King's Fund

Up the down escalator?

Health at Work implementation programmes in selected NHS Trusts

An evaluation and frameworks for understanding

Final Report

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Preface

The central finding of this evaluation, supported by parallel project fieldwork (Seymour 1998) and quantitative research (CHKS 1998) is that effective workplace health interventions are possible in the changing world of the National Health Service.

This apparently bland conclusion is nonetheless a very significant one. We conducted this research in the context of a growing body of evidence that workplace health across the NHS is deteriorating – particularly for key groups of senior management and clinical staff (Williams et al 1998 and Patterson et al 1997). This finding is echoed by the new Human Resources Strategy for the NHS *Working Together: Securing a Quality Workforce for the NHS* (Dept of Health 1998b). Attrition within a highly committed, skilled workforce is not what is needed at a time of major policy-led change!

This emerging contradiction – between the need for substantial change, well led by these same key staff groups, and evidence that they are suffering high levels of organisationally induced stress – has led us to ask: ***'What do you do if you really want to improve something in your organisation?'*** This question is directed at the leaders and managers of NHS organisations. Key colleagues in the trusts in which we worked made their own considerable attempts to address this challenge. At one level this document reports on the outcomes of their efforts and our evaluation of the factors which helped or hindered. We also offer our reflections on a national programme of work, commissioned and supported by the Health Education Authority, which has begun to open up **the workplace health agenda as an organisational and leadership development agenda.**

From a complex, collaborative research and evaluation strategy we have established that:

- Workplace health interventions supported by highly skilled teams, focused on priority needs, *can* make a positive difference to workforce health and even in some circumstances realise a high financial return on investment
- Leadership style and management culture can have a positive effect on workplace health where they are characterised by openness, rigorous support for the Health at Work Team, and a willingness to tackle poor and dysfunctional management

- Leaders and managers who do not do this are bad for the NHS workforce; and even open and aware executives can miss emerging staff health needs and become over-zealous in their management of the change agenda

- 'Stress' is code for over-work (running up an accelerating down escalator); lack of investment in supporting staff through change; ignoring real needs (e.g. violence against staff); and plain abuse (bullying and discrimination in all their forms)

- Investment in support for individuals wishing to change their personal lifestyles (smoking cessation help, staff gyms, healthy eating/catering, etc.) is appreciated as a means of valuing staff. However, so many other factors influence individuals' physical health that we found no significant quantifiable impact on sickness absence in our cost/benefit analysis of the impact of the staff gym in one of the trusts studied

- Sickness absence systems can be improved; but the causes of staff sickness are not addressed by this systems' improvement. Our interpretation is that the internal market reforms have created a damaging context for the health of the NHS workforce and that it will take a new, much more inclusive approach to leadership and management to create circumstances whereby professionally led workplace health interventions will make a sustainable positive difference. The best practice described in this report 'signposts' the way forward. **The will to reflect on and learn from this is the next key requirement.**

Summary

1. Policy context

We report at time when a series of major reforms introduced by White and Green papers are having an impact across the NHS – *The New NHS, Modern, Dependable* (Dept of Health 1997a) and *Our Healthier Nation: A Contract for Health* (Dept of Health 1998). Work*force* health connects the two internally for the NHS, linking the work*place* health focus of public health policy to the major change agenda of *The New NHS*. We assumed from the outset that there was and is a continuously evolving interaction between the management of workplace health, and the leadership and management of change, which has potentially profound implications for local workforce health in NHS trusts.

2. Basis for our findings

Our findings are principally based on work with two Demonstration trusts and two Reference trusts over nearly three years. They also reflect our close collaboration with our research partners (the HEA itself, IES*, CHKS** and Linda Seymour) covering a wider group totalling fourteen trusts, as well as related work on a broader front.

Our methodology was grounded in a complex systems view of the changing organisational world, designed to enable us to work with and within these trusts as they responded to new external and internal forces (see Chapters 2 and 3).

Implementing the Evaluation

Working in complex changing local health systems necessitated the use of a 'toolkit' of methods. The use of each tool provided different evidence in relation to our initial research questions:

How are we doing at becoming a health promoting trust?

What are we learning about learning to become a health promoting trust?

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* Institute for Employment Studies

** Originally our work was with CASPE, now part of CHKS (CASPE/Health Care Knowledge Systems)

Findings emerged from this fieldwork which began to illustrate the challenge of sustaining workforce health in a context of growing resource pressures, technological, epidemiological, and politically-driven change. The significance of organisational circumstances and culture, of management style, and of the approach to workplace health interventions all become much more apparent during this phase of the evaluation. Throughout this period we also addressed the continual tension between our eclectic, reflective approach to evaluation and the 'cause-effect' thinking that tends to characterise programme evaluation in the NHS.

