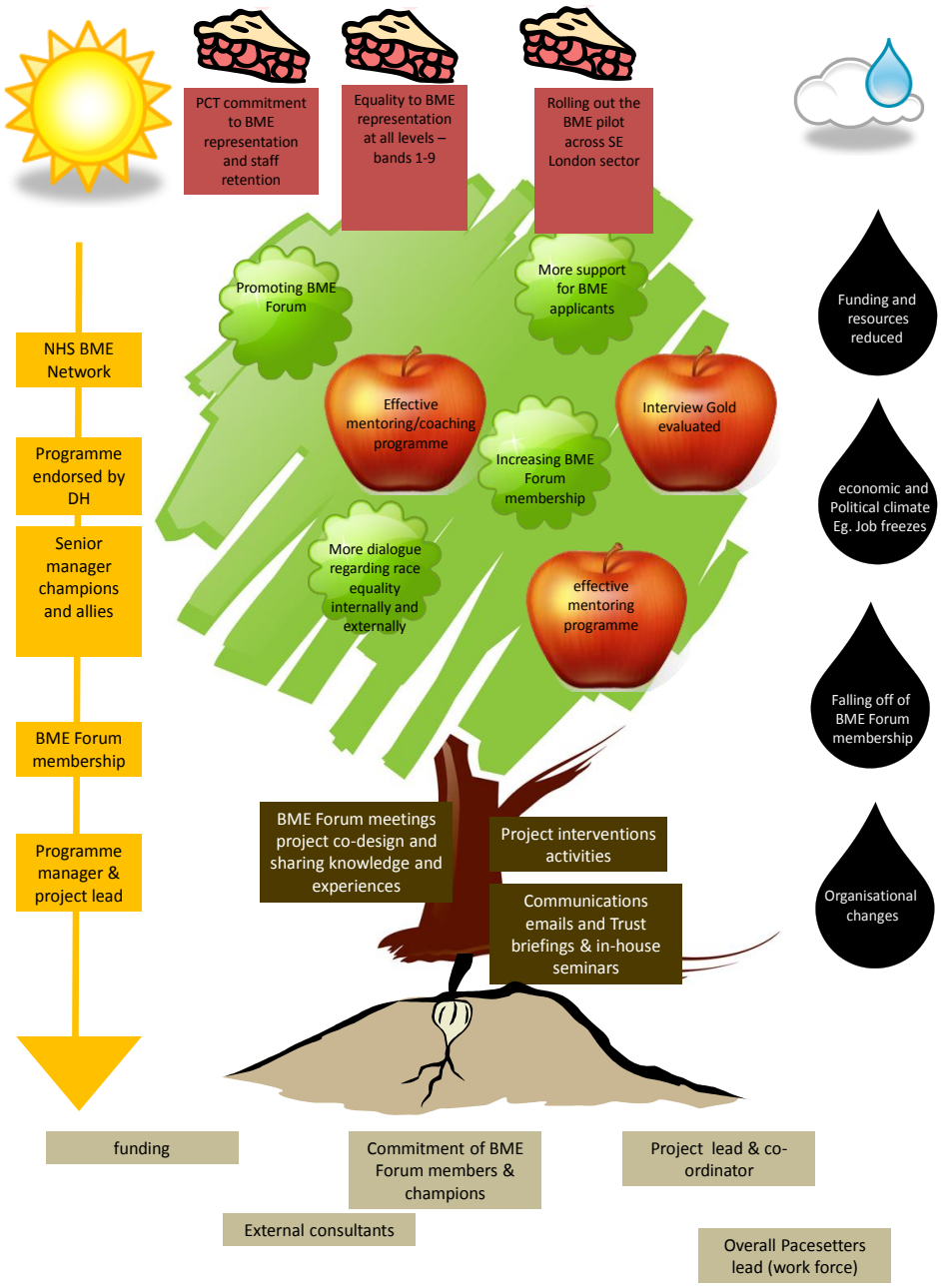
Appendix D6

Tree 1



Appendix D7

Evaluation Tree (ii)



Appendix E 1

Lincolnshire Staff Network Launch Programme

Launch of the Lincolnshire NHS Staff Network for Deaf, Deafened and Hard of Hearing Staff

Friday 30th April 2010
The New Life Centre, Sleaford,

Programme for the Day

9.30am	Coffee and Registration
9.45am	Introduction to the Day (Steve Day, Facilitator)
10.00am	Opening Remarks (Carol Baxter, NHS Employers)
10.30am	Pacesetters East Midlands (Leon Charikar, Pacesetters)
10.45am	Coffee Break and Information Stalls
11.15am	Why We Need a Staff Network
11.30am	Questions and Answers with the Panel
12.00pm	Lunch and Information Stalls
12.45pm	Learn to Sign Taster Session (DEAF Lincs)
1.15pm	Steve Day (Facilitator)
1.30pm	Closing Remarks (Maqsood Ahmed, East Midlands Strategic Health Authority)
2.00pm	Close

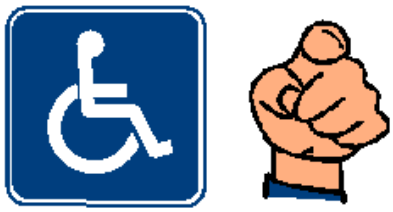
Appendix E2

Extracts from Easy-Read Job Application Form

United Lincolnshire Hospitals NHS

NHS Trust

Job Application Form

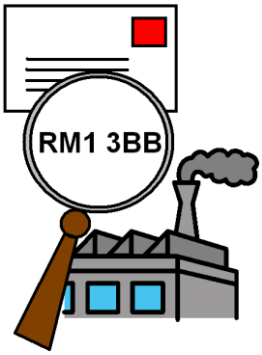


Easy Read

POSITIVE ABOUT DISABLED PEOPLE

Employer's name

Tell us the name and address of your current or last employer [the person you work for].



Employer's address and post code

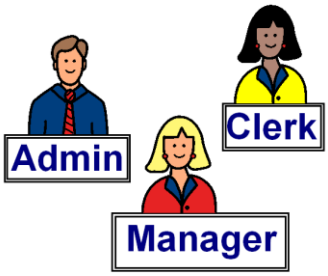
Include the Post Code [6 or 7 numbers and letters at the bottom of the address]

How much money were you paid in one year?

Tell us your annual salary [the amount of money you are paid each year]?

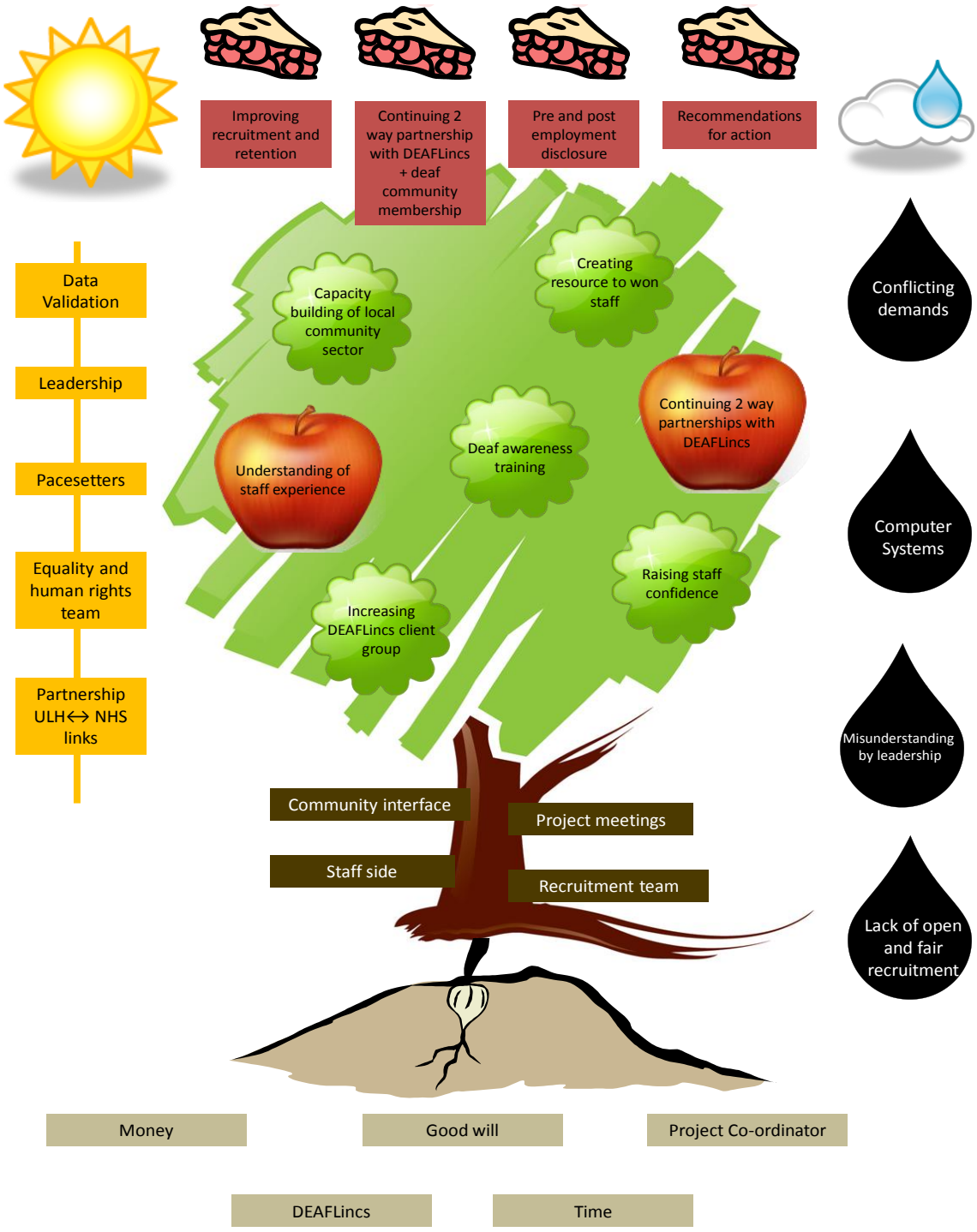
What was the name of your job?

Tell us the title of your job [the name that tells people what you do, for example: manager, administrator, and clerk]?



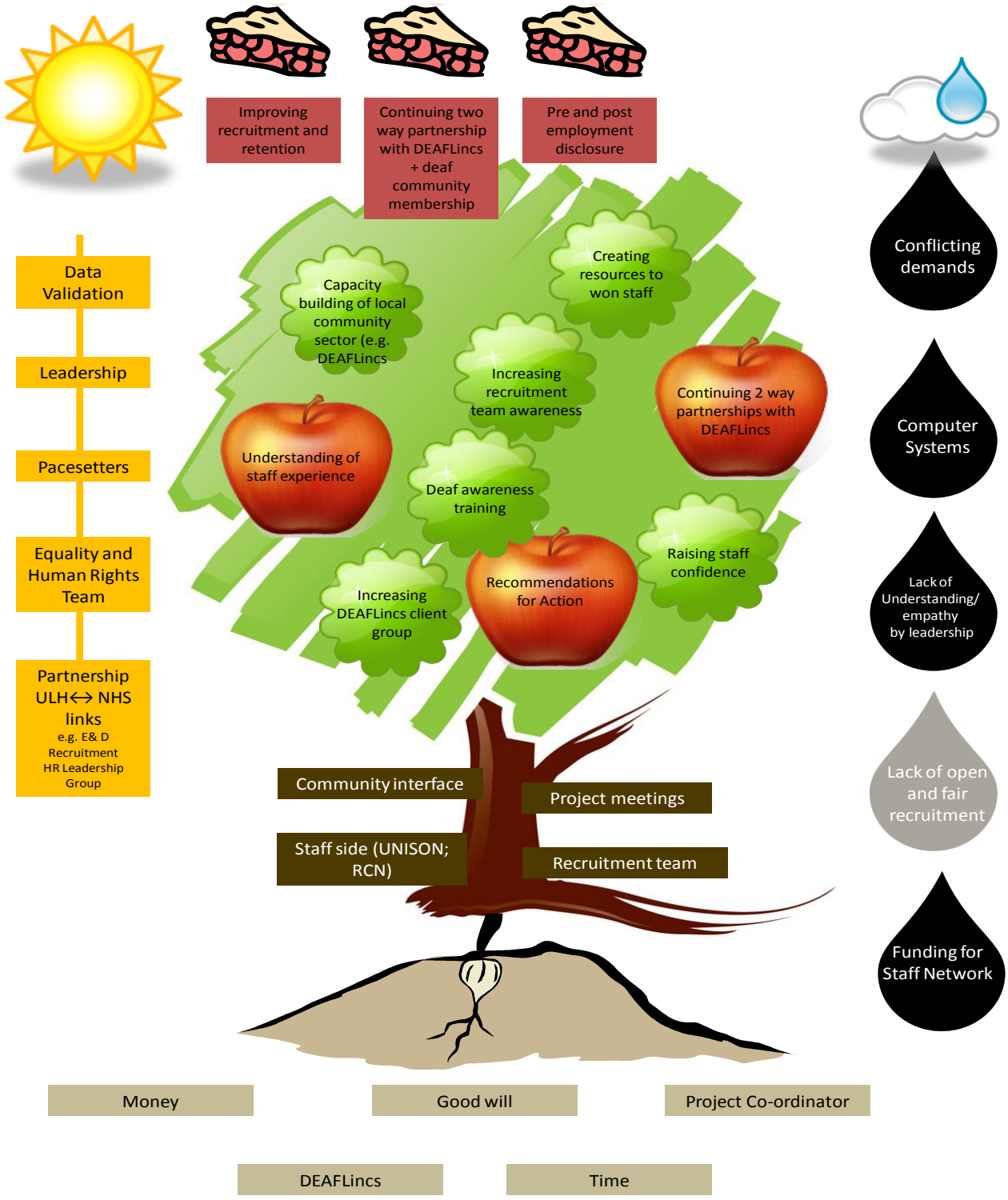
Appendix E3

Lincolnshire Logic Tree Diagram (September 2009)



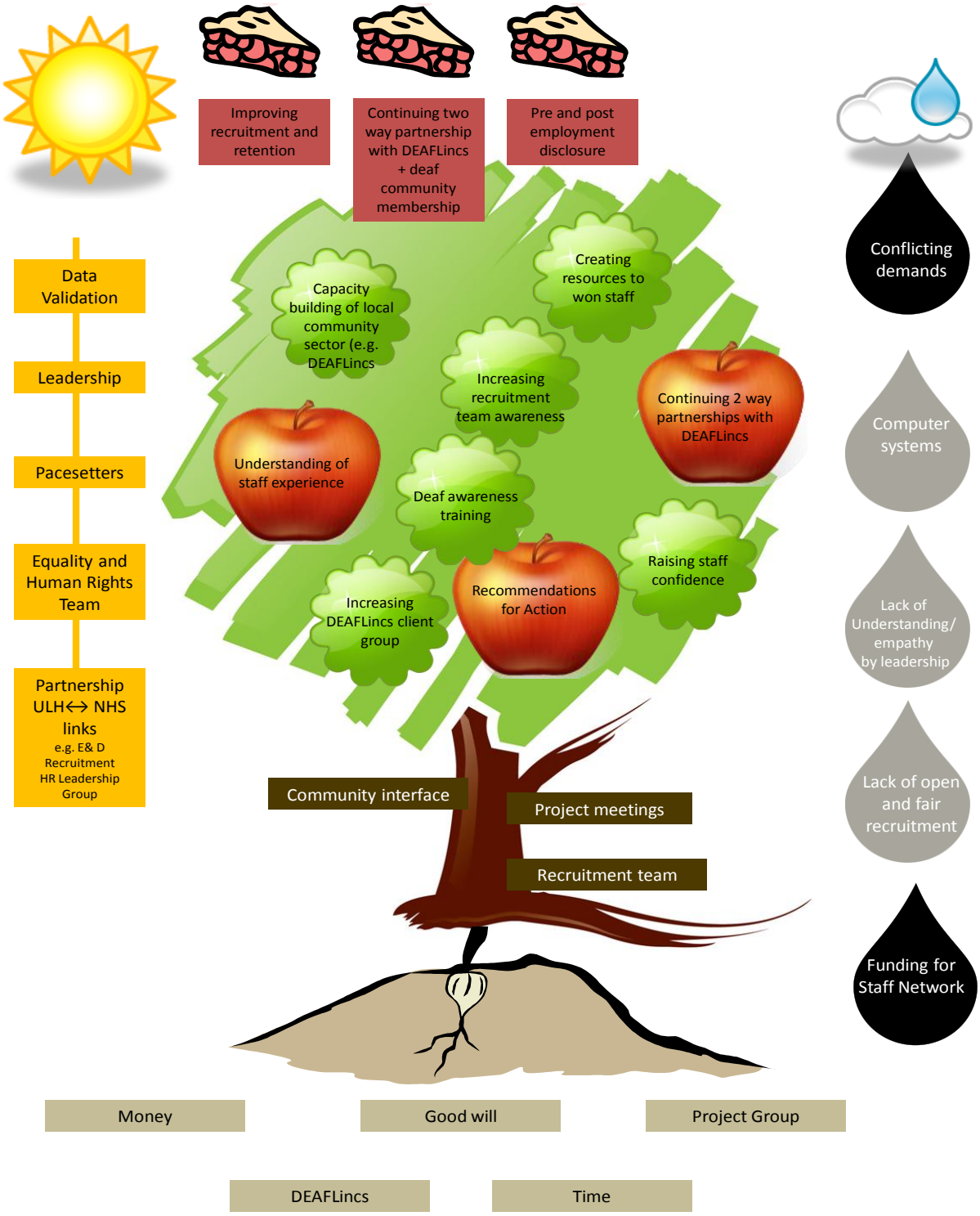
Appendix E4

Lincolnshire Logic Tree Diagram (March 2010)



Appendix E5

Lincolnshire Logic Tree Diagram (June 2010)



Appendix F1

Pacesetters Wave 2 Leicestershire Partnership NHS Trust Workforce Proposal

Target Area

Employment of people who have experience of ill mental health / use of mental health services within Leicestershire Partnership NHS Trust (LPT)

National / Local Evidence Over the years there have been numerous reports and governmental developments regarding care and support for people with mental health problems. Recently these have all emphasised access to mainstream services and facilities and the importance of social inclusion as part of the recovery process. The 2006 Social Exclusion Report had a key target area of employment for people with mental health problems and in 2007 the government established PSA 16, which aims "to increase the proportion of socially excluded adults who are in contact with secondary mental health services in settled accommodation and employment, education or training." The evidence that underpins these governmental objectives is the positive impact work can have on individuals living with mental health problems. Having a job increases a persons income thus improves standards of living but it also means improved social support networks and helps with self esteem and well being. There is also increasing evidence that people with severe mental illness recover better when employment is retained (NHS Employers 2008; Robdale 2008; East Midlands Public Health Report 2006.) Despite this people with mental health problems have the lowest rate of employment for all disabled groups. In the East Midlands the figures cited are around 18 - 27% (East Midlands Regional Employment Team 2008) compared to almost 80% of the adult population as a whole (Shaw Trust 2007.)

Scope of project

- To engage mental health service users in reviewing the Trust's capacity and capability to better promote and develop employment opportunities within the Trust for service users
- To identify and work towards developing the systems to support these employment initiatives
- To capacity build the service users engaged with the project so that their chances of employment either within the Trust or with other employers are enhanced
- To review current policies and support practices in place for employees with experience of ill mental health, across all levels of the Trust, including ensuring that staff with lived experience have the opportunity to influence policy and practice
- To identify links with Trusts / Organisations who have already developed expertise in the employment of people with lived experience of ill mental health

Methods

This project will be managed via the development of an "Employment and Vocational Opportunities" Task and Finish Group as part of the wider CORIIN programme. Membership of the group will include service users from user organisations along with service user development workers in post within clinical areas within the Trust. LPT

has two Employment Facilitators who will lead the project. This will initially focus on the design of a work plan centred around how the Trust can expand work opportunities for people who have lived experience of ill mental health, identifying the key issues and support required to take the plan forward. The group will also advise on the key policies that need to be reviewed, so as to ensure the working environment for all LPT staff cultivates openness and support. Once the key issues are understood the group will prioritise one or two issues to concentrate on. A steering group will be established which will be responsible for overseeing implementation of the change ideas. The steering group will include Human Resources staff, Managers, lead Clinical Staff and the Employment Facilitators. It is hoped that following successful establishment of the Foundation Trust a Governor will also be involved.

How does the project link in with existing work within the Trust?

The project is to sit within CORIIN, a delivery mechanism for LPT to ensure engagement with local communities and the promotion of inclusive practice. LPT recognizes its duty to work with partner organisations to deliver the opportunities that PSA 16 offers, to those individuals who are most at risk of social exclusion. There is strong representation at the PSA 16 Regional Sounding Board, Practitioners Group and at the multi agency mental health and employment group, which exists across Leicester, Leicestershire and Rutland. In 2004 six designated service user development worker positions were created. Two of the Service User Development workers are now employed as the Employment Facilitators for LPT and a key role is to review current workforce policies to consider access to jobs within the Trust, and support available to those employed, with mental health problems. This project will fit well with this existing work. There are also other small-scale initiatives taking place across the Trust for example within the PIER team.

Stakeholders

Appropriate engagement with an external organisation with people with lived experience of ill mental health – e.g. Rethink, Mind
Service Users – Open Assembly and Peoples Forum representation
LPT Staff currently in service user posts
LPT staff who have experience of mental health services as a user or carer
LPT Staff Support Disability Group - representation
Occupational Health
Human Resources
LPT Lead clinicians / Managers
County PCT Commissioner
City PCT Commissioner
LPT Inclusion Support Service Managers
Trade Union / Professional Organisation Representation
Trusts / Organisations with expertise in the field of disability and employment e.g. breaking the Barriers (employment initiative for service users in Leicester)

Intended Outcomes

1. Service user engagement with the Trust on employment
2. Capacity building for those individuals involved in project Task and Finish Group
3. In long term increased likelihood of increasing the number of service users recruited within the Trust – targets still to be agreed

4. Identification of specific areas where work is needed to ensure necessary support systems are in place to sustain people in employment

5. Improvements in practice through ongoing development and review of relevant policies around recruitment and retention

6. An agreed target to be set around increasing the number of people who disclose lived experience of ill mental health already in positions within the Trust

How will the project be monitored?

The project plan will be developed through the Task and Finish Group and at this stage particular milestones and outcomes will be identified. These will be evaluated using a range of qualitative and quantitative methods

- Views of the Task and Finish Group on the process and development of the project

- Improvements in policies measured against benchmark Trusts

- Consistent robust data collection around PSA 16 employment target. Such data will be closely monitored and improvements over longer term identified and disseminated

Governance

The project is part of the Trust's wave 2 Pacesetters Programme and as such comes under all of the governance arrangements that come with the programme. The Employment Facilitators will liaise closely with the Associate Director for CORIIN who has overall leadership of the project. The Trust Equality lead is also key to the project, with regular reporting to the Trust's equality and diversity steering group.

References

East Midlands Public Health Report (2006) Improving the Health of the East Midlands : Keeping Health in Mind

East Midlands Regional Employment Team (2008) East Midlands Mental Health and Employment Strategy 2008 - 10

NHS Employers (2008) Mental Health and Employment in the NHS

Robdale, N (2008) "Vocational Rehabilitation: Variety is the key to success." Mental Health Today

Shaw Trust (2007) Disability and Employment Statistics

Appendix F2

Appendix 2: Final Report produced by project leads (includes baseline and re-audit questionnaire results)

1.0 Introduction / Background Data

1.1 The issue of mental health and work has dominated policy and thinking over the last few years with it included as a theme in the national work on social inclusion, the Public Sector Agreement (PSA)16 targets on employment and housing and the "Shift" / "Time to Change" campaigns around stigma and discrimination. More recently there has been the launch of "Open Your Mind", a new anti stigma campaign by NHS Employers (March 2010) and a great deal of strategic guidance published such as "Work, Recovery and Inclusion" (HM Gov 2009.) This report indicates that the proportion of people who are employed who have severe mental health conditions compared to other groups is unacceptably low, despite a high proportion of people saying that they would like to work. The aim is to dramatically increase the number of people with mental health conditions in employment by 2025 and to narrow the gap between their employment rate and that of disabled people in general. For any individual access to employment and meaningful activity is part of maintaining good mental health, having a decent quality of life, positive social support and self-esteem (Perkins et al 2009.) For those struggling with a mental health condition having some form of employment focus gives them an improved sense of health and well being (NHS Employers 2010.)

1.2 The question that the above evidence all seems to be pointing to is that if "good" work is beneficial to an individual with a mental health condition why is it that individuals struggle to get jobs? Why are the statistics for employment of people with a mental health disability compared to other disabilities so shockingly low? One main obstacle is the views and consistent low expectations of the general public, including those who work in the health services that such individuals do not, should not and are unable to work. It is the barrier of stigma and discrimination, and this is by no means the only obstacle that people with mental health conditions face in getting employment, which this project has concentrated on. In order to better promote, develop and positively increase the number of employment opportunities for mental health service users within the workforce of Leicestershire Partnership (LPT) NHS Trust it was felt useful to start with the massive issue of breaking down some of the stigma. LPT employees are by nature part of wider society and therefore it can be generalised that the wider views of society are some of the views that staff within the organisation would hold. It is also a recognized fact that the number of current LPT employees with a mental health condition, either recognized under Disability Discrimination Act or not would be more than the Trust statistics would show. An awareness campaign may have wider associated benefits to such staff, at best it may help provide some with the confidence to disclose. "We must challenge out-dated beliefs about mental health and work, whether held by service professionals, employers or people who use services" (HM Gov 2009 page 9.)

1.3 The main policy drivers include:

- HM Government (2009) Work, Recovery and Inclusion
- Mind / Rethink (2008) "Time To Change" Campaign

http://www.time-to-change.org.uk/

- NHS Employers (2010) "Open Your Mind" Campaign

http://www.time-to-change.org.uk/news/time-change-welcomes-launch-openyour-mind

- Perkins, R; Farmer P & Litchfield P (2009) Realising Ambitions: Better Employment Support for people with a Mental Health Condition

- Shift (2009) Line Manager's Resource

2.0 Aims of Report

2.1 The aim of this report is to contextualize the project in light of growing evidence and policy around mental health service user employment; explain what the project consisted of, including the difficulties experienced and illustrate how the project linked well with other initiatives around LPT.

3.0 The Workforce Project

3.1 The project started with the writing of a proposal outlining the need for the intervention, which the key stakeholders would be and how this fit in with existing work around LPT. At this point there were two key but rather broad aims: Firstly to engage mental health service users in reviewing the Trust's capacity and capability to better promote and develop employment opportunities within the Trust for service users. Secondly to review current policies and support practices in place for employees with a mental health condition.

3.2 As outlined in the introduction the need for the project was widely recognized with campaigns such as "Time to Change" stating that 92% of people believed that admitting to having a mental health condition would damage one's career prospects (Time To Change 2008) and fewer than 4 in 10 employers saying they would recruit someone with a mental health condition (Perkins et al 2009.) There is a work culture **whereby people in** employment that may have or may have had a mental health condition fear disclosing or discussing this for fear of discrimination (Shift 2009.) This can take the form of a person feeling they generate more concern in terms of their ability to "cope"; policies and procedures which unknowingly discriminate and in some instances, illegal recruitment practices. There was no suggestion that the latter was ever an issue for LPT however as part of the project a review / equality impact assessment took place on all Human Resources policies for what could potentially lead to improvements and longer term benefits for current and new employees with any disability.

3.3 Employers who have participated in projects to increase awareness about the issue of mental health and employment have reported improved staff retention, reduced sickness and increased productivity (Shift 2009) and are subsequently in a better position to specifically work at increasing the number of people they employ with a mental health condition. PSA 16 is driven by the low statistics and the need to do more to encourage organisations to positively recruit individuals from the four groups (of which secondary mental health service users are one.) All organisations, but especially those in the public sector, have a key role in both contributing to, and benefiting from savings associated with long term persistent social exclusion from an economic and health improvement perspective. "Increasing the number of people with mental health conditions that the NHS employs makes good business sense, as it delivers employees who are reliable and dedicated and often have a great empathy for the patients and communities we serve" (NHS Employers 2010.) The evidence was there in terms of a

need for an awareness campaign within any organisation and the fact that LPT was a Mental Health and Learning Disability Trust did not make this any the less.
3.4 A key principle of Pacesetters is that there should be strong and genuine engagement with community and patient groups. From the onset it was accepted that service users would be involved throughout the entire project and so identifying a group of people was key to the initial stage. Six service users were recruited and a focus group was formed with these individuals and representation from other priority stakeholders ("Breaking the Barriers" as an organisation who help people with a disability into employment; LPTs Equality and Human Rights Lead and key clinical / human resource / "service user" employees of LPT.) At the initial meeting the discussion was based around how the project could be developed to best tackle stigma / discrimination towards service user employment within LPTs own workforce. The form that the awareness campaign was to take came from the Project Leads – a myth busting / fact giving awareness campaign was remembered from a Mental Health Charity in the past and it was felt that replicating something like this could have a large impact on LPT employees. Twelve myths were fairly easy to generate especially given the personal story shared of at least one of the service users in the group who had experience of discrimination in employment due to her diagnosis. Some came from anecdotal comments that an individual was asked when trying to recruit "service user workers" – "won't they be off sick all the time"; "what about patient confidentiality." The other myths were commonly held views of society "people do not want to work" "people cannot work" and the issue of violence as cited frequently in the Media. It was also agreed that an anonymous quantitative baseline and re-audit questionnaire would be sent to a random sample of 500 employees, based around the twelve myths and facts that were forming the poster campaign.
3.5 With support from the Trust's Equality and Human Rights Lead and the Human Resources department one of the initial parts to the project, the Equality Impact Assessment day went ahead as planned. This involved facilitators assisting individuals from a range of departments within LPT, from partnering organisations along with service users and carers to look at the majority of LPTs policies and practices to analyse their equality in two areas. Firstly that they promoted equality in supporting the employment of people with a mental health condition into the workplace and secondly that they would meet the needs appropriately of current staff who may be struggling. The results from this have been incorporated into a schedule for review of policies which is currently being undertaken by the Human Resources department, assisting with the prioritisation of those that are most in need of updating and why.
3.6 The questionnaire was developed and piloted on a small group of people prior to circulating. There were a few small changes to the wording recommended but it was then sent out to 500 random individuals who had been selected from Payroll list. The questionnaire had a return date of three months (July 31st 2009) to the internal Audit department.
3.7 In August 2009 the two Project Leads met with an evaluator from Liverpool John Moore University (LJMU) as part of their evaluation work for the Department of Health. At this stage the aims and outcomes of the project were articulated. In the short term the key outcome was an improvement of current employee's awareness of issues and dispelling of myths around service user employment. In the medium to long term the key outcome was an increased proportion of employment for people with mental health conditions within LPT. This could be recognized as having a workforce that represents the national proportion of individuals who at some time of their life will suffer from

mental health conditions (25%.) Furthermore, the requirement for the establishment of a team to support LPT employee service users was identified and for an evidence based "employment" approach to be operational in all clinical areas. This would ensure employment was prioritised and seen as part of the wider recovery approach.
3.8 At this session the anticipated barriers (difficulty in changing attitudes / current recession and funding issues) to achieving the above aims were discussed. A further meeting was arranged in September 2009 which explained the role of action learning and the composition of some action learning sets were proposed to start around October 2009.
3.9 During the period whilst the questionnaire was out to staff it was necessary to start the development of the posters for the campaign. It could be argued that to genuinely understand if there was a need for a campaign it was essential to wait for the questionnaire results to prove or disprove this. In reality there was not the time to allow this to happen and it had to be assumed that the views of wider society, the statistics quoted in numerous reports, the massive PSA 16 drive and the national anti stigma campaigns were all evidence of the need for a campaign in the organisation. In order to maintain the "service user" element it was felt appropriate to use a service user Art group to design the posters. Artwork created by members of BrightSparks, a service user group based in Leicester was used by the artist Paul Gent to generate the posters. The Project Leads made a couple of visits to the group whilst they were working on the designs discussing the overall project with them and engaging them in the aims of the campaign. The posters were very powerful and illustrated in many cases an individual's own battles with mental illness and society's views on this.
3.10 When the results of the questionnaire did come back from the Audit department the posters were in the process of being printed however it had already been acknowledged and discussed that regardless of the results a campaign was necessary. The questionnaire was purely to capture a small sample of views from around the Trust and was never intended to be an illustration of need. From the fully returned questionnaires (186/500) the results were overall positive perhaps illustrating that those individuals that responded were interested in and already aware of the issues.
3.11 The posters arrived back from the printers ready to start a roll out from the 1st September 2009. At this point a booklet was also being designed to accompany the posters. The aim of this was to provide more background to the campaign and provide an opportunity to link the campaign with that of "Mindful Employer" – an initiative which the Trust had recently signed up to, based around increasing awareness of mental health at work and providing organisations with support in recruiting and retaining individuals who have or had a mental health condition. The booklet took quite a lengthy period of time to finalise, with it requiring amendments following its equality impact assessment but these were crucial issues. The plan for the roll out of the campaign was to do this in person, with specific presentations to groups and by personally ensuring the posters were put up in the various areas. Due to the unforeseen long term absence of one of the Project Leads the first real change to the plan came at this point. Rather than personally distributing posters they were sent out, with copies of the booklet, to all areas and launched via an article in the E- newsletter and followed up in the Team Brief. They were also linked to the Pacesetters page on the Intranet so employees could access on-line.
3.12 It was at the time of the posters going out that the first "Action Learning" session with a facilitator from LJMU was held. Set members (excluding Project Leads) included four service users (from the original group recruited to assist with the project) and

three LPT employees (one of whom was in a service user role), making a total of seven. This is acknowledged within "DIY Handbook for Action Learners" (Chivers & Pedler 2009) as a suitable number for a viable set. The second action learning set meeting was on the 18th January 2010 and this was attended by one service user and the three LPT employees. While this is a very small set, possibly due to the ground clearing at the first set, a great deal of discussion was generated around the wider issue of stigma and barriers to employment and two key areas emerged: "benefits trap" and occupational health. It is interesting that alongside employer attitudes and low expectations of professionals / oneself it is these two obstacles that are cited within "Realising ambitions" (Perkins et al 2009) as the barriers to employment. The recommendation from this report is that these areas need to be addressed and tackled urgently by the government.

3.13 Due to the slow roll out of the posters there was a delay in sending out the questionnaire as a re – audit tool as it was felt that time had to be given for people to see and reflect on the posters. It was January 2010 when the questionnaire was put out again to another random 500 employees. This time, with pressure of time the cut off date was put as 1st March 2010 and again the Audit department collated the results. The number returned (139/500) was less than the first time. Both results are shown in Appendix A.

4.0 Evaluation

4.1 The final action learning set meeting was held in March 2010 and this was attended by three service users and one LPT employee. The agenda for the session focussed on revisiting the project outcomes which were set in August 2009. The questionnaire results were looked at in depth and the group asked whether they felt the differences were significant. The debate around this presented no real conclusion but posed many issues around the small sample size, the reduced time (4 weeks less) given for people to respond to the second questionnaire and the fact there was no way of tracing the area (e.g. admin, frontline clinical) that the respondents worked in – was a similar proportion sent to each area each time? It was also noted that although currently the posters were well displayed, they were slow to be put up and had not necessarily been seen by employees when envisaged in the project plan that they would be. Even prior to the second questionnaire some areas were not displaying posters and it took several items in internal communication briefings for action to be taken.

4.2 In the short term it would have been more realistic to have set the outcome as undertake an educational campaign to challenge the beliefs / myths held and raise awareness of issues around mental health and employment. This was felt to have been achieved however it has been difficult to actually establish if improved awareness has occurred as was the initial set outcome.

4.3 In terms of the medium to long term goal, initiatives such as Future Jobs Fund have helped to increase the proportion (even if small) of employees within LPT who have a lived experience of mental health. However, even estimating that there is an under disclosure on mental health disability from current employees, the organisation is still far from having a workforce that is representative of wider society in terms of disability and specifically mental health. As was initially thought the current economic climate and the situation with job opportunities has had an impact on this goal. Work to implement an evidence based employment approach within all clinical teams has started but remains in early stages. This will ensure that as a provider of services, LPT are not only aware of the need to but taking action to incorporate employment within the recovery model.

4.4 The project has had minimal costs associated with it – the majority of funding was required for the designing and printing of both the posters and booklets. Associated costs were obviously from the engagement of service users with the project. Designing, delivering and evaluating the project has been time consuming on behalf of the Project Leads and more so given the unexpected absence of one of these individuals. However the project has brought numerous benefits, both as already stated in raising awareness, but equally in helping to build a good working relationship with the service users specifically working on the project. The personal stories shared from these members were invaluable. It is also important to emphasize the engagement with the service user art group and the powerful messages received from them both verbally and through their artwork. Excellent feedback was received on the posters for example an email read "Just wanted to let you know how brilliant the artwork on those posters is. I thought it was a national campaign! Please congratulate the artists for me" (LPT employee 2010.) As reinforced in literature such as the "One in Four" (Spring 2010) magazine based around tackling the stigma and discrimination surrounding mental health, it is important to use people with experience of mental health conditions themselves to create materials intended to inform others and challenge stigma.

5.0 Future

5.1 Overall the campaign within LPT was well received and has complimented other pieces of work which are being undertaken around the Trust – a Future Job Fund scheme creating 6 month posts for individuals with a mental health condition / learning disability; the Mindful Employer sign up and the regional work around PSA 16.

5.2 In itself it is extremely difficult to assess what impact the poster campaign has had on people. The project has had the potential to impact on and challenge individuals but also working practices of teams and LPT as a whole. Pacesetters has definitely helped lift the work around service user employment up the agenda and helped the message reach all employees. The posters and booklets have a lifespan beyond the end of Pacesetters and will continue to be used to compliment practical initiatives which the Trust are involved in around service user employment.

5.3 There is also the possibility of sharing the learning and resources involved with this project. Colleagues in a neighbouring PCT NHS Trust have expressed an interest in using the posters within their organisation and similar interest has also been expressed from an individual from a NHS Trust further afield, who through a conference found out about the project.

Comparison of results to baseline audit

Question	Baseline	Re - audit
1) People with mental health problems can't work	**Strongly agree = 0.5% Agree = 0.5% Don't know = 1.6% Disagree = 38.7% Strongly disagree = 58.6%**	**Strongly agree = 1.4% Agree = 1.4% Don't know = 0.7% Disagree = 48.2% Strongly disagree =48.2%**
2) People with mental health	**Strongly agree = 1.1% Agree = 2.2%**	**Strongly agree = 0.7%**

problems don't want to work	**Don’t know = 5.4% Disagree = 44.6% Strongly disagree = 46.2% Missing data = 0.5%**	**Agree = 3.6% Don’t know = 10.8% Disagree = 44.6% Strongly disagree =40.3%**
3) People with mental health problems take a lot of time off sick	**Strongly agree = 2.2% Agree = 17.2% Don’t know = 24.2% Disagree = 40.8% Strongly disagree = 15.6%**	**Strongly agree = 2.2% Agree = 18.7% Don’t know = 33.1% Disagree = 34.5% Strongly disagree =10.8% Missing data = 0.7%**
4) People with severe and enduring mental health problems are not covered under the Disability Discrimination Act Legislation	**Agree = 3.3% Don’t know = 36% Disagree = 36% Strongly disagree = 24.2% Missing data = 0.5%**	**Strongly agree = 1.4% Agree = 3.6% Don’t know = 46% Disagree = 21.6% Strongly disagree =27.3%**
5) People with mental health problems have a tendency to be violent	**Strongly agree = 0.5% Agree = 5.4% Don’t know = 4.3% Disagree = 47.3% Strongly disagree = 42% Missing data = 0.5%**	**Strongly agree = 1.4% Agree = 10.1% Don’t know = 6.5% Disagree = 43.9% Strongly disagree =36.7% Missing data = 1.4%**
6) People who have been sectioned under the mental health act can never work in the health service	**Agree = 1.6% Don’t know = 23.7% Disagree = 43.5% Strongly disagree = 30.6% Agree/disagree = 0.5%**	**Strongly agree = 1.6% Agree = 2.2% Don’t know = 28.8% Disagree = 38.8% Strongly disagree =28.8%**
7) People with mental health problems would not be able to maintain patient confidentiality if they work in the health service	**Agree = 3.2% Don’t know = 6.5% Disagree = 40.9% Strongly disagree = 38.7%**	**Strongly agree = 0.7% Agree = 5.0% Don’t know = 6.5% Disagree = 42.4%**

	Agree/disagree = 0.5% **Missing data = 10.2%**	**Strongly disagree =43.2%** **Missing data = 2.2%**
8) People with mental health problems would not be able to keep to the required time commitment of the job	**Agree = 4.8%** **Don't know = 6.4%** **Disagree = 45.2%** **Strongly disagree = 32.8%** **Missing data = 10.8%**	**Strongly agree = 0.7%** **Agree = 5.0%** **Don't know = 15.1%** **Disagree = 44.6%** **Strongly disagree =32.4%** **Missing data = 2.2%**
9) People with mental health problems would always want time off for appointments	**Strongly agree = 0.5%** **Agree = 10.2%** **Don't know = 11.8%** **Disagree = 44.1%** **Strongly disagree = 21.5%** **Missing data = 11.8%**	**Strongly agree = 0.7%** **Agree = 15.8%** **Don't know = 18%** **Disagree = 42.4%** **Strongly disagree =20.9%** **Missing data = 2.2%**
10) People with mental health problems will not be very good or beneficial to a clinical team	**Strongly agree = 0.5%** **Agree = 1.1%** **Don't know = 5.4%** **Disagree = 41.4%** **Strongly disagree = 39.8%** **Agree/Disagree = 0.5%** **Missing data = 11.3%**	**Strongly agree = 0.7%** **Agree = 2.9%** **Don't know = 7.9%** **Disagree = 46%** **Strongly disagree =40.3%** **Missing data = 2.2%**
11) People with mental health problems, their health will deteriorate when in employment	**Agree = 1.6%** **Don't know = 9.1%** **Disagree = 40.9%** **Strongly disagree = 35.5%** **Agree/Disagree = 0.5%** **Missing data = 12.4%**	**Strongly agree = 0.7%** **Agree = 2.2%** **Don't know = 8.6%** **Disagree = 51.8%** **Strongly disagree =34.5%** **Missing data = 2.2%**
12) LPT does not have the structure in place to employ and support people with mental health problems	**Strongly agree = 2.2%** **Agree = 8.6%** **Don't know = 33.8%** **Disagree = 30.1%**	**Strongly agree = 2.9%** **Agree = 11.5%** **Don't know = 32.3%**

Strongly disagree = 15.1%	**Disagree = 36.7%**
Missing data = 10.2%	**Strongly disagree =14.4%**
	Missing data = 2.2%

Baseline Questionnaire Comments

Question 1

- **depends on severity**
- **However it depends upon the severity of the illness and frequent relapses**

Question 2

- **However, some don't want to work due to this impacting negatively upon mental health**

Question 3

- **what does a lot mean**

Question 4

- **I believe they should be protected by legislation**
- **they should be covered**

Question 5

- **Not all people have a tendency to be violent even though they have mental health problems**
- **Most do not – some people do needs risk assessment**
- **MD Can't answer as can't put everyone with mental health together as risks change with each individual**

Question 6

- **Hope not**
- **Maybe if a long period has elapsed**
- **it's a very big service, but in reality this often happens**

Question 7

- **depends on nature of illness**

Question 8

- **As with any health problem, there would need to be discussion with employer at times**

Question 9

- **Probably necessary**
- **They need more appointments**
- **Should always get time off work**
- **as would anyone**

- **May not want but may be necessary and should be facilitated under DDA**

- **it is their right to**

Question 10

- **Variable – more information needed regarding mental health and team**

- **Again dependent upon severity of illness**

Question 11

- **Depends on support given and degree of stress at work**

- **Depends upon individuals stress of the job**

- **might well improve**

- **depends on job and nature of illness**

- **Dependent upon support of organisation also**

- **Depends**

Question 12

- **Or the attitudes, ethos etc**

- **Depends whether this happens**

I think that perhaps 'support' not structure – and I mean for recruiting managers, not potential employees with mental health problems. As a manager I would want to know who/what/how I would be supported (if the need arose) by LPT?

- **We should be best of all at this but personally I just don't know**

<u>General comments</u>

- **Ridiculous**

- **There is such a vast array of mental illnesses from which create so many different issues therefore, I find the above questions very difficult to answer; with differing degrees of severity in 'mental health problems'.**

- **'Mental health problems' covers such a huge spectrum that answers cannot be given in two words**

- **It works better in some areas than others but needs to be across the trust and positively promoted and regarded**

- **My perceptions are a mixture of my views – and my perception of reality for people with mental health problems**

- **Can't possibly answer these questions as the term 'mental health' problems covers such a wide variety of issues i.e. mild depression, paranoid schizophrenic**

<u>Re - Audit Questionnaire Comments</u>

Question 3

- **Don't agree or disagree: some people do some people don't. Just like the rest of the population who may suffer with ongoing health problems**

- **Surely this varies depending on a number of factors**

Question 5

- **Depends on my problem**

- **Some do but very few**

Question 8

- **No different to other illnesses**

Question 7

- **Depends on the condition**

Question 11

- **With some it may, particularly if they don't have adequate support**

- **Depends on context, work can have an impact on anyone irrespective of their mental health**

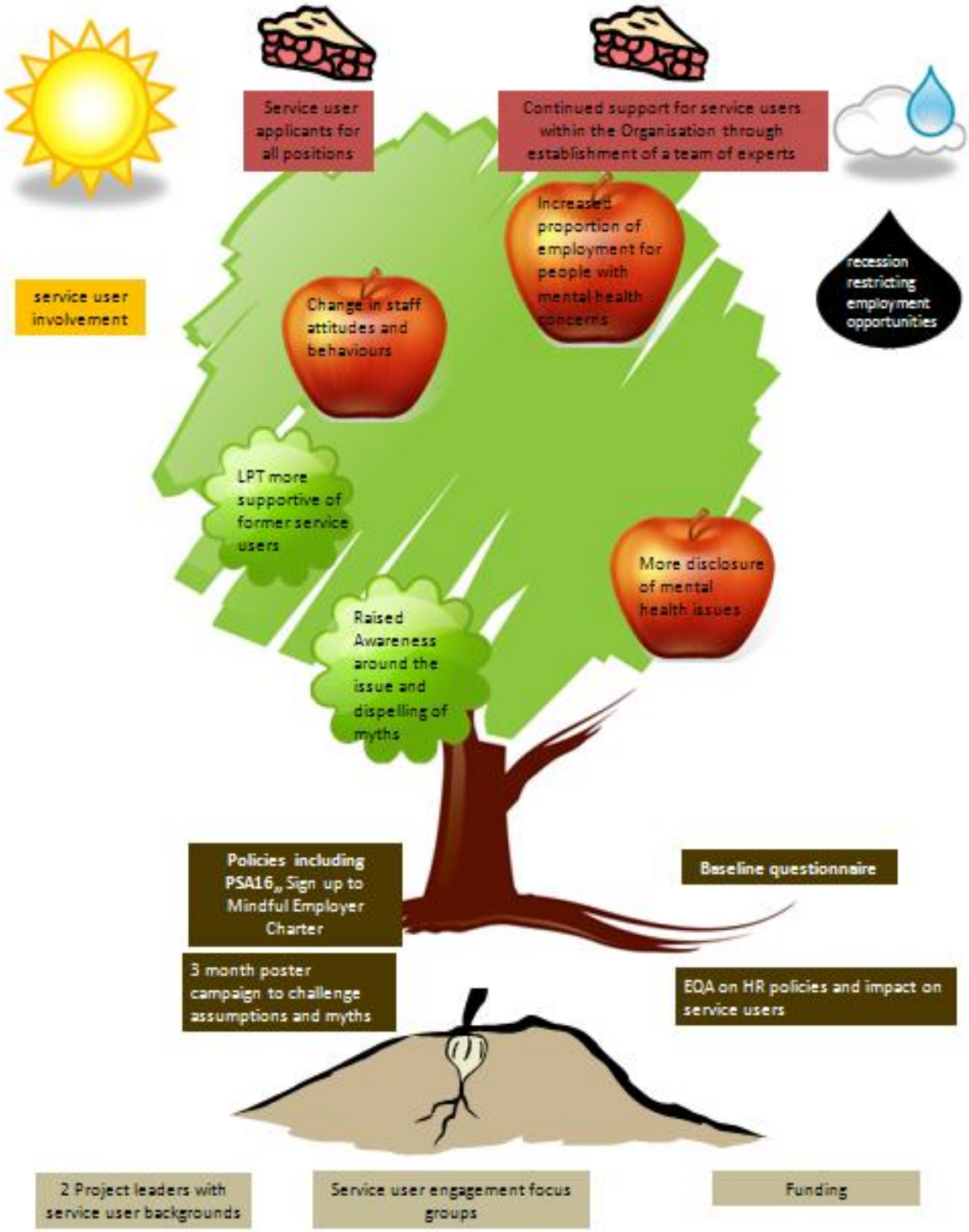
- **It will if they are not supported**

Question 12

- **Please note that my answers will reflect the fact that I am a person with mental health problems (albeit not severe) and working in the health service**

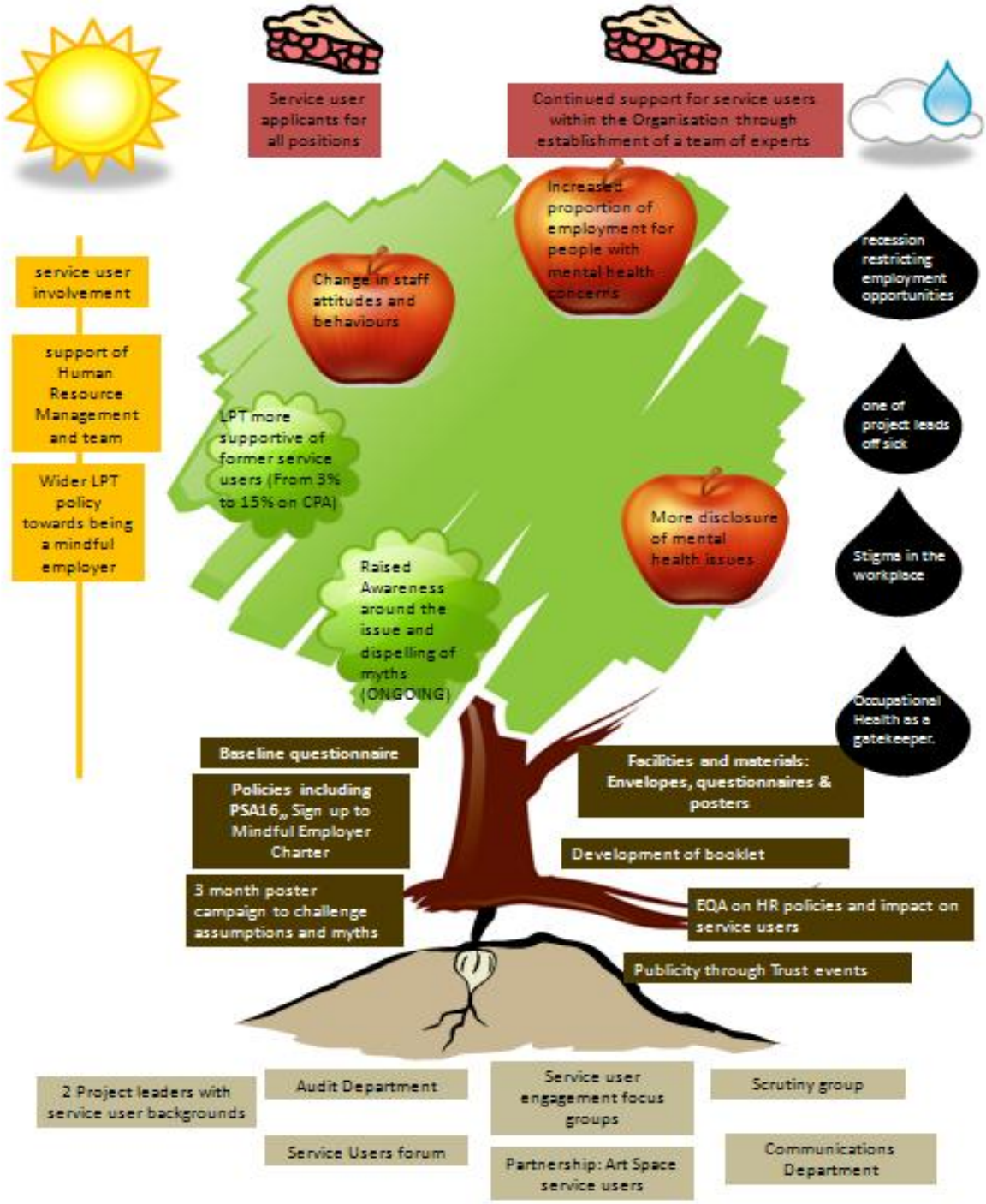
Appendix F3

August 2009 initial logic tree Leicestershire Partnership NHS Trust



Appendix F4

June 2010 Updated logic tree Leicestershire partnership NHS Trust



Appendix G1

SECoast Ambulance **Epsom Conference Programme**

South East Coast Ambulance Service NHS

NHS Trust

9.00-9.35 Registration and morning coffee

Welcome: Jagtar Singh, OBE & Shelley Collins, Just Resources. Will introduce our **Facilitators**, who will be leading on the Action Learning strand over the day.

9.45 **What are the medium/long term Opportunities and Threats, for promoting equality and diversity and supporting a Human Right based approach, in the urgent and emergency care sector**? Identification of key issues that Panel speakers will be invited to take account of over the course of the morning session. Using mind mapping techniques and in facilitated Action Learning & Networking Sets, seminar participants will begin to shape the days content.

10.30 Corporate Leadership [verses?] Emergent Transformational Leaders.....

Chaired by Paul Sutton, CEO - SECAmb: Professor Carol Baxter CBE, NHS Employers; Neslyn Watson Druée OBE, Chair Kingston Primary Care Trust NHS; Dr. Tim OJo, MBA Consultant Psychiatrist; Bernie Brooks
Head of Leadership and O.D from SEC SHA.

Effective corporate leadership is key to delivering world class urgent and emergency care for all of our communities. Transforming Leaders enable us to better respond to the needs of patients, service users and staff within diverse and complex situations.