3. *Diversity and confusion about the meaning of HaW is widespread: the HEA could help to clarify it*

What people mean by or see as included in *Health at Work in the NHS* (HaW.NHS) can be very different. Several groups and individuals said they wished there were a clearer and more widely accepted view, and there may well be a role for the HEA in developing and promulgating a more inclusive description. It became increasingly clear that there are dichotomies – between the central and local perspectives, and between staff and management perceptions of what HaW means.

Interpretations cluster into three overlapping groups in a rough hierarchy (see Chapter 6):

- Prevention of harm to health
- Promoting individual healthy lifestyles
- Integrating HaW with trust strategy.

4. *The emphasis nationally needs to shift and broaden to recognise the importance of organisational as well as individual factors affecting staff health*

Until recently, the HEA has placed most emphasis on promoting *individual* healthy lifestyles in its Health at Work programme. By contrast, staff reported to us, and to other researchers in the last couple of years, that their main concerns about Health at Work were to do with *organisational* factors: the pressure of work, the pace of organisational change, and most particularly how that change process is managed locally; and the prevention of harm to physical health.

Levels of individual stress in the NHS (as measured by the proportion of staff scoring more than 3-4 on the GHQ12 mental health scale) are high relative to those in non-NHS organisations studied. In the NHS, 27% of staff reported this level of stress compared with 18% in non-NHS organisations (Borrill 1996). There is a 2:1 range between trusts and between different staff groups, with the highest proportions reported (at about 40%) for female managers and doctors.

In health and safety and manual handling, for example, some trusts were not yet seen as even complying with basic legal requirements, in spite of strong external sanctions for non-compliance.

Because staff report that they pay attention more to what managers *do* than to what they *say*, this means that the *manner* in which organisational change is carried through (and not just how it is talked about) makes a huge difference to people's ability to handle it well and constructively, and hence to their mental health.

If managers neglect even legal requirements to prevent harm to physical health, how can they be trusted to have concern for less tangible but equally important aspects of mental health, especially in times of major change?

5. Confusion also arises because activities take place on widely varying scales, located in different parts of the organisation

Different scales of HaW activity cover a wide spectrum, including (see Box 6.1 in Chapter 6):

- Individual (time limited) *projects*
- Individual *ongoing activities*
- *Generic processes* to foster health at work in particular areas of the trust
- Linked *programmes of activity* across the whole trust
- *Strategic consideration* of HaW connected with the overall priorities and strategy of the trust.

Activities might be centred around one or more of the functional departments of occupational health, health promotion, health and safety, and human resources, or be part of broader management initiatives such as team briefing. The extent to which activities were seen as linked explicitly to HaW, or even connected organisationally, varies widely both between trusts, and within them. This variation largely reflects the degree of ownership of HaW at a strategic level.

6. Management must choose how to respond to HaW concerns — and attempt to move from a marginally compliant to a strategic and integrated response

Our research partners, CHKS, developed with us a typology of trusts' responses to HaW ranging from *marginal*, through *instrumental*, to *integrated* (CHKS 1998).

Marginal trusts tend to be minimally or even incompletely compliant with legislation, and to have a low level of HaW activities, mostly towards the individual project end of the spectrum described above, not necessarily explicitly identified as con-

nected with HaW. (More trusts in the CHKS sample were in this group than in the others).

Instrumental trusts see HaW mainly as an 'instrument' for reducing sickness absence, and will tend to have a somewhat broader mix of occupational health, health promotion, health and safety, and management activities directed towards that end.

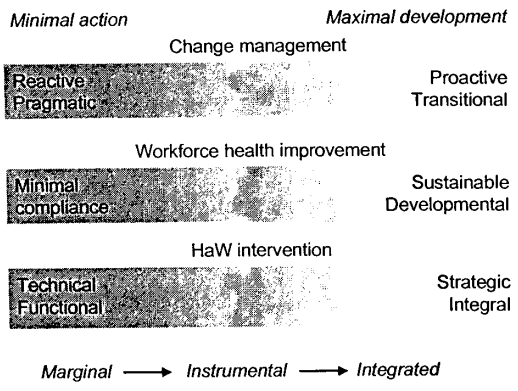
Integrated trusts will be striving towards a better connected and principled response to staff concerns about health, will have a wider range of activities identified with HaW at most points along the spectrum, and be developing a strategic sense of the links between HaW and the overall priorities of the trust. One each of the demonstration and reference trusts were making significant if still partial 'integrated' and strategic responses to HaW.NHS.