Ambulance Trusts need to sustain collaborative working, as well as attract Leaders and Managers who can enable and unleash the full potential of all people – but can this create a conflict of interests, purpose and vision? A panel of speakers will consider Ambulance Trusts' corporate and moral responsibility to identify and develop Leaders, promote new and diverse leadership paradigms, as well as work with Black and minority groups and others to redefine our understanding of Leadership.

Positive About Disabled People

Stonewall DIVERSITY CHAMPION

11.3

11.50 **Lynda Brooks** the Programme Director for Pacesetters: *Setting the Pace of Change – Clinical Excellence and Tackling Health Inequalities – Pacesetters an effective strategy for change?*

12.20 [At 12.20 you will be invited to re-join your Facilitators/Action Learning Sets

What are the Strengths and Weaknesses, in the Pacesetters model of tackling health inequalities and promoting a Human Right based approach? Identification of Key issues that Panel speakers should address/speak to.
Using mind mapping techniques and in facilitated Action Learning & Networking Sets, seminar participants will continue to shape the days content.

1.00-2.00pm Lunch – Fork Hot/Cold Buffet.

1.00pm Lunch - Screening [Ben Hole, Director and Indy Panesar, Executive Producer, will speak to latest Film Project – MIND/SECAmb – partnership supported by Pacesetters]

2.00 -3.15pm [Three sessions A, B, C -will run concurrently]
A] **Race, Ethnicity and Differential Diagnosis** – factors for consideration for urgent and emergency care providers. Chaired by: Professor Baxter; A panel of clinicians will look at the challenges of tackling heath inequalities : "Are there important racial differences in risk factors for CVD, and if so –why?", Mental Health, End of life Care, Obstetrics and public health issues.
[Jockey Room]
B] **Faith and belief** – we treat everyone equally the same....? Chaired by: Jagtar Singh OBE. Richard Pacitti, Director Mind Croydon, Mukash Barot – EMAS, Kevin Masters, Chair of Unison Branch/Involved in Faith Engagement Programme @SCAS, Sue Wilcox EAS [tbc], Asian Welfare Society and Beau Fadahunsi, NBS - Surrey.
[Board room]
C] **Evaluation tools: sharpening the Equality Impact Assessment Process.**

3.15- 4.00pm Tea and music on the Terrace – Sponsored by Voice Newspaper [Increasing BME representation in the Ambulance Service – hosted by **Neville Levy,** Chair of the National BME Committee of the ASN].

4.00 -4.30pm **Plenary – Facilitated by Shelley Collins, Just Resources – Panel:** Paul Sutton, Jagtar Singh OBE, Professor Carol Baxter CBE, DH – Pacesetters.

4.30 -5.00pm Close – **Andy Newton**, Clinical Director SECAmb- with Networking Opportunity.

[In the event of our **Resourcing Escalatory Action Plan (REAP)** being put into action, because of the Flu Pandemic or other reasons, the organisers of the event may decide to deliver the event using alternative methods, such as podcasts, recording panels for later transmission. If the event is cancelled, alternative arrangements will be communicated to all participants who have registered to take part, at the earliest opportunity]

[**STOP Press**: Board our *Law Coach* – delegates will be given the opportunity to sign up for 1-1 coaching on human right law.....]

NAMED FACILITATORS [Confirmed]:

Ricky Lawrence, London Ambulance Service Blessing Enakimio, SECAmb.
Leela Solanki, SECAmb
Ree Taylor, SECAmb
Angela Rayner, SECAmb
Winston Dwyer, SECAmb.
Richard Asmah, SECAmb
Dennis Moss, WAS NHS.
S.D (Sussex Partnerships tbc)

Appendix G2

Extract from The Voice advertorial

South East Coast Ambulance Service NHS

SECAmb Staff

Part of becoming a Foundation Trust means that you have to provide good quality health advice and education across all of your local communities.

I think this is particularly important for Asian, African and Caribbean people, as they have far higher rates of stroke, diabetes and increasingly heart and kidney disease.

You can have absolutely little or no experience of ambulance care issues and still have a winning chance of gaining an interview. I had no experience of ambulance care issues when I joined but my professional background enabled me to progress my career. SECAmb provided me with the opportunity to join the organisation in a management role as an external candidate.

The career progression opportunities within the ambulance service that are available to individuals are vast and can include working as a call operator to being a distribution manager without any clinical experience.

Home

SECAmb life to the full

Dial 999 for more heroes

Meet the staff

First black London ambulance driver

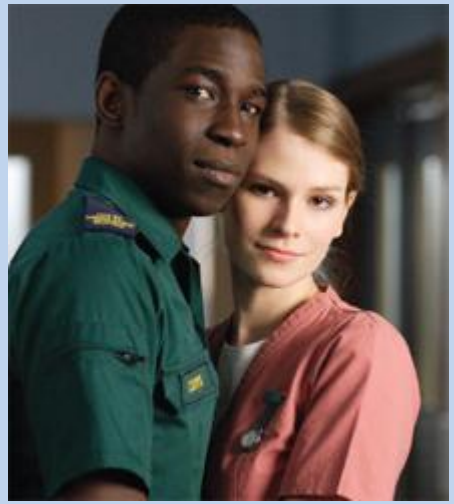
SECAmb careers

Staff who join SECAmb without clinical experience or backgrounds can undertake clinical training so they can work as community responders or become fully qualified Paramedics.
I have benefited from the existing training process, and have sat and passed internationally recognised exams. In spite of initially being recruited to work at Banstead, near Corydon in Surrey. I transferred to Kent where I now live without fuss. South East Coast Ambulance Service has been a supportive employer and I am looking forward to supporting the Trust in its journey to becoming an NHS Foundation Trust. A great place to work.

During the festivities we sadly get a lot of calls linked to overdoses and, or drinking, especially in the run up to Christmas. The types of calls we get can be really influenced by the seasons. The emergency control centre operates a 24- hour system and staff are generally expected to work on a 12 hour shift pattern on a 6 week rota. However managers are very good in telling staff way in advance, what times they are working. The trust also operates a flexible working policy and so staff can work part-time or reduced hours. The best thing about the job is knowing, I'm on the other end of the phone making a difference. At times that can mean helping to save someone's life. The most amazing experiencing was helping a mother to deliver a baby over the phone. We do get time to reflect over the difficult cases and there is a superb support system in place. I guess it's really about keeping perspective and knowing another caller will need your help. There is always support at hand. I also like the fact that I can combine my life at home and at university with my job. This is due to the shift pattern I do. It means I can have longer days off, which enables me to do my university studies and have life work balance. Once an applicant has been successful and started the job, they will go through a month training programme. Before you are thrown into the deep end to take calls on your own, you get to sit with a mentor for about another month by the end of which you are itching to get started. I've been offered loads of opportunities within the Trust to do other things in terms of career progression. But there is no pressure, it's entirely my choice and at my own pace.


BBC Casualty, Polly Emerson
Photo: Adam Pensotti

I've always been passionate about education and training. As SECAmb's organisational development training manager within the Human Resources and Organisational Development Directorate. My role includes coordinating training as well as delivering non-clinical training to nearly SECAmb's 3000 staff. As a Trainer, it is as important to ensure that any discussion on equality and diversity in the workplace takes full account of the core work of the organisation and the investment needed in staff development. I'm the Co-Chair of ASPIRE a staff network, the main purpose of the group is to recognise and celebrate the diversity in SECAmb workforce, along with the benefits this brings to the service we provide. I enjoy investing my time in leading ASPIRE, because the group has a growing dual role. It is a staff support network, which champions the interest of BME staff and those from a minority faith background, and also it champions the needs and aspirations of the wider communities we serve, through practical advice and support.



BBC Casualty, Curtis Cooper and Alice Chamtrey
Photo: Adam Pensotti

SECAmb also operates flexible working, offers part-time jobs, as well as annualised hours and job sharing for some roles a fast track program of funded therapy, physiotherapy, osteopathy, chiropractics, as well as should the need arise, free counselling support.

What job roles are available at South East Coat Ambulance Service?
Emergency Call Operator
Emergency Resource Dispatcher
Emergency Care Support Worker
Management and Support
Critical Care Paramedic

Paramedic Practitioner

'Be the change you want to see in the world', was something that my Bapuji (Dad) encouraged me to believe in. These were the words of Gandhi, who was a quiet man of great courage. Inspiring leadership in others, Gandhi firmly believed in dignity and respect. The same values, that the Ambulance Service are working hard to place at the heart of what they do. Last year I was elected Chair of the National Black and Ethnic Minority Committee of the Ambulance Service Network. With support from family, friends and SECAmb, I've combined this voluntary role, with my full-time job at as a Clinical Scheduling Manager. As a Clinical Scheduling Manager, I am part of a team of five who work to ensure that we have staff across Surrey, Sussex and Kent, 356 days a year 24 -hours a day 7- days a week. We have to take account of staff availability, leave, rest days, sickness, training, operational pressures and plan to deliver world class services, to all of our communities, all of the time. Ray Mazhindu, is our team leader, is a qualified Paramedic, who now works as Senior Clinical Scheduling Manager. It's not unusual for people with a clinical background to change career direction at the Trust. People come into work, smiling or whistling and full of enthusiasm. Sounds corny but they do. The good vibe is contagious. I think that it's because people are encouraged to take on new skills and are allowed to grow. Now South East Coast Ambulance Service is involved in the Pacesetters Programme, which is funded by the Department of Health. I am really hopeful that real change can be made on the health outcomes of Black and ethnic minority people – the communities that we keep being told are so hard to reach. For more information on Pacesetters visit the Department of Health website at:
www.dh.gov.uk/en/Managingyourorganisation/Equalityandhumanrights/Pacesettersprogramme

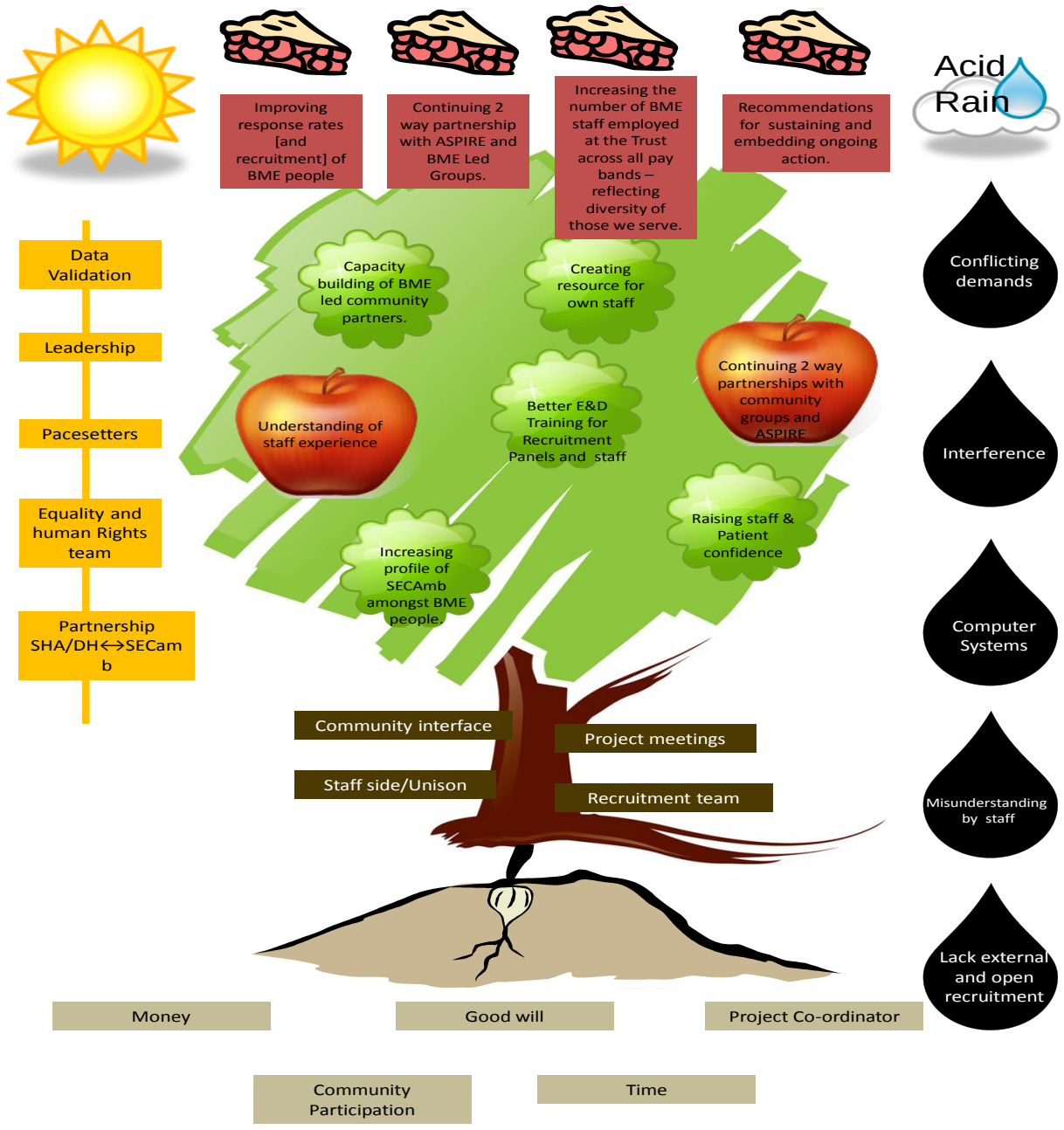
"Casualty is make believe and here at SECAmb this is how life and death really is. SECAmb is full of caring people that do a fantastic job and it's an absolute privilege, as an HROD professional, to work with a great team. The thing about Casualty is you do not see the whole picture and the other important non-emergency work we do. We don't just help save lives; we also improve the quality of people's lives by supporting our communities." Karen Cornish, Health, Child and Family Care Co-coordinator, Welfare team As one of the Trust's senior Human Resources & Organisational Development Staff, I know only too well the importance of trying to put in place good support for our staff. Without our staff, we would cease to operate over night. South East Coast Ambulance Service takes good care to address the welfare, health and wellbeing of its staff. SECAmb salaries are in line with NHS pay and terms; visit the link below to see more. We also have an assured pension and staff may be able to access support with key worker housing. The NHS recognises that affordable accommodation is a priority, whether for staff who are renting their home or who want to buy. South East Coast Ambulance has teamed up with a range of partners, to ensure its staff can access Key Worker schemes and get help with getting on the housing ladder. The Trust provides support for staff who are Carers or parents with child care responsibilities. This help is not just about giving advice, but also includes providing practical help and support, through schemes such as the trust's child care voucher programme. Giving real tax savings for staff who have to pay for child care.

Angela Rayner is Patient and Public Involvement Manager and Equality and Diversity at
South East Coast Ambulance- NHS Trust
Patient and public Involvement over the last few years, the NHS has made great strides around talking with people about how health care services should be designed and delivered.
Angela Rayner, Patient and Public Involvement Manager, has the task of ensuring that South East Coast Ambulance Service is routinely asking people from diverse backgrounds
and with different perspectives, their views and their experience of NHS services. Angela is currently working to encourage more people, from BME backgrounds who live in either

Surrey, Sussex or Kent, to volunteer their time to help the trust shape the way it works
Angela speaks about her passion to deliver excellence:
To deliver a world class ambulance service, we do need to know the needs and preferences of our local communities. We also must work with our partners in the health sector and work with local people to tackle health inequalities and promote a dialogue of equals.

Appendix G3

SECAmb Logic Tree Diagram (September 2009)



Appendix H1

Cornwall

Work Experience Questionnaire

1. Do you like your work?

☺X **Yes** ☹☐ **No**

😐☐ **Unsure**

Please explain or give an example

(E.G. I like working here because…. AND/OR I don't like working here because….)
I really enjoy it in here. I like all of the work I am doing.

2. Are the people you work with helpful?

☺X **Yes** ☹☐ **No**

😐☐ **Unsure**

Please explain or give an example

(E.G. People explain things clearly AND/OR People do not explain things clearly)
[Name1] helped with the fire drill. She explained what would happen and [Name2] helped [me] get around to the back of the car park. [Name3] helped me to frank the post. [Name4] helped me to do some photocopying.

3. Are the people you work with friendly?

☺X **Yes** ☹☐ **No**

😐☐ **Unsure**

Please explain or give an example.

(E.G. People talk nicely to me AND/OR People do not talk nicely to me)
People say hello and come and talk to me.

4. Is there anything that makes it difficult for you at work?

☹☐ **Yes** ☺X **No**

😐☐ **Unsure**

Please explain or give an example

(E.G. Work is too difficult or too boring. I do not know what I should be doing. The office is too busy or too noisy. Instructions are too complicated or childish)

5. Has the Trust supported you in your work?

☺X **Yes** ☹□ **No**

😐□ **Unsure**

Please explain or give an example

(E.G. Training, planning the future, supervision)

I am given a picture schedule of my work for the day. I am supervised and shown how to do the work.

6. Does anything still need to change to improve things for you?

☹□ **Yes** ☺X **No**

😐□ **Unsure**

Please explain or give an example

(E.G. Visual Aids, written instructions, access, more challenging work, better training, etc)

9. Is there anything else you want to say?

(E.G. Anything that you feel has not been covered in the questionnaire? Anything that you are concerned about? Anything you are especially happy about?)

Appendix H2

THE HEALTH CHAMPS STORY SO FAR .....

We are the Health Champs and work for the NHS, we help them to improve services and access for people with learning disabilities.

APPLICATION FORM

We had to apply for our jobs. Our job coach's helped us. The applications were easy read format.

INTERVIEW

When we had our interviews, we were: SCARED, NERVOUS, CURIOUS, EXCITED. But it was fine and we had support things were changed to make us more comfortable and able to understand.

FIRST DAY

On our first day we felt : Nervous, anxious, scared to meet everyone, excited.

GAINING A PERMANENT JOB IN THE NHS

INTERVIEW

This was our second interview for the job but We still felt: NERVOUS.
We had the choice of having our job coaches to support us. The questions were simple and easy to understand. We had help in filling out our CRB forms and occupational health forms.

WE WERE VERY EXCITED AND PLEASED TO HEAR THAT WE HAD A PERMANENT JOB IN NHS.

INDUCTION
We had a tailor made induction provided for Us which was easy to understand, we learnt everything we needed to know about working for the NHS.

TRANSITION INTO HEALTH PROMOTION DEPARTMENT

We had our local induction into health promotion and now feel a part of the department.

working hard to raise awareness

health needs and health promotion of

learning disabilities.

We are really

around the

people with

OUR ACHIEVEMENTS SO FAR :

- **Attended conferences**
- **Won a Health and Social Care Award**
- **Developed Easy to Read Leaflets**
- **Hospital Checks**
- **Plan Big Health day**
- **Helping Liaison nurses at hospitals**
- **Made and cast in DVD's for NHS Training – dental, discharge process, your way to health.**
- **Facilitating Healthy Living Groups**

WE ARE NOW EMBEDDED WITHIN THE NHS AND CONTINUE TO HELP THE NHS IN IMPROVING HEALTH SERVICES WITH PEOPLE WITH LEARNING WITH DISABILITIES. WE ARE ALSO HELPING IMPROVE ACCESSIBILITY TO JOBS IN THE NHS FOR PEOPLE WITH LEARNING DISABILITIES.

Appendix H3

news

Pilot champions diversity at trust

KAREN HIGGINBOTTOM
editorial@peoplemanagement.co.uk

A successful pilot project has resulted in a 47 per cent increase in the number of disabled people working at the NHS Cornwall and Isles of Scilly Primary Care Trust (PCT).

The PCT has appointed nine people with learning difficulties as permanent members of staff to work in the public health team after they spent nine months on a pilot project, known as the Champs team. The project was a partnership between the PCT, Cornwall Learning Disability Partnership Board and Cornwall Works for Learning Disabilities, explained Jon Sparkes, director of workforce development, and Kate Milton, senior equality and human rights manager at NHS Cornwall and Isles of Scilly.

The nine new members of staff will work on a variety of projects, explained Sparkes, who is also CIPD vice-president, diversity and inclusion: "They will train medical practitioners and managers in working with people with learning difficulties. In addition, they will check our services are accessible to people with such difficulties."

The Champs team with colleagues

Employing the new members of staff will mean that the trust can road-test initiatives around public health, he added. "We want to make the NHS more accessible to people with learning difficulties, both as an employer and a service provider. It's all about understanding what the customer needs."

During the pilot, the project members contributed to simplifying information on public health, explained Milton. "They have helped us produce easy-to-read information, for example, Your Way to Health, a booklet which guides people with learning disabilities through all of the services available locally. They also advised us to dispense with common jargon - for example, "A&E" - and helped us to produce some DVDs, including one for clinicians on hospital discharge for someone with learning disabilities."

The HR team trained other staff as "buddies" to support the Champs team during the pilot, said Sparkes. "These buddies worked with the project team to help them ease their way into the work and the various systems and processes that are in place."

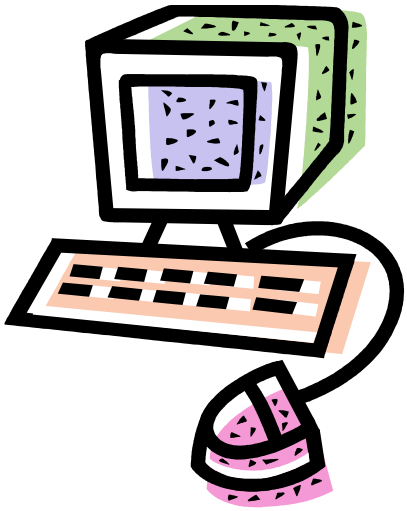
The HR team is currently training managers to highlight the benefits of working with individuals with learning difficulties, added Milton.

"Training and development and raising awareness will, over time, help managers to change their HR practices and the way they manage people, so that the new methods will eventually become par for the course," she said.

Appendix H4

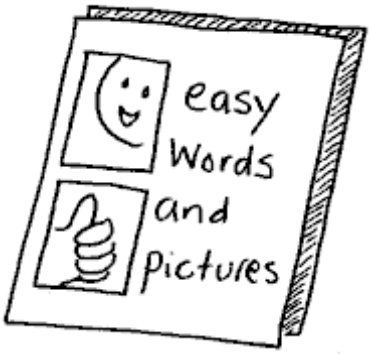
WORK EXPERIENCE JOB DESCRIPTION

Job Description	Admin Assistant, 8 hours per week Supported by a buddy Some or all of the following duties:
	Post room duties
	Photocopying
	Paperwork duties

	Keyboard Skills
	Tidying Kitchen Area, stacking/unloading Dish Washer
	Meeting & greeting visitors
	Any other duties required

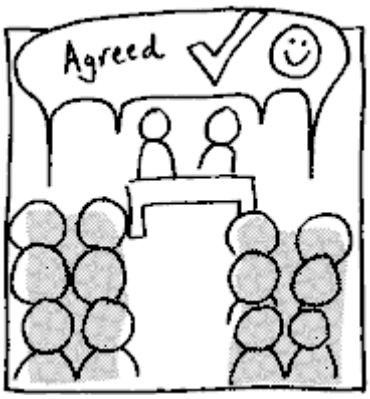
Appendix H5

Work Experience Induction Procedure



What is This Hand Book About?

This Hand Book will help you understand important things about your job. We will go through it with you when you join.



Signing This Hand Book

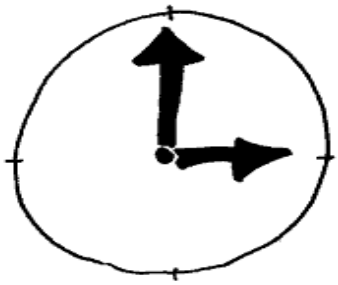
Sign when you understand it

Name…….

Your Personal File

We have made a file that contains lots of important things about you such as;

Where you live



The start date and end date of the Placement and the hours of work.
Start:
End:
Hours:

Photo

Your Buddy

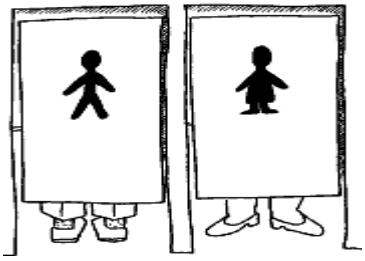
While you are at work you will have a Buddy. They will help you and answer your questions. They will introduce you to everyone and show you around.

Important Information

Fire Exits

Your buddy will show you where the fire exits are

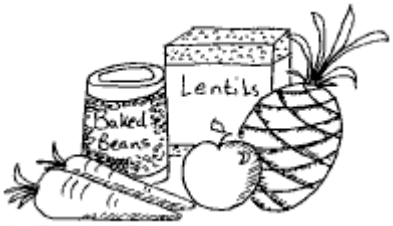
And what to do when there is a fire drill



Facilities

We will let you know where the toilets are at work

Where to get tea and coffee

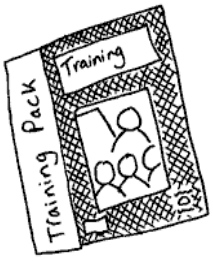


You have to bring your own lunch to work

If you want to smoke please go outside the building

Health and Safety

It is important that you work safely



We will train you in health and safety

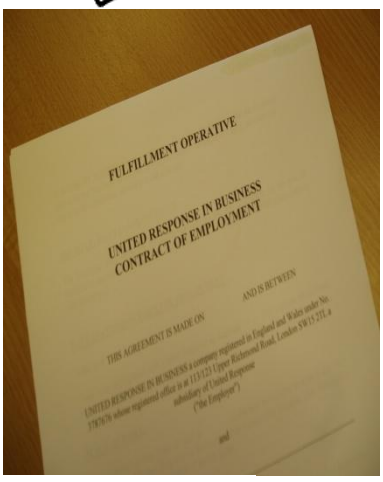
Make sure you tell your us all your important medical information

Make sure we have your emergency contact details in your file

Things You Need To Know

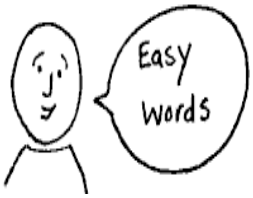
Recruitment

When you join NHS Cornwall & Isles of Scilly you will have filled out an application form



Contracts of Employment

You will be given a contract of employment

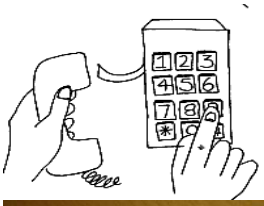


We can help you understand it

Job Description

A job description will help you understand all the different parts of your job

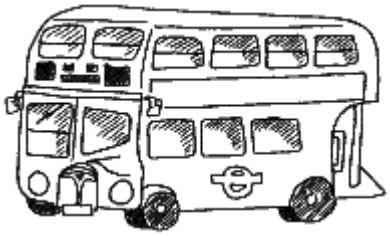
We do not pay you for this work experience placement



In emergencies we will always help you.

Signing In

Each time you work for NHS Cornwall & Isles of Scilly you must sign in and report to ……(Name)



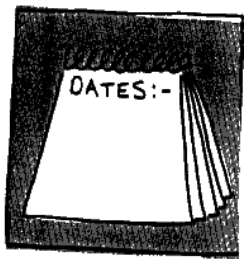
Getting To Work

Your job coach can help you with travel to work if you need help

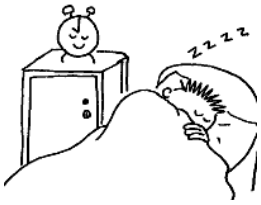
You will need to pay for your own transport to work or use your pass

Working Hours

Your working hours are 8 hours per week.

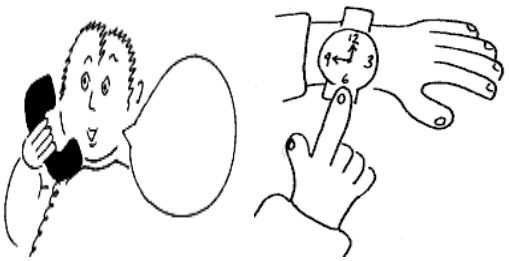


The days and hours are as follows:
Hours:
Days:



We will tell you what time work starts so that you can be on time

What to Do If You Are Ill



If you are ill please call your Buddy by 9 o'clock on the day you were going to work

Tel:

Training and Development

You will be trained as you work and on special training day.

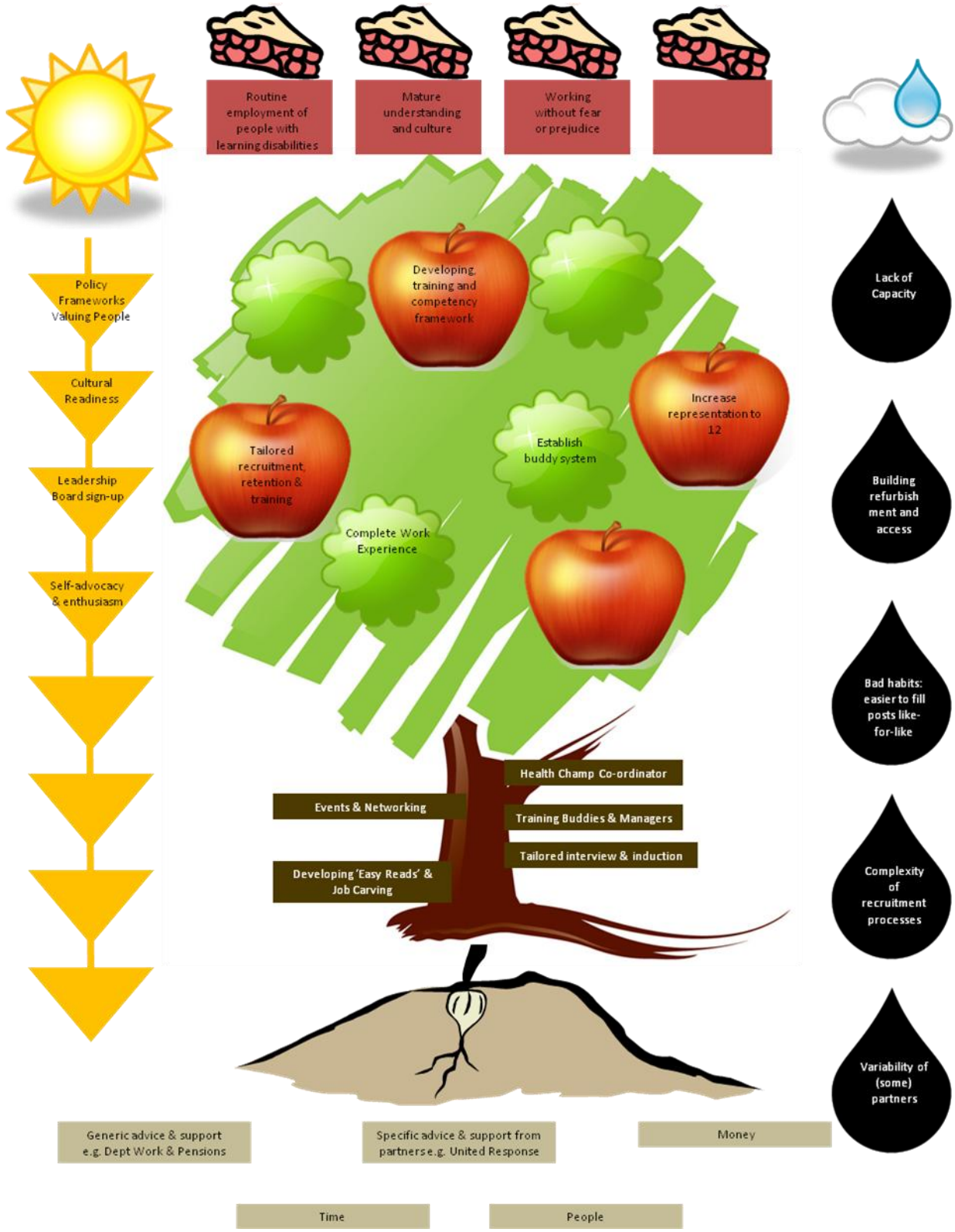
Confidentiality

It is important to remember that some of your work is very private be careful who you talk to about your work.

If you have a complaint or concern please tell your buddy

If you are happy with the above please sign section 2. A very warm welcome to the NHS Cornwall & Isles of Scilly Trust. We hope you will enjoy your time with us.

Appendix H6a



Appendix H6b

Inputs	Outputs		Outcomes		
What has been invested?	What we do!	Who we Reach!	Short	Medium	Long
Time: Senior manager time – Associate Director of Strategic Workforce Development; Senior Equality and Human Rights Manager; Nurse Consultant Learning Disabilities. Project Team; HR Adviser. Manager's time attending awareness training. **Money**: £12,000 to date **Partnership**: Cornwall Works for Learning Disabilities, Learning Disabilities Partnership Board **Equipment**: Mobile phone for Champs coordinator **Facilities**:	**Awareness Raising**: Three half day sessions so far. Six full training days scheduled for March 2010. **Increasing visibility** of Health Champs: Increasing profile so that staff are more used to having people with learning disabilities working around them **Participatory team meetings**: to discuss progress, tap into partners expertise, share work undertaken, eg experience of employing Downs Syndrome student on work experience. **Co-designing** easy read information	**Managers Staff Partners**: both those with expertise in supporting people with learning disabilities, and colleagues from other public sector bodies **National NHS organisations**: so that national policy can be influenced **People with learning disabilities**. **Public**: people with an interest in disabilities	**Improving Knowledge** about the needs of people with learning disabilities and how they benefit from independence and being economically active **Extending knowledge** about vulnerability of the Champs and the importance of safeguarding them has increased. **Understanding vulnerability** of the Champs and the importance of safeguarding them has increased.	**Adaptation**: Staff familiar with the practicalities of employing people with learning disabilities and embrace the concept so that more people can be employed knowledge Increasing our knowledge of people with disabilities and how we can adapt the workplace to suit them. **Job carving:** becomes routine so that 8 hours a week are taken out of a post to employ people with learning disabilities **Career paths**:	**Sustain**: Medium outcomes to be replicated in partner NHS organisations locally and nationally **Agenda for Change** is able to match job profiles using simple not complex language and easy read formats so that project can be spread across NHS **Sharing the learning**: Learning gained from this project may be applied to other disabilities so that workforce representation of all disabled people increases. **Environment**: It is hoped that permanent positions will be established that become

No special facilities have been designated, existing facilities used for work experience student and Champs team.	**Liaising**: Meetings with schools and colleges, meeting with NHS Employers national organisation to try to influence national policy around use of easy read job descriptions **Employment**: Interviewing the Champs to offer them substantive employment within the organisation from April 2010			rotational programme for the Champs and future colleagues to be introduced so that they have opportunities for career development **Job creation**: a higher number of people with learning disabilities employed, or on worthwhile work experience placements.	part of the evolution of CIOS.

Appendix H7

Jessica Brown at Foundry Road

Jess, a quiet, timid young lady arrived at the Cornwall and Isles of Scilly PCT offices at Foundry Road reception on a cold Friday morning, along with her Job Coach, Hailey. Greeted by Larry Sinden, one of the Human Resources administration team, she was introduced to her new work colleagues, a daunting prospect perhaps?

Her 'Buddy', assigned to oversee her workload and progress, Annie Wing, HR Business Manager, had designed a Work Diary for Jess to note down what she had done each day, and began with fun orientated quizzes on office health and safety.

Any impressions that her shyness might inhibit her ability to interact professionally or socially with the HR team were soon dispelled. She was keen to learn and learn she did! She was very soon collecting the mail, opening, date stamping and distributing accordingly to all the different departments within the Directorate, face-to-face and by courier. Photocopying and collating of documents were carried out accurately and timely, and many other administrative tasks completed to the satisfaction of her workmates.

Since then, she has gone from strength to strength, and has worked with the Children's Services Team, the Pharmaceutical Lead and Business Development Team at Foundry Road. She's helped in Reception, franked and sorted mail, assisted with producing training documents, and many other administrative duties.

Gill Bennett the Foundry Road Business Support & Facilities Manager, and one of Jess's work buddies said, "Jess has been a pleasure to have around. She is quick on the uptake, works hard and has an impish sense of humour that has left us in stitches sometimes. We hope to continue working closely with the Pacesetters Programme, to find work placements for people with learning difficulties, thus enabling them to work in the wider NHS community."

Appendix I

On Online Survey February 2010

1. Data collection

The survey was conducted via an online questionnaire developed using the Bristol Online Surveys package. An online method, rather than a postal or telephone survey, ensured the respondents had a simple and convenient way of participating, which thus helped promote a larger response rate. The survey was confidential, rather than anonymous, in that the identities of the respondents were known to the survey team but this information cannot be determined from the results in this document. Having this information enabled the survey to ensure that no one could bias the survey by submitting multiple entries, the NHS trust the respondent worked for could be determined and tardy respondents could be prompted by a reminder email.

An advance email informing of the forthcoming survey was sent out to all persons in the population 12 days before the survey opened. On the first day of the survey an invitation email was sent to all persons in the population. This email contained a link to the online questionnaire and the person's unique survey login details. During the time the survey was open two reminder emails were sent out to those who had not yet responded 7 days after the invitation email and a further 7 days after that.

Figure 1.1: Daily response count

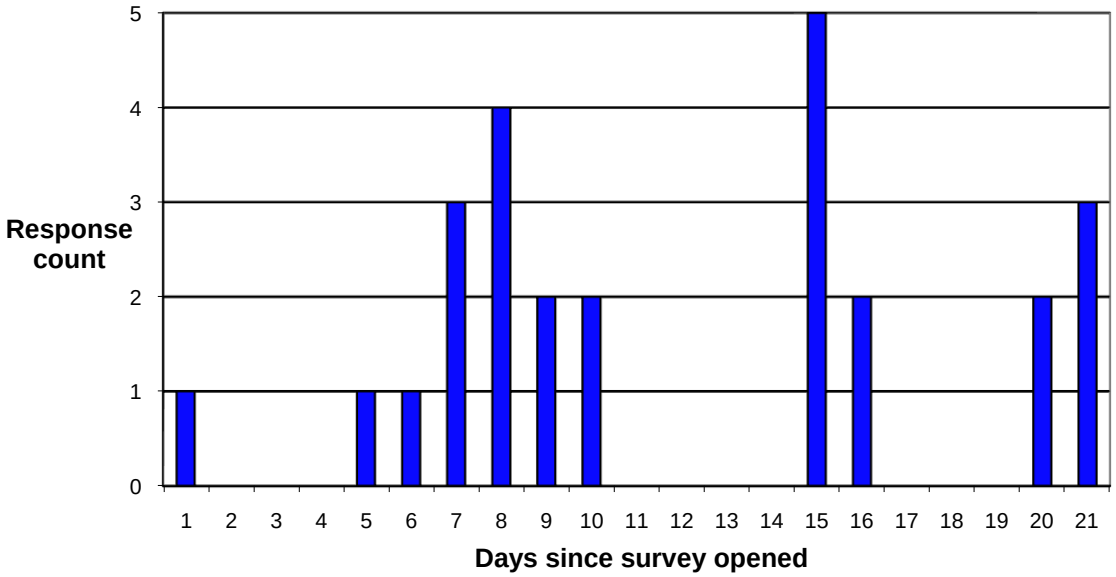


Figure 1.1 shows that the days on which the greatest numbers of responses were received were on days that the reminders were issued (days 8 and 15 of the survey). There was also a flurry of activity just prior to the closing of the survey (days 20 and 21). There were 2 respondents who missed the initial deadline but who completed the survey after being given special permission to complete the survey within 10 days. It appears very much as if the reminder emails were useful in raising the response rate of the survey.

2. Basic data

The initial population, as supplied by the Department of Health, comprised 52 persons. Following the advance email a number of the original population indicated that they were unable to take part and some of these offered substitutes for themselves. The number leaving and the number joining balanced out so that the net size of the target population remained at 52. The number of respondents was 28 giving a response rate of 53.8%. Since the entire population was invited to participate but only about half actually did the sample is clearly self selected, so caution should be exercised if generalising the results from the sample to the population as a whole. Further, a random sample of this size this population would give for a 95% confidence interval a margin of error as high as ±12.7%, which adds further to this caution.

2.1 About the respondents

Of the 28 respondents all but 1 were NHS employees. The single non-NHS employee worked for a consultancy. As shown in table 2.1, of the 27 NHS employees the majority (19 or 70.4%) executed their role of Pacesetters Work Force Lead as part of an existing job (18 explicitly stated they were leads as part of an existing job and a 19th explained that the project given to them as part of the work they do on the staff disability network)

Table 2.1: Position as a Pacesetters Workforce Lead

	Frequency	Percent	Cumulative percent
Secondment from within your Trust, full-time	0	0.0	0.0
Secondment from within your Trust, part-time	1	3.7	3.7
Secondment from outside your Trust, full-time	0	0.0	3.7
Secondment from outside your Trust, part-time	0	0.0	3.7
Part of an existing job	18	66.7	70.4
Full-time temporary appointment	3	11.1	81.5
Part-time temporary appointment	4	14.8	96.3
Other	1	3.7	100.0
TOTAL	27	100.0	

Eleven (29.3%) of the 28 respondents stated they were programme leads and seven stated they were project leads with 3 doing both roles. Of the remaining 7 respondents three were actually in the primary lead role, one was a joint lead whilst three worked supporting the lead.

Table 2.2: Lead role performed

	Frequency	Percent	Cumulative Percent
Programme lead	11	39.3	39.3
Project lead	7	25.0	64.3
Both Programme and Project leads	3	10.7	75.0
Other	7	25.0	100.0
Total	28	100.0	

When asked, in their role as Pacesetters Workforce Lead, where the respondent was located in the organisation's structure most indicated in which operational area they were located, see table 2.3.

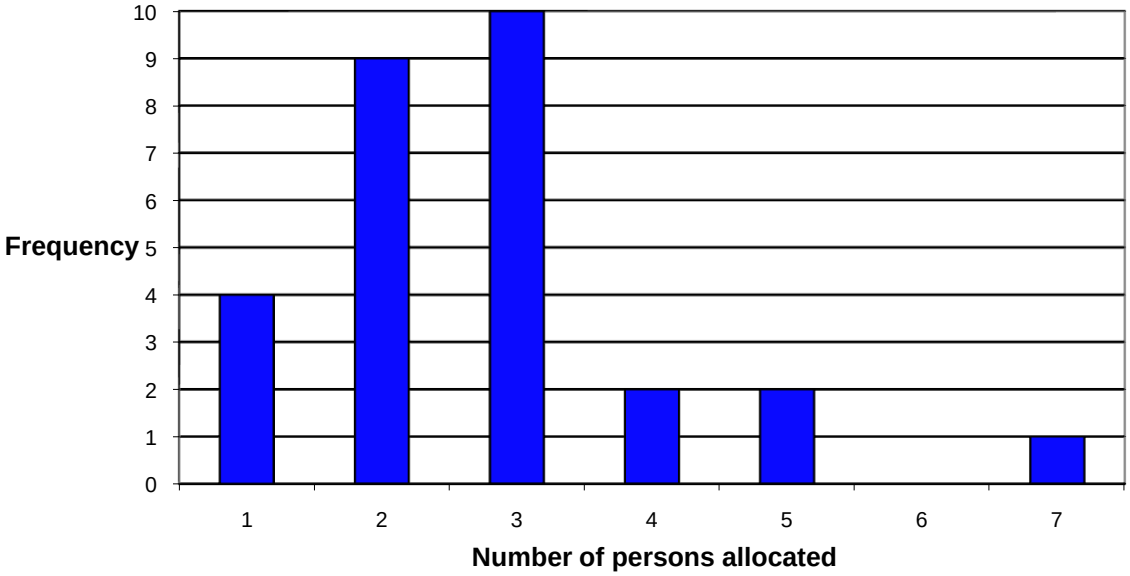
Table 2.3: Location in organisation's structure: operational area

	Frequency	Percent	Cumulative Percent
Human resources	7	25.0	25.0
Equality & diversity	10	35.7	60.7
Service delivery	2	7.1	67.8
Other	5	17.9	85.7
Unknown	4	14.3	100.0
Total	28	100.0	

The 5 others in the sample were operating in the areas of corporate development, communications, children and young people's directorate, directorate of assurance and engagement. A number of respondents attempted to indicate where in the organisation's hierarchy they were located but this question was answered in different ways e.g. Band 7 manager, deputy HR director, line managed by HR manager, by respondents and this makes comparison difficult, though one respondent did describe the hierarchy's branch on which he was located: "I am the HR Manager, report into Head of HR, who reports into HR director, who reports into CE".

The frequency distribution of the number of persons allocated to Pacesetters Workforce projects is given in figure 2.4. The average count is 2.75 and the most common count is 3.

Figure 2.4: Persons allocated to Pacesetters Workforce projects



2.2 About the Trust worked for

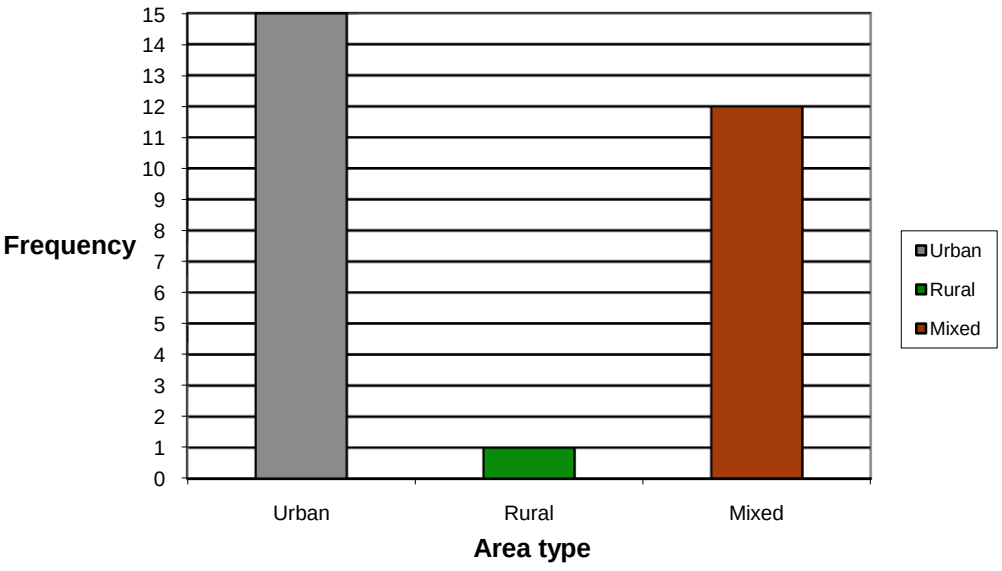
As shown in table 2.5, by far the majority of trusts worked for by respondents in the sample (19 out of 28, 67.9%) are Primary Care Trusts. One of the respondents was a member of a Strategic Health Authority.

Table 2.5: Type of Trust

	Frequency	Percent	Cumulative Percent
Foundation Trust	2	7.1	7.1
Primary Care Trust	19	67.9	75.0
Ambulance Service Trust	2	7.1	82.1
Acute Health Trust	2	7.1	89.3
Mental Health Trust	1	3.6	92.9
Learning Difficulties Trust	1	3.6	96.4
Strategic Health Authority	1	3.6	100.0
Total	28	100.0	

Participators were asked to describe their trust as either urban, rural or mixed urban and rural. Most trusts were described as being urban (15), though a similar number (12) were described as mixed urban and rural, with just one described as rural.

Figure 2.6: Type of area trust operates in



Just six of the ten regional strategic health authorities in England are participants in the Pacesetters programme. Trusts in all six Pacesetters SHA's were invited to take part in this survey. The response rate for the SHA's ranged between 50% and 57.1%, which compares well with the overall response rate of 53.8%. Thus the sample is a good representation of the population as a whole.

Table 2.7: Strategic Health Authority trust is part of

	Sample Frequency	Population Frequency	Response by SHA
East Midlands SHA	4	7	57.1
London SHA	4	8	50.0
South East SHA	4	7	57.1
South West SHA	5	10	50.0
West Midlands SHA	3	6	50.0
Yorkshire and The Humber SHA	7	13	53.6
National NHS organisations	1	0	n/a
Unknown	0	1	n/a
Total	28	52	

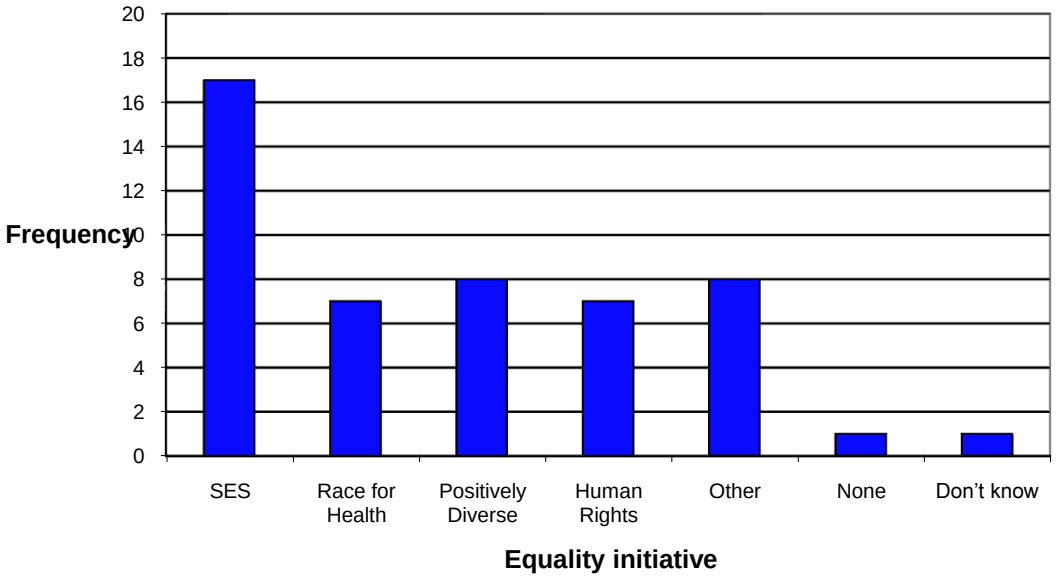
The 28 respondents originated from 24 different trusts. In counting the number of equality initiatives, in addition to Pacesetters, that each respondent's trust is involved in just one respondent from a trust was considered (table 2.8). Only one respondent (4.2%) of the 24 reported that their trust is definitely not involved in equality initiatives other than Pacesetters, with one other respondent not knowing whether or not their trust was involved. Thus 22 of the 24 (91.7%) of the trusts in the sample were known to be involved in one or more equality initiative in addition to Pacesetters.

Table 2.8: Number of equality initiatives involved in (other than Pacesetters)

	Frequency	Percent	Cumulative Percent
0	1	4.2	4.2
1	10	41.7	45.9
2	4	16.7	62.6
3	3	12.5	75.1
4	3	12.5	87.6
5	0	0.0	87.6
6	1	4.2	91.8
7	1	4.2	96.0
Unknown	1	4.2	100.0
Total	24	100.0	

The most popular equality initiative that trusts in the sample were involved in is the Single Equality Scheme (17 from 24, 70.8%), as shown in figure 2.9. Almost one third were involved in Race for Health (7 from 24, 29.2%), exactly a third (8 from 24, 33.3%) were involved in Positively Diverse and just under a third (7 from 24, 29.2%) were involved in Human Right. Eight of the 24 (33.3%) trusts were involved in other equality initiatives including: Two Ticks, Stonewall, Disability forum, Leadership and Inclusion programme, Breaking Through Programme, Innov8: Reframing Diversity.

Figure 2.9: Equality initiatives involved in



3. Workforce Development Projects

3.1 Distribution of projects

The population surveyed was expected to comprise project leads only; however, 5 of the 28 who responded were not actually leads but operated in a support role of some kind to a project lead. Since project related questions were aimed at leads, just the 23 who were leads responded to these questions.

The 23 project leads worked on a total of 42 projects, of which 6 (14.3%) were Flexible Working projects, 9 (21.4%) were Bullying and Harassment projects and the remaining 27 (64.3%) were Representation projects (table 3.1).

Table 3.1 Distribution of projects by type

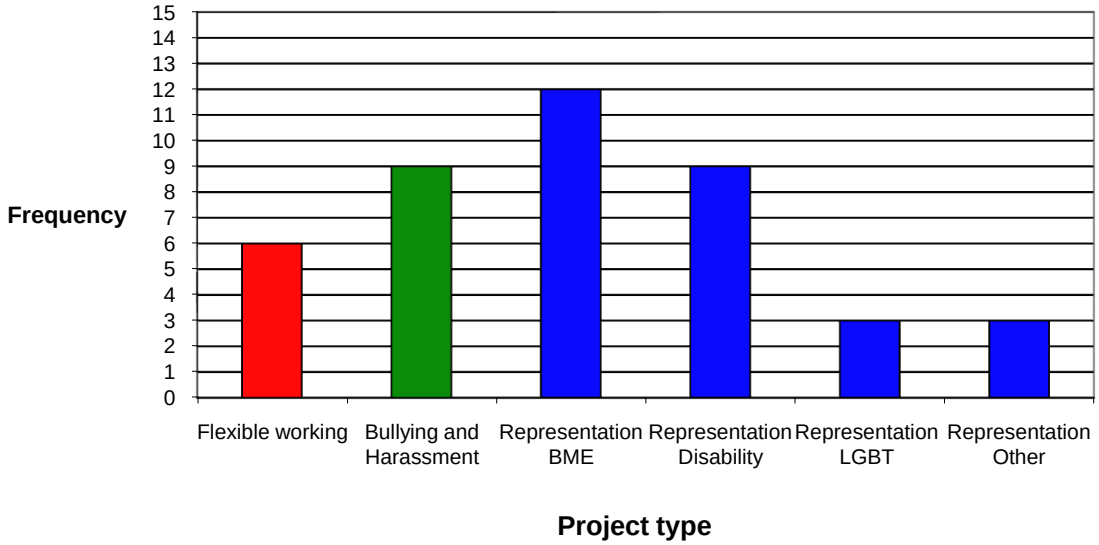
	Frequency	Percent of all projects
Flexible working	6	14.3
Bullying & Harassment	9	21.4
Representation	27	64.3
Total	42	100.0

The Representation projects themselves were of different types (table 3.2): Black and Minority Ethnic (BME), Disability, Lesbian, Gay, Bisexual and Transgender (LGBT) and three others, which were: a combined data project, a whole equality project and a comprehensive data project that should enable a more accurate recording of ethnicity.