Given the constant or increasing pressures on most trusts from long term health and demographic trends, financial constraints, and central policy initiatives, **attempts to improve workplace health will do well merely to prevent deterioration – trusts are running up the down escalator** (Chapters 1 and 6). Trust boards and management which take on board the importance of staff health to the successful delivery of (intensely personal and individually provided) health care services will find it increasingly helpful to build consideration of HaW into their overall strategies. Without that, they run growing risks of failure to sustain their own and the staff's ability to *continue* to perform under pressure (Chapter 5, and Fig 5.4).

Yet the range of potentially useful interventions to sustain workplace health is too large for even most of them to be followed by any single trust – so trusts have to choose their strategic priorities in the light of locally determined HaW needs.

7. Trusts can learn how to improve HaW, and need to do so to deliver on the government's white and green papers agenda

The findings from our evaluation can help trusts to improve HaW, or at least prevent staff health from deteriorating. Three inter-related processes combine to influence workforce health improvement (Fig 7.1, reproduced below)



Helpful learning points include (see Chapter 6, section 6.8):

- set realistic expectations, and explain 'HaW' consistently and widely in the trust
- establish an ethical basis for action on HaW – and acknowledge and respond to the emotional blockages which make it difficult for NHS staff to look after their own and their colleagues' health: *avoidance* – 'patients always come first'; *denial* – 'that's occupational health's responsibility so I don't need to do anything'; and *collusion* – 'we have a multi-disciplinary HaW group so it must be being dealt with'
- recognise the current shifts in the HaW agenda in setting overall organisational priorities – and acknowledge that new elements of the agenda will continue to emerge
- use a systematic and analytic method of identifying local HaW needs and priorities – for example, using the CHKS Self Assessment tool – and continually adapt it to recognise newly emergent needs
- develop organisational capabilities and relevant skills to support a wide range of HaW activities, and progressively connect them organisationally
- use the frameworks described throughout this report to help you see where you are now, and to plan for improvement – this is about how you **are** as much as what you **do**
- establish a reflective approach to learning from your own, your colleagues' and your organisation's experience.

Above all, we offer in this report different ways of thinking about managing the process of sustaining or improving work*force* health. We describe some insights into the relationship between the development of change management capabilities in health organisations, and the planning and implementation of HaW interventions in the work*place*.

Our principal message is that the evidence from the research and the evaluation, taken together, demonstrates that organisations can (and must) positively influence sustainable workforce health provided that they focus on those factors over which they have direct control:

Leadership style	- how change is addressed throughout the organisation
Management culture	- what managers do with staff
Workplace health	- the investment in and support for those with a lead responsibility (both corporately and within service units)
Staff development	- a continuous open process of learning and involvement.

Summary

The new HR Strategy for the NHS makes workplace health a central, ***essential*** element of trust boards' responsibilities towards their staff. This report offers some new ways of thinking about and engaging with this fundamental principle of good management.

Chapter 1

An ever-changing context

The purpose of this chapter is to explain the challenges of delivering workplace health in the modern NHS, and of evaluating it during a period of major change.

'Change has become very, very personal' — Nurse Manager

'Little things can mean a lot' — Clerical Officer

'We have got to get away from the 'unit of production' approach to managing and delivering health services' — Chief Executive

National drivers for change

Since the beginning of 1998 the new Government has launched a White Paper, *A New NHS – Modern, Dependable* (Dept. of Health 1997a) and a Green Paper *Our Healthier Nation: A Contract for Health* (Dept. of Health 1998). The former is designed to reform the NHS by building on principles of co-operation, continuous service improvement, clinical governance and rigorous stewardship of public resources. It is intended to remove the bureaucracy and conflict perceived to have been created by the reforms of the late 1980s and early 1990s, by replacing the 'internal market' system with locally negotiated agreements between Health Authorities, Primary Care Groups, and NHS trusts. The Green Paper identifies key targets for health improvement and *inter alia* initiates 'a contract for Healthy Workplaces' (para. 3.78):

> *Our aims in developing the healthy workforce are twofold. First, to improve the overall health of the workforce; and second to ensure that people are protected from the harm to health that certain jobs can cause (p.51)*

The document goes on to propose a tripartite contract for Government, employers and employees which indicates how these aims might be achieved. Thus, an initiative promoted and supported by the Health Education Authority (HEA) entitled *Health at Work in the NHS* has the potential to contribute much to the development of NHS organisations as they address the new policy agenda while endeavouring to sustain and improve workplace health. This agenda is considerable and is at the focus of a set of forces that offer a mounting challenge to the diverse groups that constitute the NHS workforce.