Table 3.2 Distribution of Representation projects by type

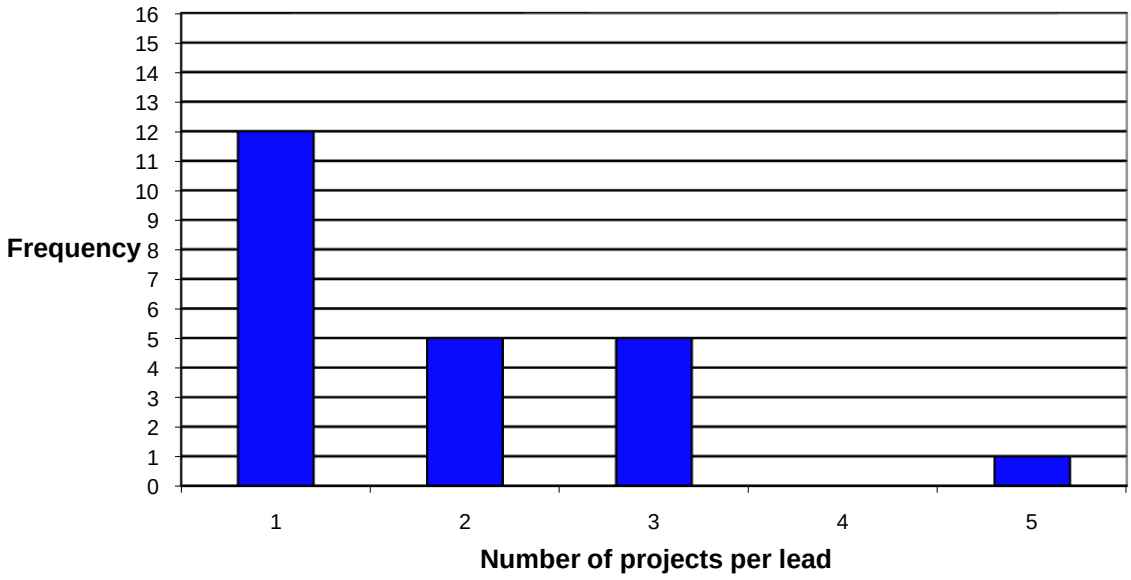
	Frequency	Percent of Representation projects	Percent of all projects
BME	12	44.4	28.6
Disability	9	33.3	21.4
LGBT	3	11.1	7.1
Other	3	11.1	7.1
Total	27	100.0	64.3

Figure 3.3 Distribution of all projects by type



Just over one half (12, 52.2%) of leads led just the one project, thus almost a half (11, 47.8%) of the 23 leads led one or more projects (figure 3.4).

Figure 3.4 Number of projects per lead



3.2 Design

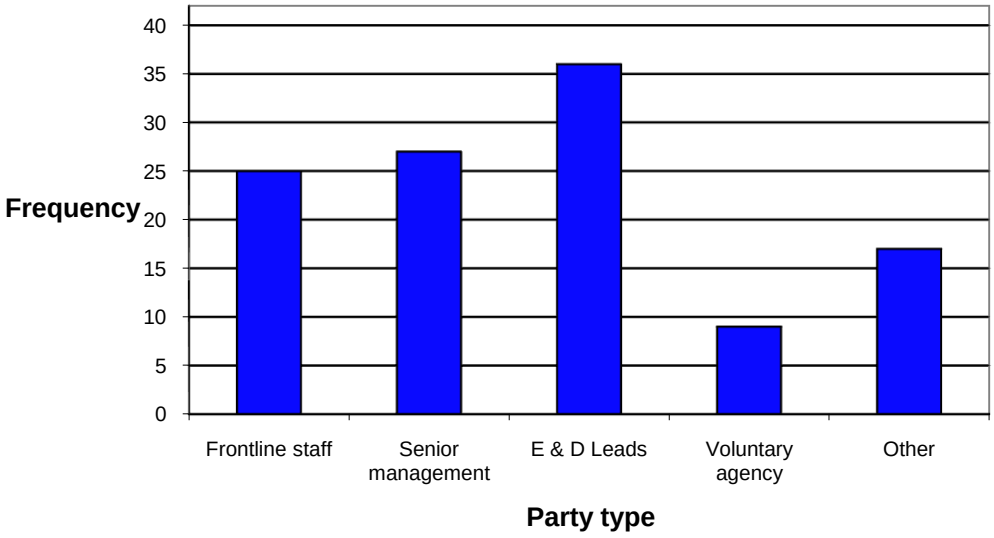
The results of asking the question *Which parties were involved in designing the Representation Innovation* are summarised in table 3.5 and figure 3.6. All projects used at least one party in designing the innovation, the most popular number used was 3 and the average (mean) number was 2.71.

Table 3.5: Distribution of parties used

Party size	Frequency	Percent	Cumulative Percent
0	0	0.0	0.0
1	7	16.7	16.7
2	8	19.0	35.7
3	18	42.9	78.6
4	8	19.0	97.6
5	1	2.4	100.0
Total	42	100.0	

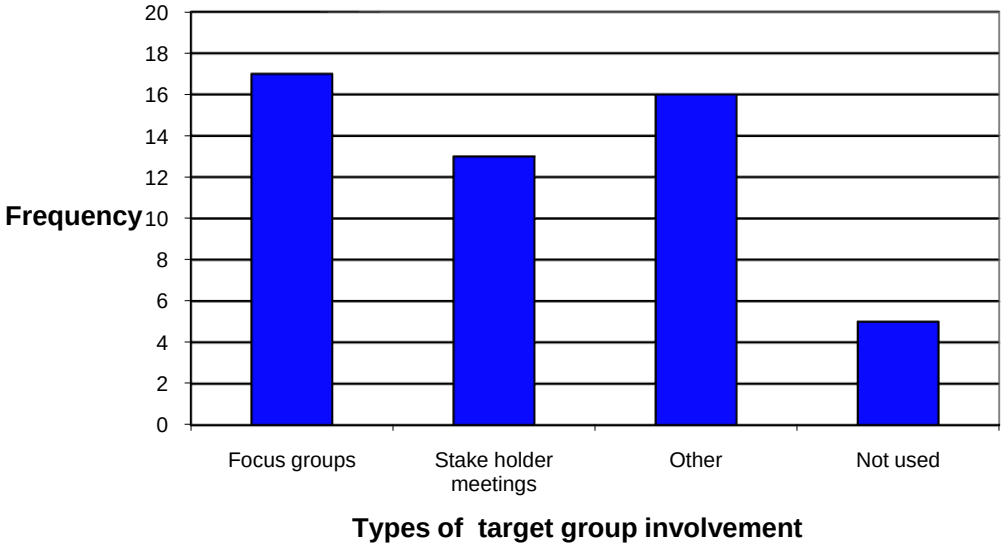
As shown in figure 3.6 the most popular type of party used was an Equality and Diversity lead, used in 36 of the 42 projects (85.7%). In 17 projects respondents reported using other parties, most of which were staff such as HR staff,

Figure 3.6: Distribution of party types



In 32 of the fort-two (76.2%) projects respondents reported that people from the target group were included in designing the innovation, 5 projects definitely did not involve people and the status of 5 others was unknown. How people from the target group were involved is shown in figure 3.7. Use was made of exploratory focus groups (17 from 42, 40.5%), decision making stakeholder meetings (13 from 42, 31.0%) and other means (13 from 27, 38.1%) including staff newsletter, staff surveys, staff networks, staff forums, 1:1 in-depth interviews, anonymous contribution, steering groups, support advisors, voluntary groups.

Figure 3.7: How people from the project's target group were included in the design



3.3 Baseline

Respondents were asked open questions about what quantitative and qualitative base line data they used to identify the issues to be addressed. The responses to these questions were project specific and are dealt with in the relevant project sections.

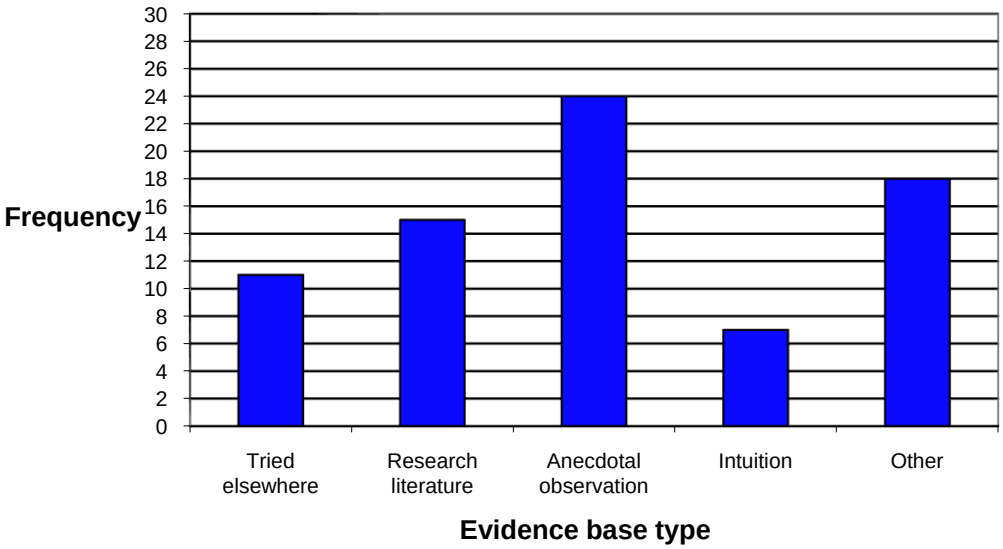
The results of asking the question *What was the evidence base for the chosen innovation?* are summarised in table 3.8 and figure 3.9. All projects used at least one evidence base in designing the innovation, the most popular number being just 1, which was used in just over a half (52.4%) of the projects. A single project used 5 different evidence bases.

Table 3.8: Distribution of number of evidence bases

Count of evidence bases used	Frequency	Percent	Cumulative Percent
0	0	0.0	0.0
1	22	52.4	52.4
2	11	26.2	78.6
3	6	14.3	92.9
4	2	4.8	97.7
5	1	2.4	100.0
Total	42	100.0	

As shown in figure 3.9 the most popular type of evidence base used was anecdotal observation , which was used in 24 projects out of 42 (57.1%). Research literature was used by 15 (35.7%) projects and the fact that the method had been tried elsewhere was used by 11 (26.2%) projects. Seven projects (16.7%), led by five different respondents, made use of intuition as a guide in choosing the innovation, but in making the choice this evidence base was not used alone.

Figure 3.9: Distribution of evidence base types



3.4 Project status

The start and end times of all 42 projects are shown in figure 3.10. The earliest a start for a project was given as sometime in 2005 and the latest start was November 2009. The earliest finish for a project was December 2009 and the latest finish is given as April 2011, though four projects go on indefinitely. One project is yet to start. The shortest project is given as 6 months.

Figure 3.10. Project start and end

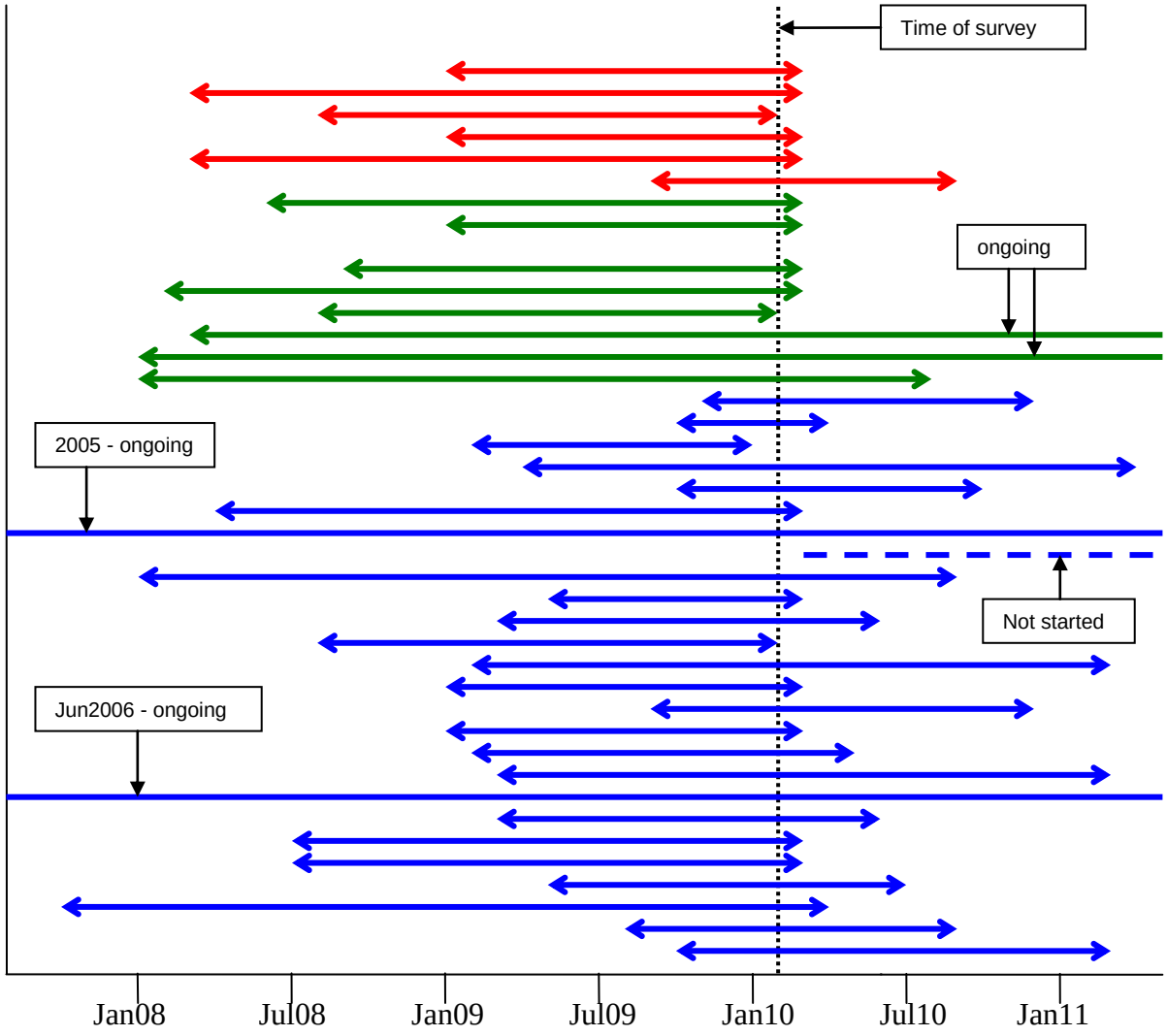
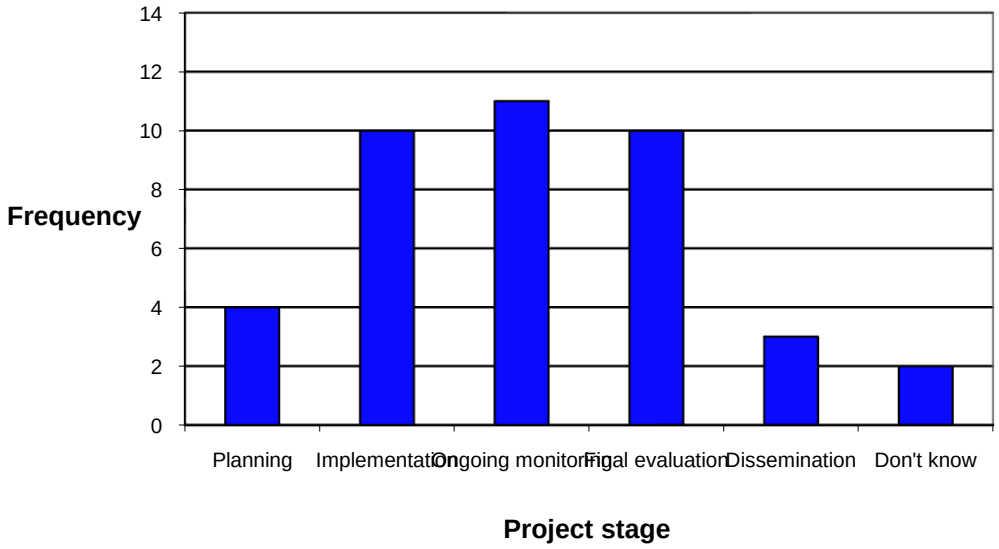


Figure 3.11 shows the replies given to the question *Which one of the terms below best describes the stage you are currently at?*. Two projects were not reported on and for two projects respondents said they did not know the stage they were at.

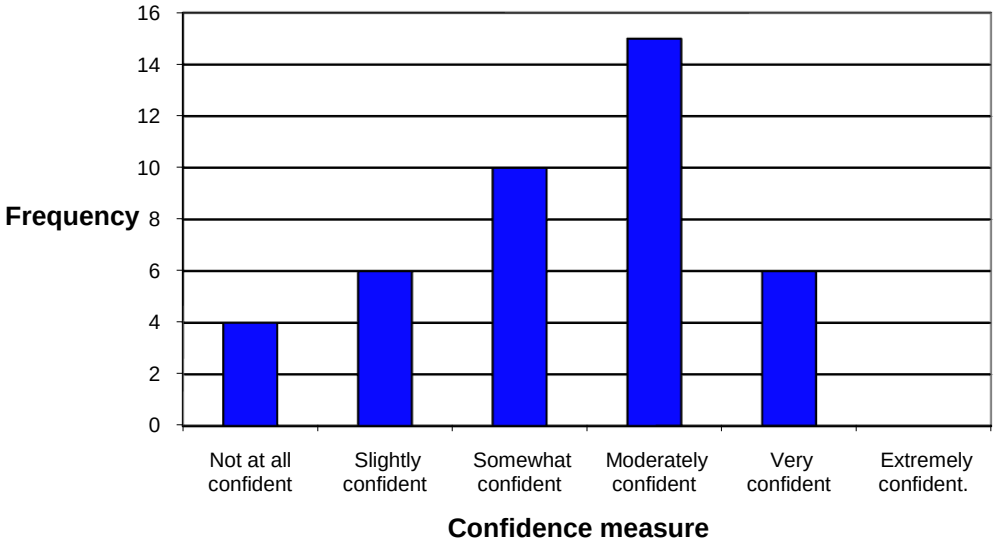
Figure 3.11: Stage project is currently at



3.5 Outcomes

The questionnaire requested information about project outcomes. The question: *What short-term outcomes have you achieved?* was asked first followed by: *What long-term outcomes do you **aim** to achieve*. Finally, the question was asked: *How confident are you that the long-term outcomes aimed for will be achieved?* The short and long-term aims were very project specific and are dealt with in the relevant project sections. The responses given by all respondents to the question about how confident they are about meeting their long-term aims are shown in figure 3.12.

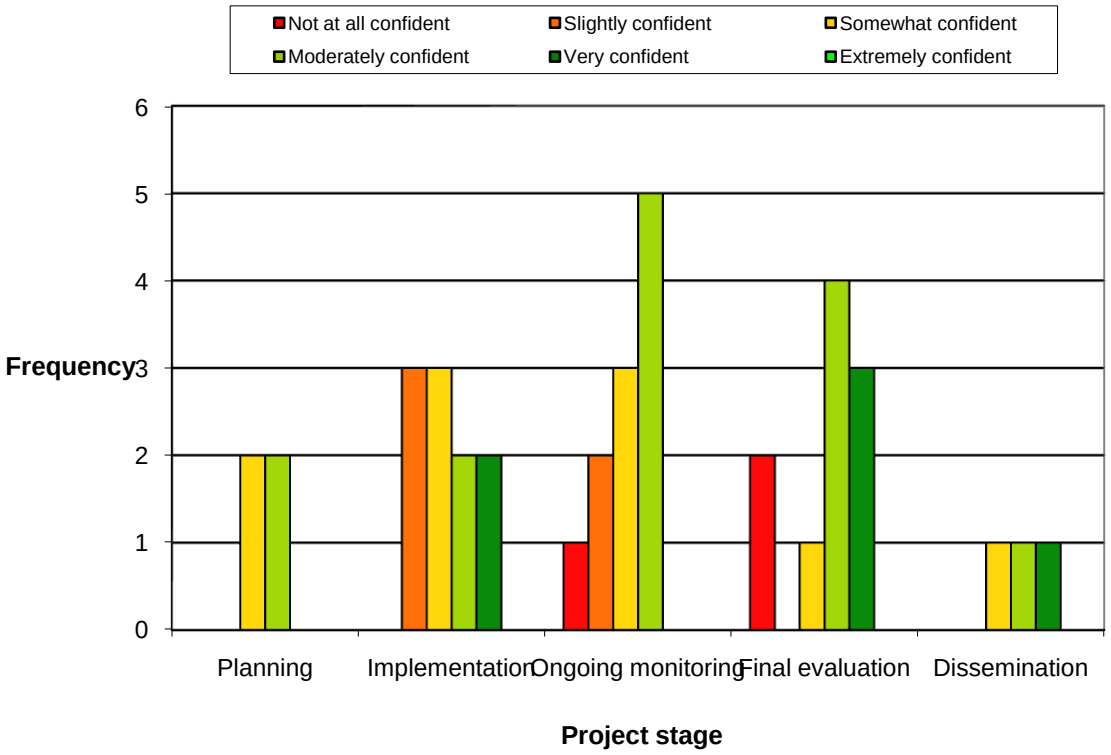
Figure 3.12: Level of confidence that long-term outcomes will be achieved



How confident respondents are about their project meeting its long term goals at the stage the project is at is shown in figure 3.13. This bar chart shows how confidence is tentative at the early planning stage of a project: there is neither pessimism nor great optimism. A lack of confidence

begins to show at the Implementation stage and increases towards Final evaluation. Confidence follows a similar path: it begins to show at the Implementation stage and increases beyond Final evaluation into the Dissemination stage.

Figure 3.13: Confidence at different project stages



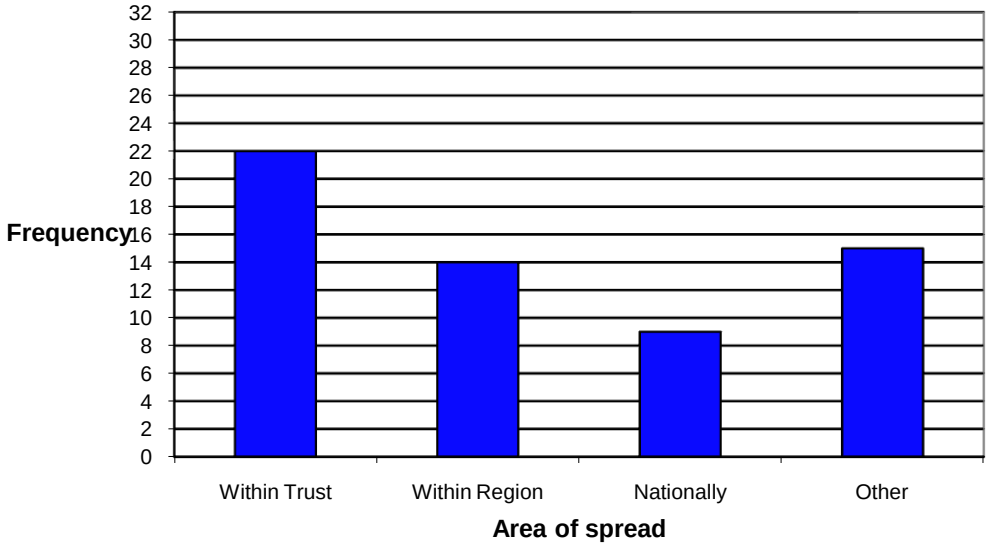
3.6 Sustainability

The questionnaire asked the open questions *How will you sustain and/or develop this innovation.* and *What resources are required to achieve this?*. The responses to these questions were project specific and are dealt with in the relevant project sections.

Thirty-two of the forty-two (76.2%) respondents said that they planned to spread their innovation, six (14.3%) did not know whether this was intended and four (9.5%) did not respond. Of the 32 projects planning to spread their innovation just over a half (17, 53.1%) intended to restrict the spread to one area only, a quarter of the projects (8, 25%) were aiming at 2 areas, just 1 (3.1%) project was aiming at just 3 areas whilst 6 (18.8%) intended to spread in 4 different areas.

Where the 32 projects intended to spread their innovation is summarised in figure 3.14. Over a two-thirds (22, 68.8%) intended to spread the innovation within their own trust, whilst 14 (43.8%) projects are aiming to spread within their region and 9 projects (28.1%) nationally. Almost a half (15, 46.9%) said they intended to spread into other areas, which include the local area, such as the local health economy, other interested NHS sites, especially other Pacesetters sites, and one stated "as far and wide as possible".

Figure 3.14: Where innovation is to be spread



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3.7 Further development

The respondent was asked a number of open questions about each of their projects' further development. The answers to these are project specific and are dealt with in the relevant project sections.

4. Flexible Working Projects

There were 6 respondents who lead Flexible Working projects, each from different trusts, which belonged to 4 different strategic health authorities.

4.1 Design

The results of asking the question *Which parties were involved in designing the Flexible Working Innovation* are given in table 4.1.

Table 4.1: Parties involved in designing the innovation

	Frontline staff	**Senior Management**	**E & D leads**	**Voluntary agency**	**Other**	**Total**
1	Y	Y	Y	N	N	**3**
2	N	N	Y	N	Y	**2**
3	N	N	Y	N	N	**1**
4	Y	Y	Y	N	Y	**4**
5	Y	Y	Y	N	N	**3**
6	Y	Y	N	Y	N	**3**
Total	**4**	**4**	**5**	**1**	**2**	**16**

All respondents reported they made use of other parties in designing the Flexible Working innovation, ranging from using just 1 party to 4 parties, with the most likely number being 3. The most popular party to use was an Equality and Diversity lead, used by 5 of the six respondents (83.3%). Both Frontline staff and Senior management were used by 4 of the six (66.7%) with only 1 using a Voluntary Agency. Two reported using other parties, which were the Disabled Staff network and the BME workforce.

Four of the six respondents reported that people from the target group were involved in designing the innovation, with 2 saying they did not know if this was the case. To involve people from the target group use was made of exploratory focus groups (2 from 6, 33.3%), decision making stakeholder meetings (1, 16.7%), road show questionnaires (1, 16.7%) and voluntary agencies (1, 16.7%).

4.2 Baseline

Respondents were asked what quantitative and qualitative base line data they used to identify the issues to be addressed

On the quantitative side, 5 of the six (83.3%) made use of staff surveys, 3 of the six (50.0%) made use of workforce data, some using electronic staff records (ESR). One respondent reported using an audit separate to a staff survey and another made use of four staff briefing sessions.

On the qualitative side, four of the six (66.7%) made use of focus group interviews. Other sources of evidence used included staff stories, feedback from road shows and staff meetings.

Table 4.2 gives the responses to the question *What was the evidence base for the chosen innovation?*. No respondent reported that the method had been tried elsewhere was used as an evidence base. However, in reporting other evidence bases one did state that results from a survey were used "to drive this change idea". Only two reported making their choice using research literature. Three made their choice using anecdotal observation, one of which used this method only. One reported using intuition, though they did combine it with anecdotal observation. One was unsure where the evidence originated. At most only 2 sources of evidence base were used to make the choice of innovation.

Table 4.2: Evidence base for the chosen innovation

	Tried elsewhere	**Research literature**	**Anecdotal observation**	**Intuition**	**Other**	**Total**
1	N	N	N	N	Y	**1**
2	N	N	Y	N	N	**1**
3	N	N	N	N	Y	**1**
4	N	N	Y	Y	N	**2**
5	N	Y	Y	N	N	**2**
6	N	Y	N	N	N	**1**
Total	**0**	**2**	**3**	**1**	**2**	**8**

4.3 Project status

The earliest a start for a project was March 2008 and the latest September 2009. Five of the six are due to end February or March 2010, the sixth by September 2010. The shortest project duration is one year and the longest is 2 years.

Figure 4.3: Project start and end

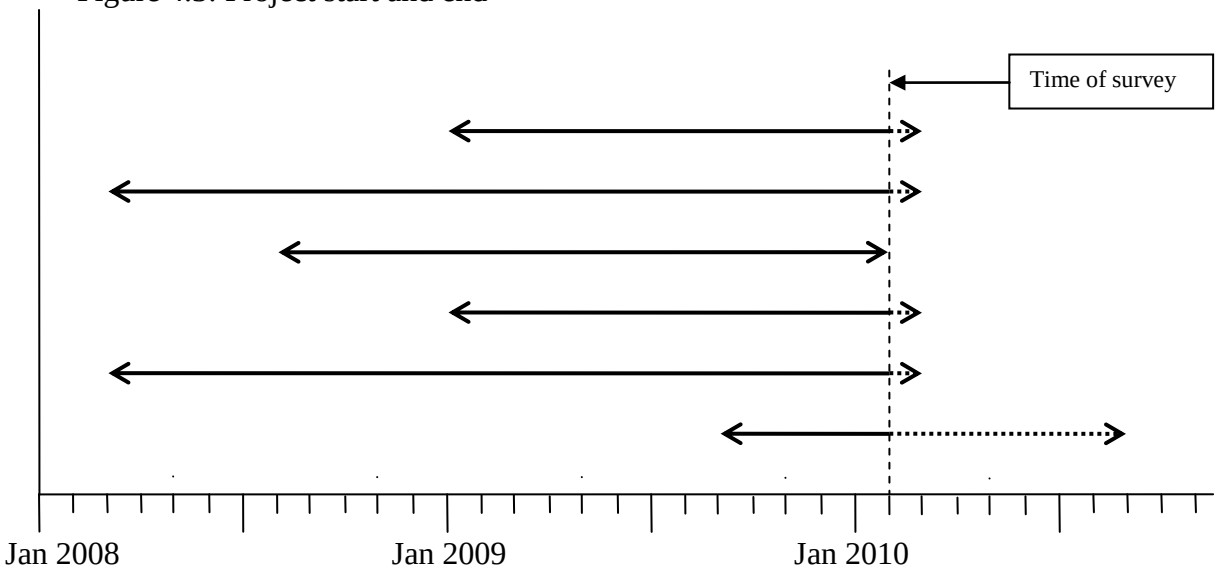
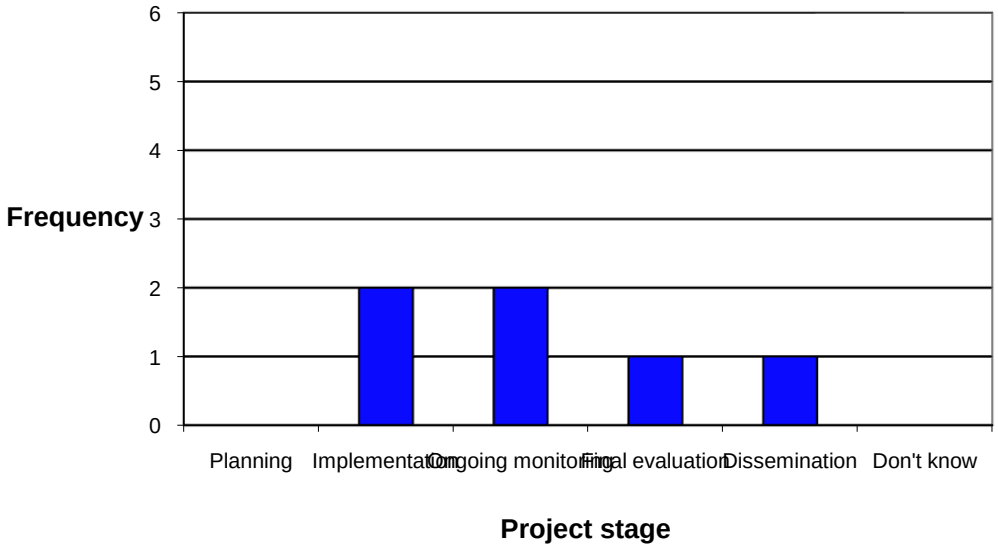


Figure 4.4 shows the stages that the projects were at. Of the two projects at the implementation stage, one reported being at an early stage of development (they had started the project only in September 2009) and the other was close to completing workforce training. Of the two projects at the ongoing monitoring stage one reported one reported still being progressed and the other that training was complete but it was too soon to measure change (this project is due to complete in

March 2010). One of the projects was reported being in final evaluation and a sixth project being in a dissemination stage, where Human Resources department had both the responsibility of disseminating information to all staff and training managers and the responsibility of ensuring sustainability.

Figure 4.4: Stage project is currently at



4.4 Outcomes

The questionnaire requested information about project outcomes. The question: *What short-term outcomes have you achieved?* was asked first followed by: *What long-term outcomes do you **aim** to achieve*. Finally, the question was asked: *How confident are you that the long-term outcomes aimed for will be achieved?* and the following set of options was offered: *Not at all confident, Slightly confident, Somewhat confident, Moderately confident, Very confident, and Extremely confident*. Two respondents said they were somewhat confident, 3 moderately confident and just one was very confident.

The responses varied from reporting little change and modest, general long-term aims to concrete achievements and definite long-term aims. For example, one respondent reported that the only change was that flexible working policy had been updated, and that the long-term aim was to help more disabled staff into employment, reflecting the local population. They were moderately confident of achieving the outcome because they felt that the profile of disabled staff had been raised and that this could be maintained by ongoing training and updating of managers.

Another respondent reported that, in addition to reviewing the flexible working policy, staff now had a choice of flexible working approaches, including annualised hours[15], term time working[16] and zero hours[17]. Their long-term aim was to offer staff flexible working that also met the service needs. They were very confident of achieving the long-term aim: there was staff engagement at all levels and also trade union engagement with the aim linked to business plans and financial targets.

[15] annualised hours: staff are contracted to work a specified number of hours in the year
[16] term time working: staff have a have a permanent contract but do not work during school holidays
[17] zero hours: there is no guaranteed work: staff are 'on call' to work according to short-term needs

A third respondent gave comprehensive answers to both questions. In answer to the first question they could report that management training was taking place to inform and discuss staff rights, a booklet on *Work/Life Balance & Health*, containing a chapter on flexible working, had been distributed to all staff and a system had been set up to monitor flexible working. The answer to the second question stated the aim was to increase the take up of flexible working options (flexi-time, annualised hours and reduced working time), especially for male staff and that, if successful, the project would be rolled out across all service areas. Despite their short-term achievements and the firm long-term aim they were only somewhat confident of meeting this aim: even though tools were in place to support information dissemination and managers' understanding of staff rights, they feared that in those sites where there was "staff limitation" then the right may be not be carried forward. They also felt that insufficient information had been collected about male staff not taking up flexible working and therefore it would difficult to address this issue.

4.5 Sustainability

The questionnaire asked how the respondent would sustain or develop their innovation and what resources would be required to achieve this. Most respondents (4 of 6, 66.7%) are looking to the HR or Workforce department, with support from ELD (English Language Development) in one case, to sustain the innovation. Half of the respondents reported that training, including the training of managers and the provision of apprenticeships, followed up by monitoring are to be used. One intended to make use of newsletters and other forms of communication to develop flexible working. To achieve their aims most require increased capacity in HR and E&D departments and increased staff time, though one did say that no additional resource was required.

Five of the six respondents, the sixth did not know, said that they planned to spread their flexible working innovation: three within their trust, two regionally, one nationally and one locally. Three respondents intended to make use of Corporate and local HR departments, and two intended to showcase the achievement, one through a document to made available via their SHA website.

4.6 Further development

In enquiring about future development a number of questions were set, the first of which asked the respondent to reflect by asking *What has been learnt so far?* One learning was concrete: that funding to assist personal flexible working is available from central government. Three expressed frustration: that not everyone is willing to develop even though they can benefit themselves, and similarly that to deliver the objectives staff must be more flexible, adaptable and open to different ways of working. One was satisfied that their organisation had a good work/life balance policy and that "uptake of Flexible Working is good for a range of reasons". One was ultimately optimistic: they said that, even though there were still discrepancies in practice concerning flexible working they held that "through effective communication and support much can be achieved".

In response to the question *What has been the main barrier to success so far and why?* three respondents stated a lack of resources - through staff shortages, poor financial support for training and especially time constraints. Two respondents also noted a lack of support: one lamented the "lack of understanding by line managers for positive action". One respondent did report there were no barriers. Other concerns about the project were lack of financial support in challenging times, lack of access to those at the top in the hierarchy and one respondent voiced concern that momentum will be lost and put forward the "Provider/Commissioner split" as a cause.

Asked if they were to run the project again, how they would do it differently the earlier expression of frustration with lack of resources surfaced: the project needed a full-time lead, with administration support built-in, more staff dedicated to the project and an agreed budget. The need for wider consultation and participation was expressed by 2 respondents. One respondent said they would
question the remit and recommend that “the emphasis of energy was placed on increasing the accessibility of the workplace”.

5. Bullying and Harassment Projects

There were 9 respondents who led Bullying and Harassment projects, from 8 different trusts, which belonged to 6 different strategic health authorities in the Pacesetters programme

5.1 Design

The results of asking the question *Which parties were involved in designing the Bullying and Harassment Innovation* are given in table 5.1.

Table 5.1: Parties involved in designing the innovation

	Frontline staff	**Senior Management**	**E & D leads**	**Voluntary agency**	**Other**	**Total**
1	Y	Y	Y	N	N	**3**
2	Y	Y	Y	N	Y	**4**
3	N	N	Y	N	Y	**2**
4	Y	Y	Y	N	N	**3**
5	Y	Y	N	N	Y	**3**
6	N	N	Y	N	N	**1**
7	Y	Y	Y	N	N	**3**
8	Y	Y	Y	N	Y	**4**
9	Y	Y	Y	N	Y	**4**
Total	**7**	**7**	**8**	**0**	**5**	**27**

All respondents reported they made use of other parties in designing the Bullying and Harassment innovation, ranging from using just 1 party to 4 parties, with the most likely number being 3. The most popular party to use was an Equality and Diversity lead, used by 8 of the nine respondents (88.9%). Both Frontline staff and Senior management were used by 7 of the nine (77.8%) but no one made use of a Voluntary Agency. Five reported using other parties, which included the Pacesetters dedicated middle management, staff networks, an external training provider and trade unions. One wished to emphasise that the project focused specifically on mediation.

Eight of the nine respondents reported that people from the target group were involved in designing the innovation, with one saying they did not know if this was the case. To involve people from the target group use was made of exploratory focus groups (7 from 9, 77.8%), decision making stakeholder meetings (4, 44.4%), email questionnaire (1, 11.1%), a means of anonymous contribution (1, 11.1%), through a workplace advisor scheme (1, 11.1%), discussion with staff groups (1, 11.1%).

5.2 Baseline

Respondents were asked what quantitative and qualitative base line data they used to identify the issues to be addressed

On the quantitative side, all of the nine (100.0%) made use of staff surveys, and of these 2 (22.2%) carried out additional surveys specific to bullying and harassment, 2 respondents (22.2%) reported examining data from grievance and discipline monitoring. One respondent also simply stated that "It is recognised that Bullying and Harassment occurs in the workplace."

On the qualitative side, 6 of the nine (66.7%) made use of focus group interviews with staff. One (11.1%) held "face to face one to one" discussions with staff. Two received evidence from those involved in harassment and bullying training. Other sources included workplace support advisor meetings, qualitative data from a local survey, feedback from staff networks and simply anecdotal evidence.

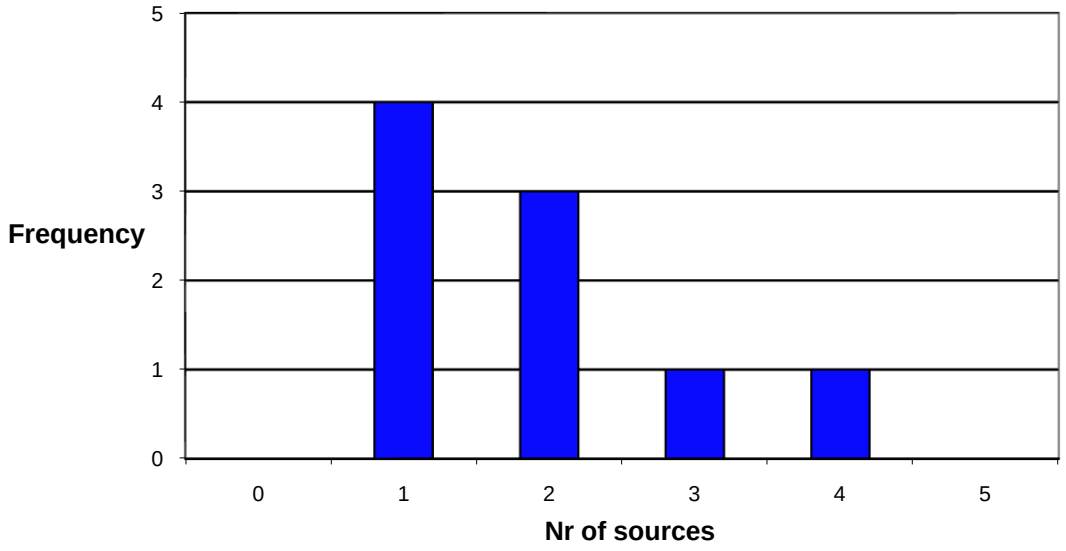
Table 5.2 gives the responses to the question *What was the evidence base for the chosen innovation?*. Five (55.6%) respondents reported that they made their choice because the method had been tried elsewhere. Four (44.4%) reported making their choice using research literature. Three (33.3%) made their choice using anecdotal observation. Two reported using intuition, though they did not used intuition alone. One made use of information from their training provider regarding suitability and effectiveness of training from elsewhere. Another said that the policy adopted made use of the experience of internal HR managers and users. One did not actually specify the evidence base for their chosen innovation.

Table 5.2: Evidence base for the chosen innovation

	Tried elsewhere	**Research literature**	**Anecdotal observation**	**Intuition**	**Other**	**Total**
1	Y	N	N	N	N	**1**
2	N	N	N	N	Y	**1**
3	Y	N	N	N	N	**1**
4	Y	N	Y	N	N	**2**
5	N	N	N	Y	Y	**2**
6	N	Y	N	N	N	**1**
7	N	Y	Y	N	N	**2**
8	Y	Y	N	N	Y	**3**
9	Y	Y	Y	Y	N	**4**
Total	**5**	**4**	**3**	**2**	**3**	**17**

As shown in figure 5.3 the number of different sources ranged from 1 to 4, with the average being 1.89 and most likely being 1.

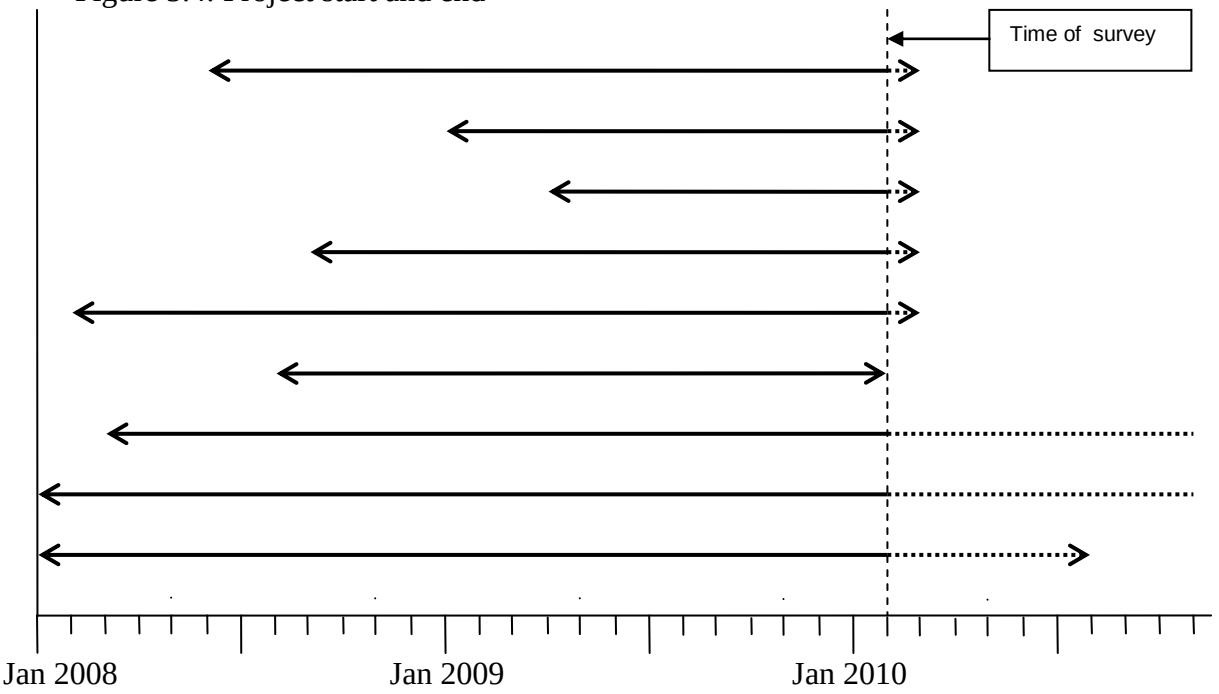
Figure 5.3: Frequency of number of evidence bases



5.3 Project status

The earliest a start for a project was January 2008 and the latest start was April 2009. One finished in February 2010, five of the nine are due to end by March 2010 and two will be ongoing. The shortest project duration is 12 months.

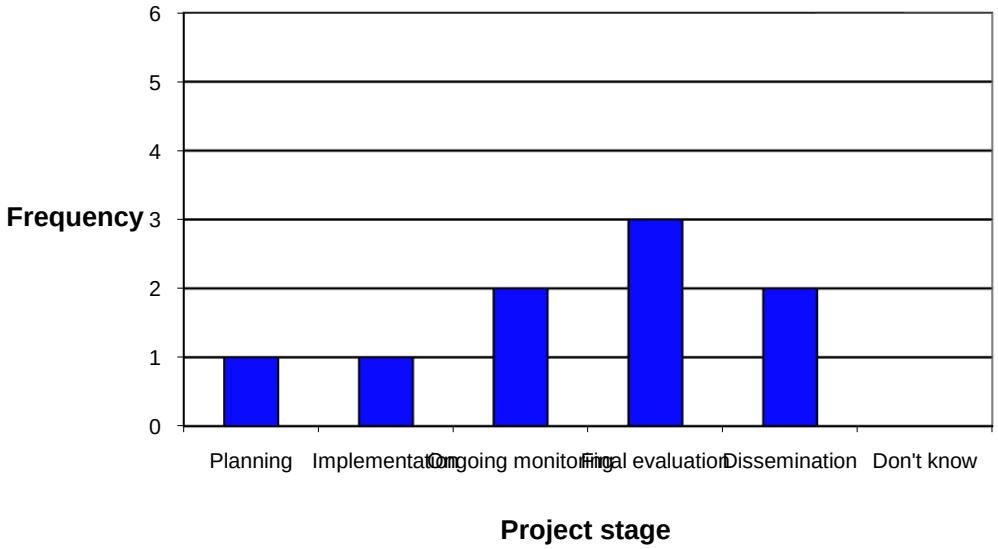
Figure 5.4: Project start and end



The single project at the planning stage reported that they had experienced delays to do with their producing a DVD that duplicated a DVD from the DH. The project at the implementation stage was currently involved in recruitment and training. A project undergoing ongoing monitoring reported doing some evaluation but were held back due to a time lag in data and a lack of capacity. One project in the dissemination has trained several mediators through Corporate HR and has publicised the service through various media, including their trust's magazine and intranet. The

other project at the dissemination stage has set up a new Workplace Advisory group and advertises their services throughout the trust.

Figure 5.5: Stage project is currently at



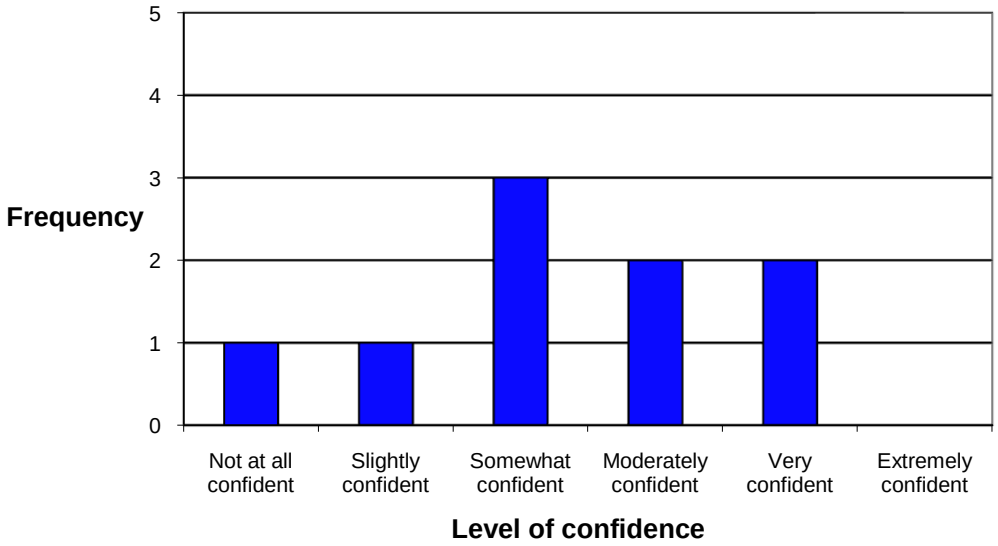
5.4 Outcomes

The questionnaire requested information about project outcomes using three questions, the first of which was: *What short-term outcomes have you achieved?*. Three responded how the project had raised awareness of the issue of bullying and harassment, including its effects, what is not acceptable behaviour and the right and need to challenge such behaviour. Six referred to the scheme now set up, or re-invigorated, for staff to contact regarding this issue. One project talked about how they were using the DVD they had made as part of their induction process

The second question asked was: *What long-term outcomes do you **aim** to achieve*? Seven of the nine (77.8%) respondents stated an aim was to reduce the incidence of bullying and harassment. One stated they wished to identify key issues or potential key issues before bullying and harassment actually occurred. Two stated they wished to raise the proportion of incidents that were resolved early, without the need for formal action. Two stated that an aim was to enable staff to feel more confident in challenging inappropriate behaviour, either on behalf of themselves or others. One simply wished to lower the rate of bullying and harassment below the national average. The respondent who had developed the DVD wished to produce a handbook to go with it and disseminate what they had done regionally and nationally.

Finally, the question asked was: *How confident are you that the long-term outcomes aimed for will be achieved?* and the results are shown in figure 5.6.

Figure 5.6: Level of confidence that long-term outcomes will be achieved



The lack of confidence expressed was largely due to there being a lack of material and human resources, especially where the scheme to deal with bullying and harassment was just one of a number of schemes to be implemented. One of the two who were very confident based their outlook on the fact that the project had already been running for a number of years and that advisors had shown dedication in supporting staff.

5.5 Sustainability

The questionnaire asked how the respondent would sustain or develop this innovation and what resources would be required to achieve this.

Some respondents (3 of nine) are looking to the HR to manage the innovation. Four intend to use evaluation through monitoring trends or analysing the next staff survey. Three intend to continue with training, with one introducing a new mandatory training course. One of these three aims to investigate other means of complementing training such as mediation and advocacy and another who uses theatre workshops in training aims to explore more cost effective ways of training. Two have said they intend to try and recruit more volunteers to support the service. One said they intend to rollout the project across the trust and another said they were going to re-launch the project with the help of "branding" to help the project become more visible.

To achieve their aims all expressed the need for further funding. Most (7 of the nine) wished to use this funding to increase staffing by increasing HR support and the number of mediators, and engage trainers to train the mediators. Three expressed using funding to promote the service through marketing. More specifically, one wanted to incorporate a question into the Personal Development Review about challenging bullying and harassment behaviour. Another wished to introduce "a quiet room for face to face meetings (between advisor and 'client' where appropriate)".

Seven of the nine (77.8%) respondents, the other two did not know, said that they planned to spread their bullying and harassment innovation: four within their trust, three regionally, two nationally, one to a partner trust and one to other areas such as education and the private sector. The means of spreading the innovation were through Human Resources (HR) department, the

Diversity Steering Group, by adding more volunteers and through informal networks. To do this the main resources required were time, increased HR capacity and more trained mediators.

5.6 Further development

In enquiring about future development a number of questions were set, the first of which asked the respondent to reflect by asking *What has been learnt so far?* Some respondents report that they found that bullying and harassment can be a complex area with unexpected results: some people do not recognise there is a problem, others have stories about their own experiences of bullying. Two respondents reported that there was a raised awareness of what constituted inappropriate behaviour. One reported that staff could be unaware of what options were available and that there was no clear process. Some reported that the service was clearly useful and that training received was highly valued by staff and one respondent said that that there had been interest by staff to become mediators. One respondent observed that the service they provided was low cost but that it could be extended, for example to offer advocacy and mediation support, but this would increase costs significantly. A number identified that the service takes time to develop and needs focus and solid follow up to ensure success.

In response to the question *What has been the main barrier to success so far and why?* four identified a lack of resources: either insufficient funding to offer courses to more staff or insufficient time for staff to attend.. Some identified project management failings, such as no person in overall charge of the scheme, changes in management causing delays or failure to agree project scope with unions.

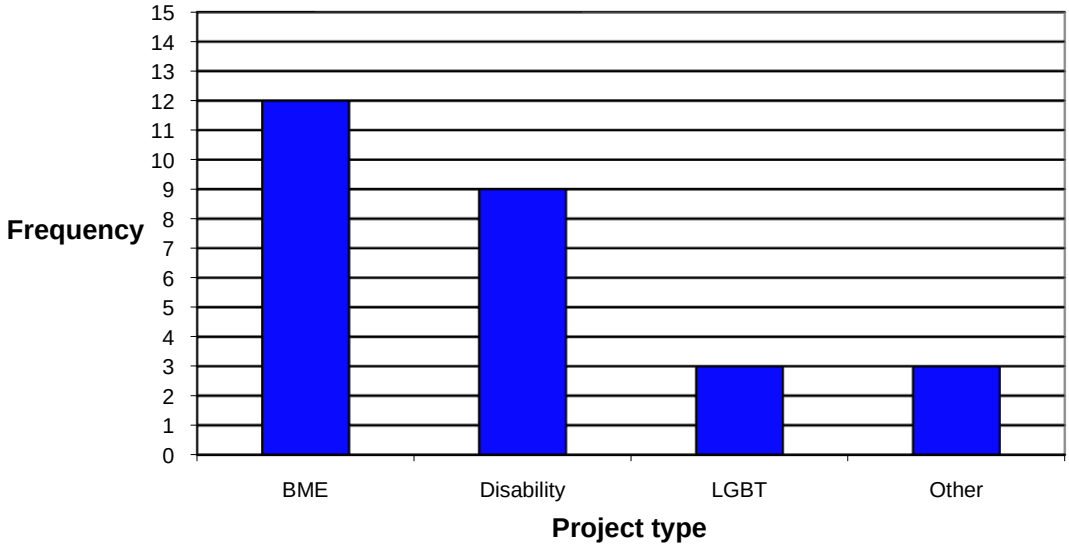
Asked for other concerns about the project two respondents expressed concerns that once they were no longer on the project then it may not sustain. Another was concerned that impact assessment would not take place. Two others were concerned that about stress affecting staff on the scheme. One said that although general awareness had been raised more work was needed with specific staff groups. Another was concerned that developing a culture of feedback was a lengthy process.

Asked the question: *If you were to run the project again, how would you do it differently?* six of the nine responded with their thoughts on how they would actually do it differently. Of the remaining three just one made a response saying that the project as set out worked really well. In doing it differently one would have carried out in the early stages a deeper analysis of the problem and another observed that the project evolved but could have been thought through from the outset. One thought it would be beneficial to get the various staff side representatives to agree the scope before entering the formal process to approve the scheme. One felt that the responsibility for the project really lay at the SHA level but they would also not have given the project a regional focus since this would have allowed organisations to avoid dealing with what is a serious issue. Two identified the importance of follow up with staff, one of whom had the idea of making available an on-line Bullying Experiences Audit, which would have allowed a staff member to provide feedback on what did help and what would have helped.

6. Representation Projects

There were 21 different respondents who led a total of 27 Representation projects: one respondent led 3 projects , 4 led 2 projects and 16 led 1 project only. The projects were run in 20 different trusts, which belonged to the 6 different strategic health authorities in the Pacesetters programme. The frequency of the types of project are shown in figure 6.1.

Figure 6.1: Types of Representation project



The three projects under the heading “Other” were: a combined data project, a whole equality project and a comprehensive data project that should enable a more accurate recording of ethnicity.

6.1 Design

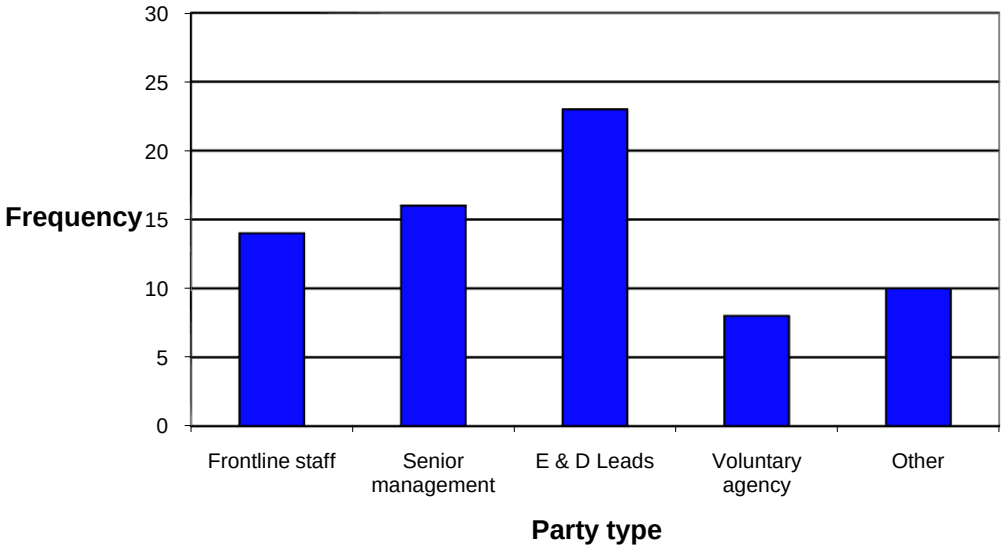
The results of asking the question *Which parties were involved in designing the Representation Innovation* are summarised in table 6.2 and figure 6.3. All projects used at least one party in designing the innovation, the most popular number used being 3. Five projects used only 1 party, eleven projects used 3 different parties and one project made use of 5 different parties.

Table 6.2: Distribution of parties used

Party size	Frequency	Percent	Cumulative Percent
0	0	0.0	0.0
1	5	18.5	18.5
2	6	22.2	40.7
3	11	40.7	81.4
4	4	14.8	96.2
5	1	3.7	100.0
Total	27	100.0	

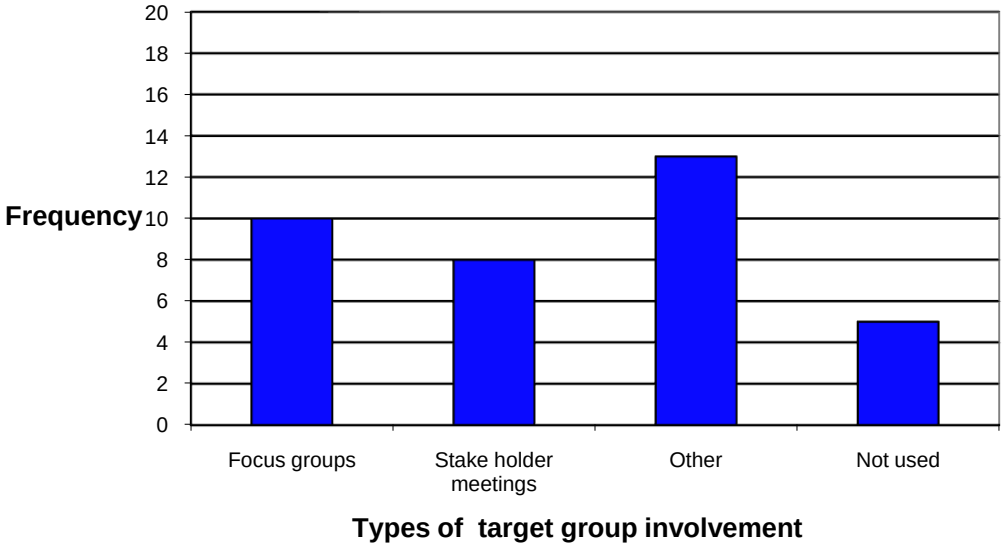
As shown in figure 6.3 the most popular type of party to use was an Equality and Diversity lead, used in 23 of the 27 projects (88.9%). Senior management was used by 16 of the 27 (59.3%), frontline staff by 14 (51.9%) and 8 (29.6%) made use of a Voluntary Agency. In ten projects respondents reported using other parties, which included BME staff, HR staff, LGBT network and one made use of a commercial partner and another support from the third sector organisations.

Figure 6.3: Distribution of party types



In 20 of the twenty-seven (74.1%) projects respondents reported that people from the target group were included in designing the innovation, 5 projects definitely did not involve people and the status of two was unknown. How people from the target group were involved is shown in figure 6.4. Use was made of exploratory focus groups (10 from 27, 37.0%), decision making stakeholder meetings (8 from 27, 29.6%) and other means (13 from 27, 48.1%) including staff newsletter, staff surveys, steering groups, staff networks, staff forums and 1:1 in-depth interviews.

Figure 6.4: How people from the project's target group were included in the design



6.2 Baseline

Respondents were asked what quantitative and qualitative base line data they used to identify the issues to be addressed

On the quantitative side, there were four main sources of data. Eight projects (8 from 27, 29.6%) made use of staff surveys, 16 (59.3%) made use of workforce data, with 9 explicit references to ESR (Electronic Staff Records) and seven (25.9%) made use of staff recruitment and leavers reports. Some respondents reported relating this information to statistics about the national population, presumably to check how representative distributions in their workplace were compared to the national situation.

On the qualitative side, in three of the 27 (11.1%) projects there was no use of qualitative data. There were 20 reports of getting the data via staff feedback. Within these reports there were specific references to focus groups (7), one to one interviews (3), staff meetings (2), and surveys (2). Other sources were also reported, including: action learning sets, academic research, steering group consultation. One respondent wished to inform that for their project they "will use qualitative data to look at [the] issue, but not to identify it" .

The results of asking the question *What was the evidence base for the chosen innovation?* are summarised in table 6.5 and figure 6.6. All projects used at least one evidence base in designing the innovation, the most popular number being just 1, which was used in just over a half (51.9%) of the projects. A single project used 5 different evidence bases.

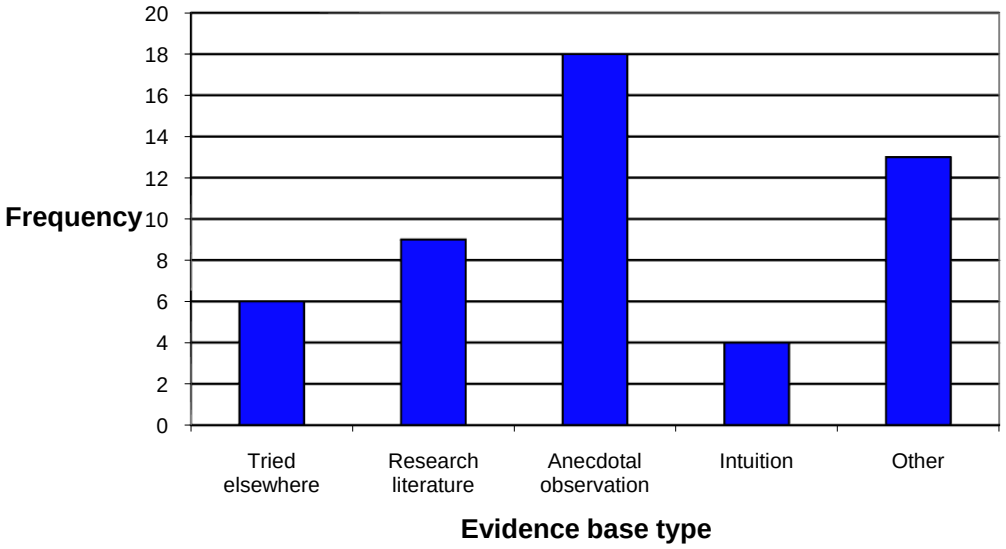
Table 6.5: Distribution of number of evidence bases

Count of evidence bases used	Frequency	Percent	Cumulative Percent
0	0	0.0	0.0
1	14	51.9	51.9
2	6	22.2	74.1
3	5	18.5	92.6
4	1	3.7	96.3
5	1	3.7	100.0
Total	27	100.0	

As shown in figure 6.6 the most popular type of evidence base used was anecdotal observation , which was used in 18 projects out of 27 (66.7%). Research literature was used by 9 (33.3%) projects and the fact that the method had been tried elsewhere was used by 6 (22.2%) of the projects. Four different respondents, leading 4 different projects, reported they had made use of intuition to guide them in choosing the innovation, but in making the choice this evidence was not used alone.

Almost a half (13, 48.1%) of projects were reported as making use of other evidence bases. Of these, four projects made use of feedback from various organisations, such as the local Sexual Orientation and Health Stakeholder Group and the Regional Lead for the *Breaking Through Programme*. One in particular reported that they met with race advisors and organisational development consultants to explore "what had been done before and what didn't work - and to try to think of a fresh solution to test as part of project". Two respondents, in two different projects, said they made use of their own personal experience. However, 6 respondents leading 7 different projects appear to have misunderstood the question – they reported making use of statistical evidence but in a way that was more of a justification for making an intervention rather than as a justification for the innovation used.

Figure 6.6: Distribution of evidence base types



6.3 Project status

The earliest a start for a project was given as sometime in 2005 and the latest start was November 2009. The earliest finish for a project was December 2009 and the latest finish is given as April 2011, though two projects go on indefinitely. One project is yet to start. The shortest project is given as 6 months.

Figure 6.7. Project start and end

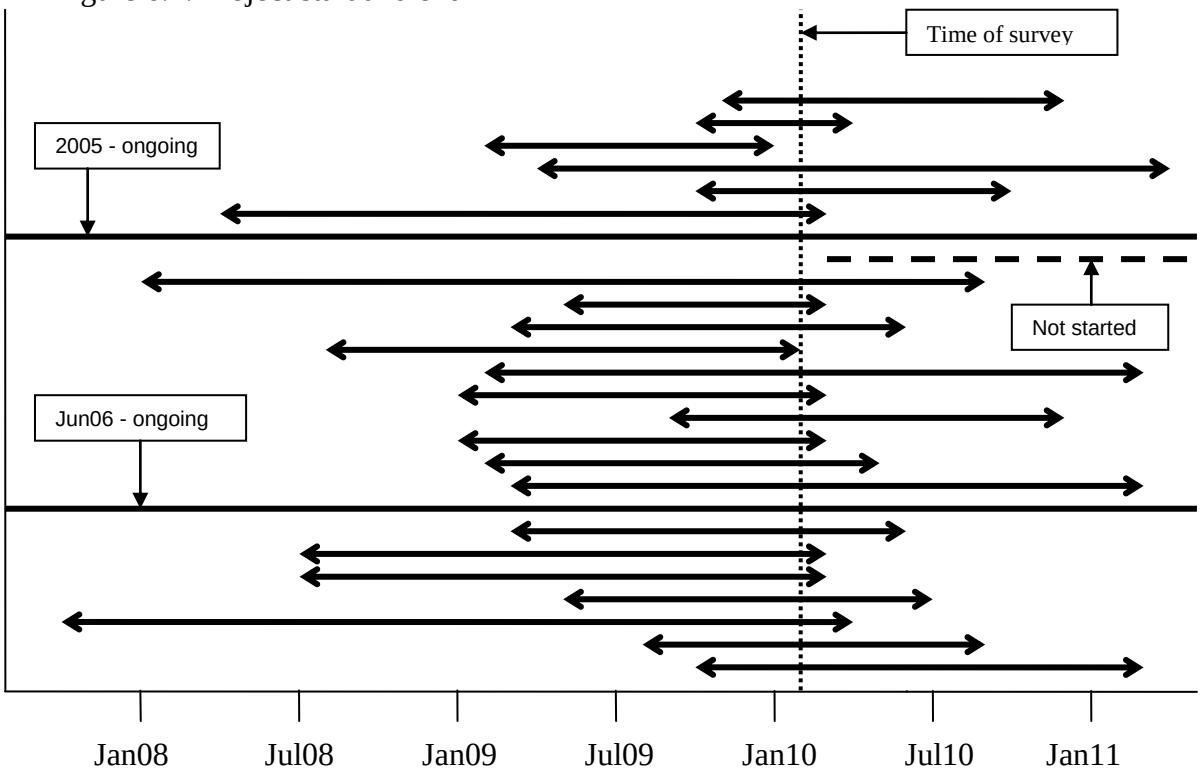
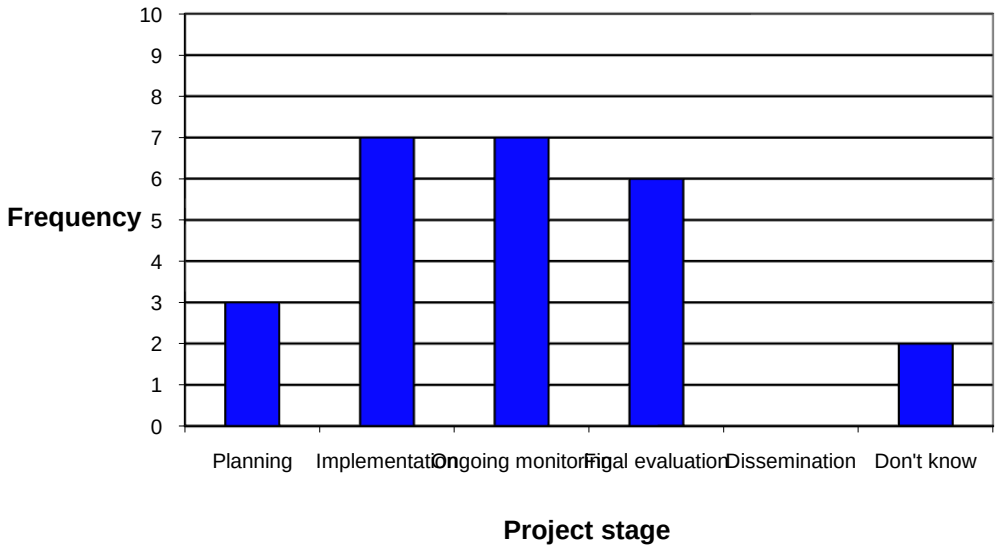


Figure 6.8 shows the replies given to the question *Which one of the terms below best describes the stage you are currently at?*. Respondents were also invited to comment on the stage their project was at. Two projects were not reported on and for two projects respondents said they did not know the stage they were at. One of latter two projects reported being in this position because, for a number of different reasons, the project started late and had deviated from its original aims and the other project was reported as actually working on two innovations at once: one of which was at the ongoing monitoring stage and the other was at the planning stage. None of the 3 projects at the planning stage gave any further comment. Of the 7 projects at the implementation stage one reported having experienced slippage but that the extra time had been used profitably to refine the programme and had allowed them to "use ROI to assess and realise the Business Impact". Of the 7 projects at the ongoing monitoring stage one reported that their ESR system was now being continually monitored and another reported that they were testing interventions. Two of the six at the final evaluation stage reported that the evaluation report was being written up, one said they had commissioned an external evaluation and another was able to report that the final evaluation had been completed.

Figure 6.8: Stage project is currently at



6.4 Outcomes

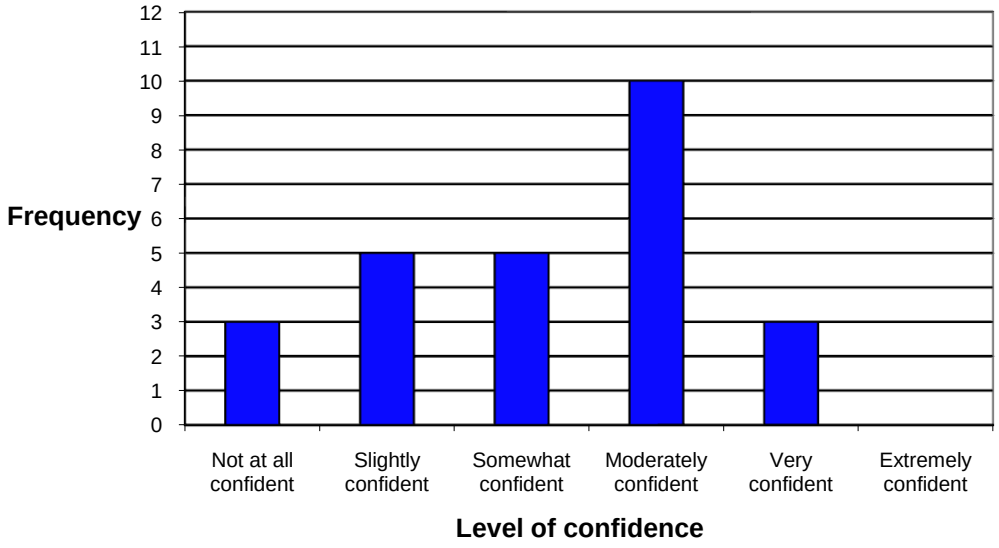
The questionnaire requested information about project outcomes using three questions, the first of which was: *What short-term outcomes have you achieved?*. Three respondents stated that they had gained feedback about the project itself: one reported that their project was proceeding along the right lines, one reported they had identified new issues they had been unaware of prior to the project, and another reported they were changing the format of the project. A number of respondents reported improvements in the situation. Thirteen reported their projects having implemented new schemes or improved existing schemes: for example, three mentioned setting up discussion forums, two have introduced mentoring schemes, another has set up a staff network and another had introduced Easy Read literature. Nine respondents have reported there had been more general improvements, such as more staff in minority groups have been employed and risen to more senior posts. Three reported improvements in the self confidence and self esteem of staff and reported their feeling more valued. Seven respondents mentioned a raised awareness of the issues

amongst staff and management and one reported there had been a spread of the debate to other trusts.

The second question asked was: *What long-term outcomes do you **aim** to achieve*? A large number of projects (20 from 27, 74.1%) stated their aim was to increase the representation of minorities in the workforce. This was to be achieved through increasing the number of employment opportunities for minorities, increasing the number of job applicants, improving applicants' success rate and reducing staff turnover. Further, an aim was to increase the representation of minorities, possibly through promotion to higher grade posts, throughout the organisation, which one respondent expressed as: "achieve a representative workforce at all levels from trust board/non-executive directors to frontline staff.". The means to achieve these targets included improving links with supported local employment agencies, building strong and sustained forums and networks, introducing a staff development programme and, for LD staff, training staff to support them and through using job carving[18]. Almost a third (8 from 27, 29.6%) stated they wished to change the culture of the organisation so that management are more accepting of minorities and that senior management in particular develop a commitment to keep "the promotion of equality and valuing diversity high on the agenda". One saw their project being embedded in existing systems and influencing the way they operate. Two respondents expressed the aim of spreading their innovation throughout the NHS and even to local authorities and Job Centre Plus agencies

Finally, the question asked was: *How confident are you that the long-term outcomes aimed for will be achieved?* and the results are shown in figure 6.9

Figure 6.9. Level of confidence that long-term outcomes will be achieved



The lack of confidence expressed for the 8 projects that were in the least confident two categories was in most cases due to a lack of time, money and staff to carry the project forward. Respondents who were somewhat confident about their projects were aware that effecting change in recruitment policy in the NHS is a difficult process, especially in the current financial climate, since, as one respondent put it, "qualities issues and related initiatives, training and investment are a possible 'soft target' for financial and staffing cuts". Even those respondents who were moderately confident about their projects had reservations: effort and commitment are still needed to ensure success.

[18] *job carving* – the breaking down of a job into component parts so as to create more job opportunities

Two expressed the fear that they may invest in individuals who may then move on taking their learning with them. Those who expressed confidence did so because their success in the past gave them belief that they could achieve success in the future.

6.5 Sustainability

The questionnaire asked how the respondent would sustain or develop this innovation and what resources would be required to achieve this.

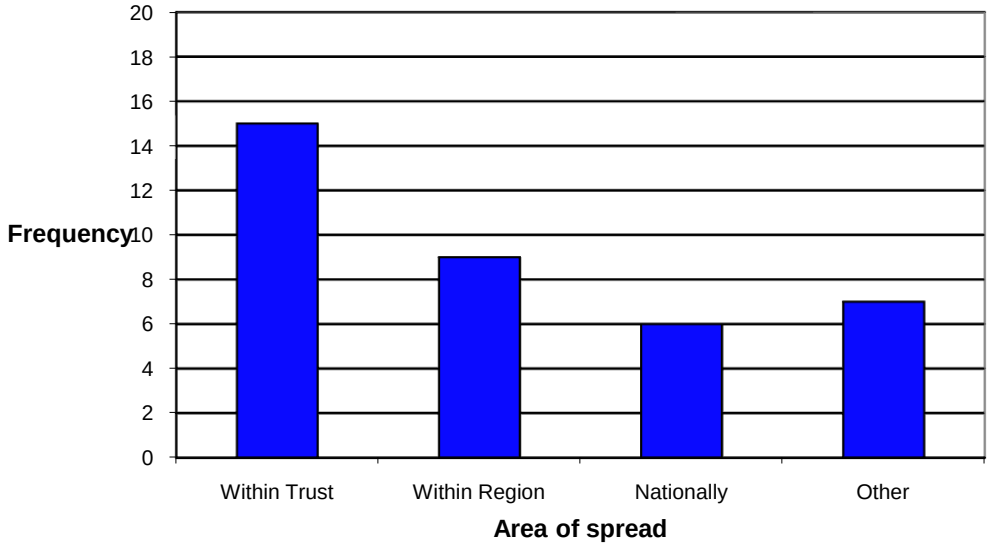
Almost one third (8 of 27, 29.6%) of the projects are looking to monitoring or evaluation, with some feeding back to staff and management, as a way of sustaining the innovation. Six (22.2%) projects aim to sustain and develop by spreading the innovation through offering it to other groups, especially where this can be done with little additional funding, or by forming partnerships with local groups. Three projects (11.1%) aim to develop forums, with one of these projects aiming to invest in individuals who will carry the learning with them. A number of projects have their own particular method: by having champions, by making an E & D appointment or by reviewing best practice. One hopeful respondent aims to ensure their project is sustained by "ensuring it is seen as a priority by senior management in trust". Four respondents pointed out that their projects continue to be works in progress.

Over two-thirds (19 of 27, 70.4%) of the projects stated they required human resources to achieve the aim of sustaining or developing their innovation. Four expressed this by saying the resource they lacked was staff time. Three projects were looking to the HR department to supply extra capacity, four wanted to fund an external facilitator. One project reported that they were to make an E & D appointment. The additional capacity was required "to carry out analysis and investigation", pay for course tutors and to allow staff to deliver the programme. Two projects wanted to employ a part-time website administrator. Financial resources were also required, such as for books for courses, website maintenance and a database to help monitor and track the progress of programme participants. Required resources for three projects included commitment and support from senior management. Just one project stated no additional resources were required.

Twenty of the twenty-seven (74.7%) respondents said that they planned to spread their representation innovation, three (11.1%) did not know whether this was intended and four (14.8%) did not respond. Of the twenty projects planning to spread their innovation a half (10, 50%) intended to restrict the spread to one area only, whilst four intend to spread in 4 different areas.

Where the projects intend to spread their innovation is summarised in figure 6.10. Over a half (15, 55.6%) intend to spread the innovation within their own trust, whilst a third (9, 33.3%) are aiming to spread within their region and 6 projects (22.2%) nationally. A quarter (7, 25.9%) said they intended to spread into other areas, which include the local area, such as the local health economy, other interested NHS sites, especially other Pacesetters sites, and one stated "as far and wide as possible".

Figure 6.10: Where innovation is to be spread



Some of those spreading the innovation with their own trust only aim to do so through their E & D lead as part of their SES, by promotion of the innovation with the workforce and some expect that success of the project will encourage others to take part. Six of those intending to spread the innovation outside their trust are to work in partnership, especially with E & D leads. One aims to make use of a high quality evaluation and communication (but does not say how): their belief is that transformative change is possible by "looking issues in the eye". Again, the resources required to achieve the spread were largely human and financial.

6.6 Further development

In enquiring about future development a number of questions were set, the first of which asked the respondent to reflect by asking *What has been learnt so far?*

Seven (25.9%) projects reported that in making the innovation they experienced a difficulty of some kind. That there could be difficulties is only to be expected when introducing innovation, but these seven expressed unexpected difficulty or disappointment even. Four reported a reluctance of staff to get involved: staff were less keen than expected to be mentored or be part of a reference group, were reluctant to give information, through data collection for example. Others reported that some staff was poor at making applications for jobs even though they had attended job search programmes. Another reported difficulty in appointing appropriately qualified staff to their E & D department. One working on an LD project observed that the workforce had "a significant lack of understanding and awareness of the potential role and value of people with a Learning Disability".

Seven (25.9%) different projects considered there were definite requirements for a project to work and these included: support for both staff and management; that management needed to be committed; a change in attitudes, policy and practice around recruitment practices; staff should shape the work at each stage. One respondent learned that commitment and focus are needed to achieve aims and that patience is needed to build relationships and for people to gain confidence that "initiatives are not tokenistic". One identified the need for a fundamental change in approach:

> *"that there needs to be a different model in relation to the honing and development of leadership competencies of BME staff. A move away from the deficit model of competencies,*

giving a focus on BME staff being able to bring their authentic self to work and focussing on dismantling the barriers to progression."

Six (22.2%) different projects learned how important certain aspects could be, such as diversity, local activity and support, effective partnership and peer working. One learned the importance of the virtual forum they had developed, especially since their trust was spread over a number of different sites. One respondent pointed out that the project's progress was due mainly to people being honest and having a commitment to change and that the Trust should "trust its workforce to come up with solutions to the problems the organisation faces."

Three (11.1%) respondents expressed satisfaction with their projects, saying that the project had been very rewarding and successful. One respondent observed that disabled staff felt valued and, further, that they felt empowered to advise the Trust.

In response to the question *What has been the main barrier to success so far and why?* eight projects specified a lack of resources in the form of time and finance. Three did not receive sufficient support and commitment, either from staff or management. Five reported a reluctance of disabled employees and those who were LGBT but not 'out' to come forward with information. Others reported more specific problems, such as delays in training, the geographical spread of their organisation discouraging attendance at meetings, difficulty in making links with existing programmes and networks and difficulty in influencing the national NHS jobs website.

When asked *What other concerns, if any, do you have about the project?* there were 10 (37.0%) projects for which no response was made and "None" was the response for a further 5 (18.5%), of which one was able to add "It's gone really well - shows what a bit of commitment, support and letting go can really achieve!" but another was more circumspect with "None – as yet". Three (11.1%) were concerned about resources continuing to be available in the form of funding, time for staff and time to complete development.. Four (14.8%) were concerned about the project being sustained: one fearing the project would be compromised once they left and another fearing that the emphasis would change from workforce development to service delivery. That staff would be reluctant to participate was the concern for three (11.1%) projects. One (3.7%) project expressed the concern that evaluation would not be built around the "capacity-building model".

Asked the question *If you were to run the project again, how would you do it differently?* 11 of the twenty-seven (40.7%) made no substantive response and two (7.4%) thought it too early to say. One would want a clear goal from DH. Two were concerned about resources for the project: one would choose another funder and the other would insist on being formally allocated time to work on the project. Three would seek greater support, two of whom through promoting the project in the Trust from early on. Seven would make better use of information: five would do so through planning, preparation and making good use of available expertise early on and two would be guided by evaluation results. Six would be more inclusive: five would make sure that more people were involved at the beginning and throughout, including stakeholders, especially managers, and voluntary organisations; one would research better ways of sharing what they had learned. One had the idea of seeking to swap mentors from other organisation so as to give a choice of external mentors. One respondent reported rather darkly that they would not have undertaken the management of this project since it offered an opportunity for the organisation *not* to meet its legislative obligations nor its obligation to become "an employer of choice".

7. Change model

Respondents were asked about the change models and methods used to help guide the introduction of innovations.

7.1 PDSA

There were specific questions about the Plan, Do Study, Act (PDSA) method of effecting change, which is advocated by the NHS Institute for Innovation and Improvement. The method aims to "test an idea by temporarily trialling a change and assessing its impact" [19].The motivation for using this method is that making changes to processes can produce unexpected results, so it is safer and more effective to introduce the change to a limited area first before applying the change more broadly. The method follows the four stages suggested by the method's name:

Plan - the change to be tested or implemented
Do - carry out the test or change
Study - data before and after the change and reflect on what was learned
Act - plan the next change cycle or full implementation

Of the twenty-eight respondents 19 used this method and how useful they found the method is shown in table 7.1:

Table 7.1: How useful was the PDSA method?

	Frequency	Percent	Cumulative Percent
Very useful	3	15.8	15.8
Useful	10	52.6	68.4
Of little use	4	21.1	89.5
Not useful	0	0.0	89.5
Don't know	2	10.5	100.0
Total	19		

Thirteen of the nineteen respondents (68.4%) who used the method found it either useful or very useful. Four users (21.1%) found the method of little use. No one said that the method was not useful. Two (10.5%) said they did not know whether the method was useful or not, one because it was too soon to say and the other because they were not actually involved with using the method.

Respondents were asked to justify their assessment of how useful the method was by answering the question: *In what ways was the PDSA method useful?* Six respondents said that the method gave them a structure to follow. Four found it useful that the method gave permission to fail, which, as well as being liberating, allowed learning from trial and error. Five found that the method provided an opportunity to review events and reflect on them. Two found that the method helped identify and correct problems, especially early on. Other comments were that the method helped staff understand the change process and helped determine the training needed.

Responses to: *In what ways was the PDSA method useful?* in categories

[19] See webpage: NHS Institute for Innovation and Improvement

Structured approach:

Some structure to follow
Structured approach
It encouraged us to do a proper evaluation
To provide a structure for change
Gives a process to follow
Nice action research approach leading to us capturing our learning in stages.

Permission to fail:

Learning by trials is acceptable
It also gives permission for failure.
Allowed changes to be made according to learning - errors were corrected
It enabled me to plan the change, carry it out, test it and if it didn't work that didn't matter, there was still learning from it.

Review and reflect:

It provided a means of reviewing what had happened
We used it as a tool to looking at reviewing the focus of the project
It allows for good reflection and learning.
Provides validity to building in reflection and time
Identified changes to the initial project agreements and was a way of capturing these.

Identify and correct problems:

Early identification of what is and is not working, enabling adaptation early and refinement of the change process.
Allowed changes to be made according to learning - errors were corrected

Other:

[PDSA was useful] in determining training needed
Assists staff in understanding the process

*note: an entry may appear in more than one category

Respondents were also asked to indicate the limitations they found with the method by answering the question: *What were the limitations of the PDSA method?*. Six found that you had to be aware of the time being taken, since the method could be time consuming. Two found that they did not have a good knowledge of the method and that more training was needed. Three reported that they were either not sure or it was too soon to say what the limitations were. Three found no limitation with the method but there were five reports of specific problems, which are given in the box below.

Responses to: *What were the limitations of the PDSA method?* in categories

Time consuming:

Although the cycle allows for continue improvement care needs to be taken to not overload the process. - on the other hand each cycle may be overlooked due to time constrain

Typically the cycle is too long in practice

Time consuming

Not always compatible with objective timelines

Tried to do too much, too big, too soon and without the time to modify etc.

Lack of training:

Staff not offered training in this, and so for example the idea of the "small Pilot" and gradual growth and spread lost in most projects

In truth, this was not used as formally as it might have been, and I suspect it could have been of much more use if it had been more formally implemented. Staff not having sufficient knowledge of the tool.

Unsure:

Too soon to say

Timing - we are only part way through!

Not sure

No limitation:

Didn't feel too bound by it so none

None identified

None

Specific problems:

Whether the next course of action would provide the expected outcome

Not always compatible with trust processes

It's a process but doesn't give out the answers

If the project doesn't go completely to plan you need to adapt

Did not capture the whole of the issues which needed to be recorded. Ended up writing things in the boxes which we thought was meant to be included, when not being so clear.

*note: an entry may appear in more than one category

7.2 Other approaches

All persons, whether they used PDSA or not, were asked: *What other approaches to improvement have you adopted?* Of the nineteen PDSA users 5 used formal methods, which were: impact mapping, fish bone [diagrams], RACE, 4-D Cycle, ROI. Six of the nineteen used more informal techniques ranging from service improvement models to simply "being persistent, focussed, and committed". Seven reported that no other method was used. The remaining one held that the question was not applicable, saying that this was "Not something I'm involved in to answer".

Of the nine who did not use PDSA, 7 said they used no other method, including one reported having actually used PDSA but they failed to complete the paperwork. One used the formal method action research and another used an informal method similar to PDSA. The combined results for the sample as a whole, where the formal method category includes PDSA, are given in table 7.2.

Table 7.2: Improvement methods used

	Frequency	Percent	Cumulative Percent
Formal methods	20	71.4	71.4
Informal methods	1	3.6	75.0
None	7	25.0	100.0
Total	28	100.0	

Thus taking the sample as a whole, 75% (21 respondents) reported using some method, either formal or informal, whereas 25% (7 respondents) said they used no method at all.

8. Further comments

The final question of the questionnaire was an open question that allowed respondents to make any further comment, if they wished to do so. Six of the twenty-eight actually entered a response, albeit one stated that they did not wish to comment at this stage since their project was far from completed. The responses are given in the box below and range from very general to very specific observations on working on their Pacesetters Workforce project.

Responses to: ***If you wish to make further comments please do so:***

Consistency and meaningful documentation is vital in project management; for instance, if the project lead or programme manager leaves or is absent someone else can pick-up the work. Ownership of the project brings success - clarity of roles is essential. Good planning will lead to less difficulties running a project.

Pacesetters is a good driver to initiate change within an organisation.

Appreciation required of the workload involved in undertaking the project when this was an additional part to the leads current role, so not enough time could be spent on the project as would have liked.

We are first wave sites and there we did not have the opportunity to pre-plan our work in the manner the second wave have done. This was new territory and very much based on what we could do that was an essential requirement. We didn't have the opportunity to be very creative or innovative. BUT we have now after a long process got the First Contact Scheme.

I found the training day on workforce projects in London very unhelpful and did feed this back

Not at this stage - we look forward to the full evaluation at the end of this project as we have much more to make happen.

Appendix J

Follow Up Survey

1. Introduction

The Pacesetters programme is a change initiative, and so this survey aimed to find out about two areas of change in Pacesetters Workforce Development projects.

One area of change applies to the period since the Pacesetters Workforce Development Evaluation survey in February 2010 and is concerned with the change that occurred in a Pacesetters Workforce Development project where the project did not run as originally planned. This unplanned change was divided into two main parts: change that has been due to external factors in some way, for example: re-organisation, reduction in resources, and change that arose through the project naturally evolving, for example: re-adjustment to reflect learning.

The second area of change is concerned with the legacy of a project, since, even after a Pacesetters Workforce Development project finishes, it is likely to have a continuing impact. The survey aimed to find out what respondents thought would be the likely legacy of their projects.

This survey, a follow-up survey to the first Pacesetters Workforce Development Evaluation survey carried out in February 2010, was conducted in September 2010 to investigate these areas of change.

2. Data collection

The survey made use of an online questionnaire developed using the Bristol Online Surveys (BOS) software package. The BOS software package had been successfully used in the first Pacesetters Workforce Development Evaluation survey conducted in February 2010 and was used again for the same reason: an online method, rather than a postal or telephone survey, ensured respondents had a simple and convenient way of participating, which thus helped promote a greater response rate. As before, the survey was confidential, rather than anonymous, in that the identities of the respondents were known to the survey team, but this information cannot be determined from this document. Having this information was useful in that it enabled the survey to ensure that no one could bias the survey by submitting multiple entries, the NHS Trust and SHA the respondent worked for could be determined and tardy respondents could be prompted by a reminder email.

To each person in the population, an advance email informing of the forthcoming survey was sent out 4 days before the survey opened. An invitation email, containing the person's unique survey login details and a web-link to the online questionnaire, was sent on the opening day of the survey. The survey was open for ten days, and three days before the survey closed, a reminder email was sent out to those who, at that time, had not yet responded.

3. Basic data

The 52 persons invited to take part in the February 2010 survey formed the initial population for this survey. Following receiving advance notice about the follow-up survey, some replied that they were no longer part of the Pacesetters programme, and some of these helpfully gave contact email addresses of those who were now likely to be suitable to take part in this follow-up survey. The net result was that 50 persons were actually invited to take part in the follow-up survey. Of these 50 persons, 15 responded. Nine of these 15 had taken part in the February survey. Of the 6 new participants, 4 had been suggested by participants from February's survey who could not take part in the follow-up survey, and 2 had been invited to last February's survey but had not taken part then. Fourteen of the respondents from the February survey did not participate this time.

Fifteen respondents from a population of 50 is a response rate of just 30%. Since the entire population was invited to participate but just under one third actually did, the sample is clearly self selected, so caution should be exercised if generalising the results from the sample to the population as a whole. Further, a random sample of this size from a population of this size would give, for a 95% confidence interval, a margin of error as high as ±21.4%, which adds further to this caution.

The response rate of 30% (15 respondents from 50) is somewhat lower than the response rate of 53.8% (28 respondents from 52) from the first survey in February. However, only 35% (14 projects from a total of 40) of the first sample's projects were expected to be still running at the time of this survey and 85% (17 projects from a total of 20) of the follow-on sample's projects were still running: it appears that most of the original sample whose projects were still running did respond to the follow-up survey, but those whose projects were no longer running did not respond. It may be that a number of those who responded in February were less inclined do so this time because their project had already finished. In addition, one person contacted the team to apologise for not being able to participate, since "due to the organisational change taking place in the Trust, it is not the right time to carry out such an evaluation."

3.1 About the respondents

Respondents worked in trusts that came from all the Strategic Health Authorities taking part in the Pacesetters Programme, as shown in Table 3.1

Table 3.1: Strategic Health Authorities represented

	Sample Frequency	Population Frequency	Response by SHA
East Midlands SHA	1	7	14.3%
London SHA	1	7	14.3%
South East SHA	2	8	25.0%
South West SHA	5	9	55.6%
West Midlands SHA	2	5	40.0%
Yorkshire and The Humber SHA	4	13	30.8%
Unknown	0	1	0%
Total	15	50	30.0%

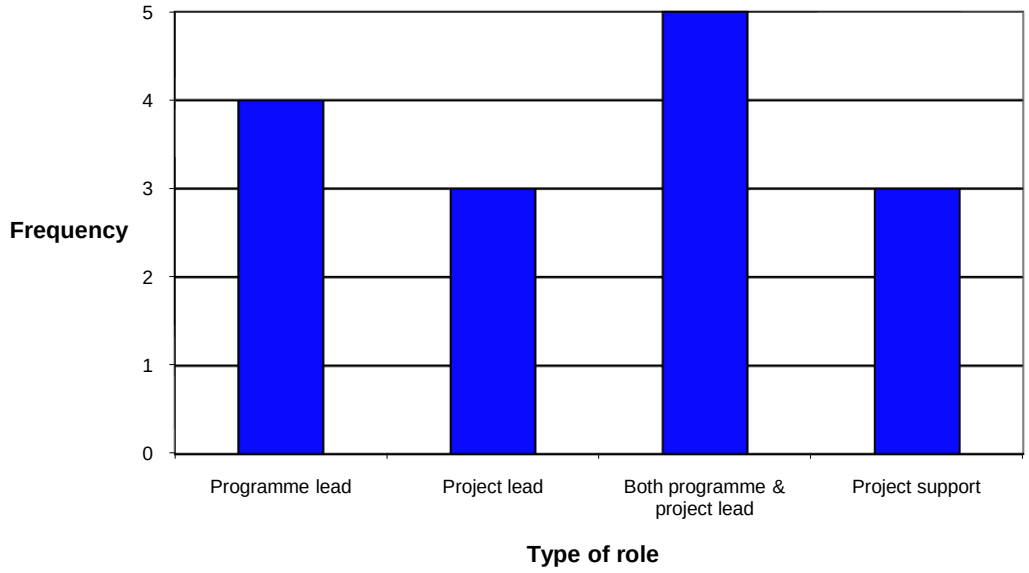
By far the majority (86.7%) of respondents worked in primary care trusts (Table 3.2).

Table 3.2: Distribution of sample by trust

	Sample Frequency	Response by Trust type
Foundation Trust	0	0.0%
Primary Care Trust	13	86.7%
Ambulance Service Trust	0	0.0%
Acute Health Trust	1	7.7%
Mental Health Trust	0	0.0%
Learning Difficulties Trust	0	0.0%
Specialist Trust	0	0.0%
Community Health Trust	1	7.7%
Total	15	100.0%

Most respondents (13, 86.7%) worked in a permanent rather than temporary post, and most (12, 80%) were in full-time employment. Respondents worked on the projects as either programme lead, project lead, in a combined programme and project lead or in a support role to the lead in roughly equal numbers as shown in Figure 3.3

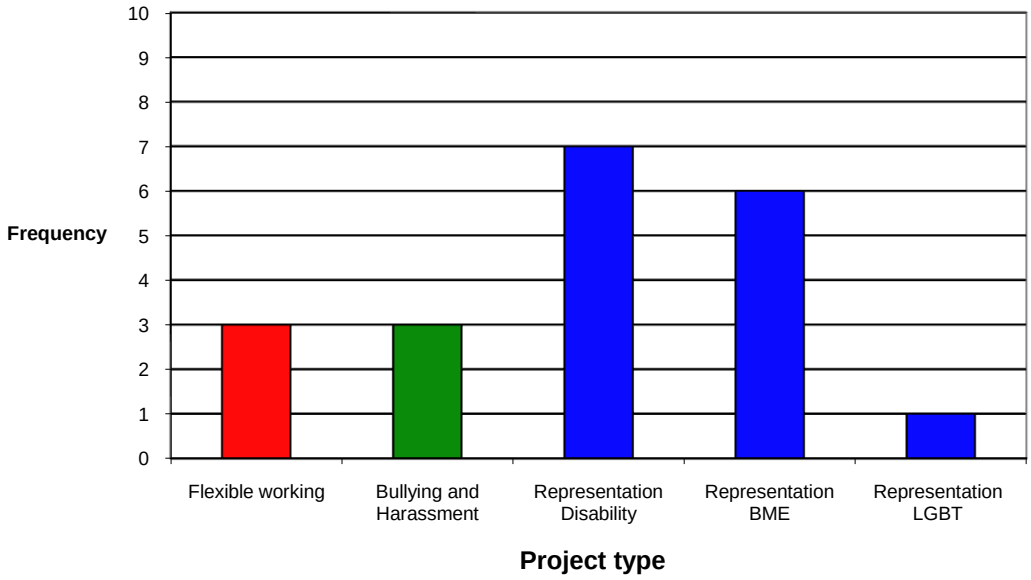
Figure 3.3: Distribution of sample by role



4. Workforce Development Projects

The 15 respondents worked on a total of 20 different projects, and most of these projects (14, 70.0%) were representation projects, which were disability, BME and LGBT projects (figure 4.1).

Figure 4.1 Distribution of all projects by type



Most of the projects (17, 85%) were still running at the time of the survey: 2 of the 3 Flexible working projects, 2 of the 3 Bullying and Harassment projects and 13 of the 14 Representation projects. The 3 projects that were no longer running had stopped because they had reached a planned finish.

4.1 Unplanned changes

The Pacesetters programme is concerned with effecting change and the first area of interest for this survey was the change that happened where the project did not run as originally planned. Of the 20 projects, only 5 had not, since February 2010, run as originally planned. Since most projects in the sample had started over a year before, it is likely they had attained a maturity that increased the likelihood of smooth running. All of the five projects that had not run as originally planned were representation projects: 2 Disability projects, 2 BME projects and 1 LGBT project.

The unplanned change was divided into two main parts: change that has been due to external factors in some way and change that arose through the project naturally evolving. The change due to external factors was further divided into change that had been positive and change that had been negative for the project.

Asked what the most significant positive external factor was, the answers were diverse: one respondent stated new leadership, another stated improved policies and procedures and two stated improved partnership working. When asked what was the most significant impact of the positive factors, answers were again diverse: four respondents each made different replies: new ideas emerging, the initiative being taken up by other organisations, improved partnership working, improved relationships between staff. One respondent reported no positive external factor at all.

Asked what the most significant negative external factor was, the answers were again diverse: one respondent stated re-organisation, another stated the loss of the project lead, another stated problems in management arrangements and communication, and another stated conflicting demands of other Pacesetters projects. When asked what was the most significant impact of the negative factors, answers were once again diverse. The replies were: increase in conflicting demands, changes in staff, a freeze on recruitment as part of a savings drive and two said stalled progress.

The subgroup for whom there were unplanned changes numbered only 5, so discerning a pattern is, at best, tentative. However, it does look as if projects can be subject to very different external factors and impacts, and this applies whether the external factors are positive or negative.

Regarding change that naturally evolved, participants were asked what had made the most significant contribution to the initiative. Given a choice between continual learning, top management support, passion of the change agents, networks created, using PDSA, drawing on community experience and the opportunity to state an influence of their own, 4 of the 5 respondents stated passion of the change agents. The fifth said it was too soon to say. Asked for their reasons for their choice, three gave replies:

- "Having one person who had a passion to see progress and success was what made our project successful initially. When they left (to go onto maternity leave) the project stalled significantly."

- "Very dedicated and passionate project worker championing the project and working with a range of partners to implement the best outcomes possible given the constraints."

- "Accountability for the project appears to be somewhat unclear, but the passion of the individual change agents remain strong."

These responses give the clear message that the passion of change agents, sometimes just one who leads, is key to the success of a project.

4.2 Legacy of projects

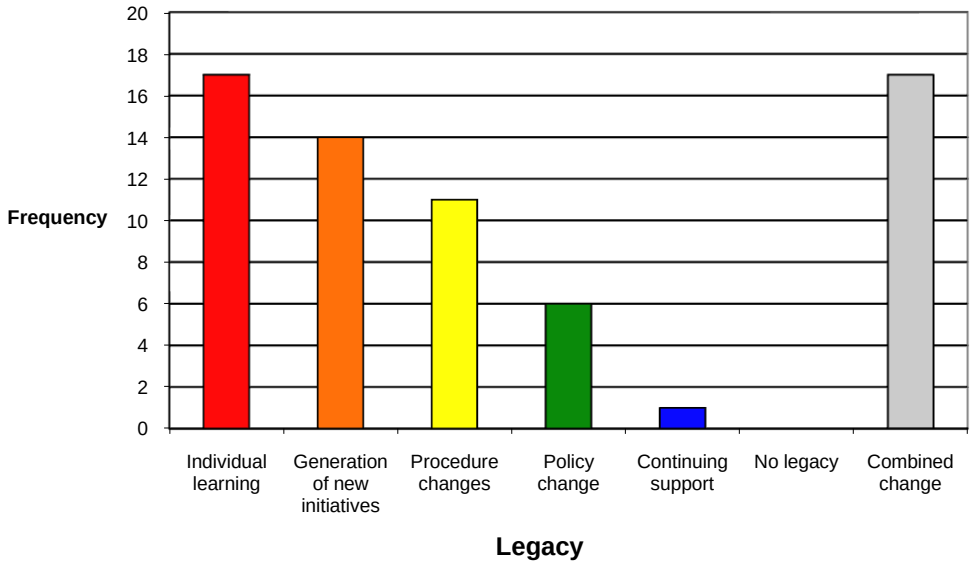
Even after a workforce project finishes, it is likely to have a continuing impact. Each respondent was asked what they thought would be the likely legacy, however small, of each project they were involved in. The question offered a number of possibilities for selection, asked the respondent to select all those that applied and allowed for the respondent to name other legacies, if appropriate. The most popular choice was individual learning, selected for 17 (85%) of the 20 projects, followed by generation of new related initiatives (14 projects, 70%) (table 4.2). No respondent thought there would be no legacy from a workforce development project.

Table 4.2: Likely legacies of project

Legacy	Frequency	Percent
Individual learning	17	85.0%
Generation of new related initiatives	14	70.0%
Changes in procedures	11	55.0%
Policy change	6	30.0%
Continuing support	1	5.0%
No legacy	0	0.0%

However, changes in practice could be expressed as either policy changes or changes in procedures, and combining their scores gives a total for changes in practice of 17 (85%), the same score as the most popular choice, as shown in figure 4.3.

Figure 4.3: Likely legacies of project



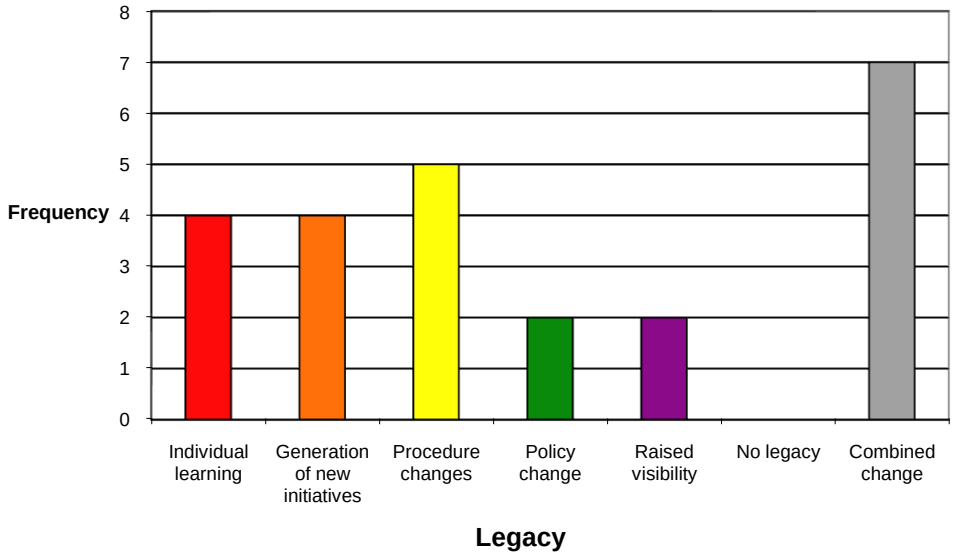
Further, each respondent was asked to identify which *one* their choices they thought would have the most impact, and to give the reasons for their choice. Three respondents did not answer this question, despite answering the question about likely legacies. Two respondents said that the legacy with most impact would be the raising of the visibility of the subject the project dealt with. Changes in procedure was the legacy likely to have most impact (table 4.4), though individual learning and the generation of new related initiatives had scores not far behind.

Table 4.4: Likely legacy of project

Legacy	Frequency	Percent
Individual learning	4	23.5%
Generation of new related initiatives	4	23.5%
Changes in procedures	5	29.4%
Policy change	2	11.8%
Raised visibility	2	11.8%
No legacy	0	0.0%
Total	17	100.0%

Again, if the score for changes in procedure is combined with the score for policy, then with a combined score of 7 out of 17 (41.2%), changes in practice is easily the legacy likely to have most impact (figure 4.5). Since Pacesetters is a change initiative, this is a significant finding about the Pacesetters Workforce Development programme.

Figure 4.5 Likely legacy of project



When asked for the reasons for their choice of legacy that would have the most impact, a number reported on the learning gained through the Pacesetters programme. In particular, they had learned that changes in practice do bring about improvements, especially for the disabled, BME and LGBT sections of the workforce and that flexible working policies can benefit both the organisation and the individual. Some expressed concern whether such learning will be sustained given expected changes in the future, including that that primary care trusts will no longer be operational. Some in BME and LGBT projects reported that these projects had helped raise awareness of the difficulties faced by these groups.

5. Further comments

The final question of the questionnaire was an open question that allowed respondents to make any further comment, if they wished to do so. Just 3 of the 15 (20%) actually entered a response.

Responses to: ***If you wish to make further comments please do so:***

We have not managed to find a way to really embed the project and disseminate the taking on of similar projects. The project will succeed because of the enthusiasm of a small group of people - but as soon as they leave, any continued progress will stop. It seems (as with many things) employee commitment and a personal desire to contribute to the achievement of an equitable society are the main "push" factor in terms of success.

The project specifically concerns learning disability. The people we have worked with and employ bring a tremendous pride and enthusiasm to their work which affects all colleagues around them.

Pacesetters has been a valuable project. It is unfortunate that wider changes seem to have resulted in the central team and support winding down early, which may impact on the wider dissemination of learning and good practice.

Through their final comments, respondents have expressed the view that Pacesetters Workforce Development projects can be and have been successful, but there is concern about this success being maintained and spread, since this depends not only on maintaining funding but also on retaining a core group of dedicated people.