Box 1.1 The critical context of the NHS

The continuing impact of regional and local socio-economic inequalities

A growing proportion of the 'Health £' (65% +) is absorbed by people with long-term complex, chronic conditions

The potential for epidemics/pandemics of communicable diseases is increasing globally (e.g. HIV/Aids; TB)

Public expectations of health care systems far exceed possible improvements – on an increasingly informed basis

Scientific advance and technological innovation will continue to drive up revenue and capital costs in health systems

Indeed, the workforce itself is changing (Schofield *et al* 1996) and the White Paper will create a context of continuous structural and functional development – let alone cultural development – across the NHS, for the next ten years. **The 'Workforce Agenda' is the 'hidden' strategic agenda for the health and social care sector.**

Strategic HaW needs of NHS staff

The critical forces noted in Box 1.1 all have implications for people who choose to work in the NHS, resulting in an almost continuous set of demands for staff development and support.

Box 1.2 The strategic needs of NHS staff

Personal development: growing the capacity to anticipate and respond to significant change

Work practices: acquiring and developing new skills as patient/client needs change and as services are reconfigured

Generic and specialist: developing the adaptability to work generically within services and/or as a specialist within a team (e.g. in cancer care)

Leadership: learning to facilitate others in responding to change

Partnership: working collaboratively across traditional professional and organisational boundaries

This agenda is evolving at a time of skill shortages, redundancies, reorganisations and service reviews, mergers and closures, and — at a national level — continuing uncertainty about pay and the funding of training and professional development. Throughout the evaluation we saw evidence of the impact of all this change working its way through in different ways for different staff groups in the trusts. Concurrently, these organisations were achieving significant improvements in performance — one trust treated fifteen percent more patients with five percent fewer staff in one year alone — in a climate of attrition and mistrust as the pressures of the internal market resulted in an increasingly adversarial approach to contracts management. Anxiety and fear were characteristic of this climate.

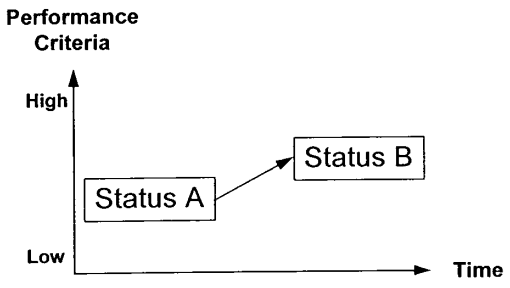
How change is managed has the biggest impact on staff health

Tremendous determination and enthusiasm are displayed in support of service innovations and local initiatives. Thus, one of our primary, and almost self-evident findings, was that **in this context any new intervention had an impact on staff health, especially their mental health.** This finding echoes the focus in the Green Paper on the workplace and its significance not only in the prevention of harm to health in relation to safety and known health risks but also in respect of the reduction of stress *(The Healthy Workplaces Contract)*.

We shall return to this theme later and, in noting the changing circumstances of the focus of our evaluation, it is also worth reflecting on the changing role of the HEA as the originator and 'owner' of *Health at Work in the NHS* (HaW.NHS).

The central desire for measurable results from HaW.NHS interventions cannot be met at a whole-organisation level

Central agencies, including Special Health Authorities like the HEA, face a particular challenge when investing in the development, implementation and evaluation of programmatic interventions such as HaW, NHS. The goal, over a given period of time, is to achieve measurable improvement:



For a return on investment in HaW.NHS to be measurable in this way, a trust would have to be seen to raise its overall level of performance in relation to workforce health from status A to status B.

We found that the extremely dynamic, ever changing context in which many unpredicted factors affected NHS trusts and their staff, means that the impact of interventions made under the HaW.NHS scheme cannot easily be measured at the whole-organisation level, although some assessment could be achieved at the level of a carefully specified project. (See our analysis of the local Cost Benefit Analyses in Appendix A, and the correlation between our work and the CHKS quantitative findings, Chapters 5 and 6.)

Preventing staff health from deteriorating is a substantial achievement in this context

Our second contextual finding, strongly affirmed by colleagues in the trusts, was that **to sustain the health of staff in the current level of organisational change is in itself a substantial success**. The notion of work*place* health promotion is unrealistic and even a disincentive to hard-pressed staff. (Work*force* health promotion is another matter which is addressed below in Chapter 2.)

The research partnership approach of the HEA was much valued

Finally, in this review of the context in which the evaluation was conducted, we wish to note the changing role and style of the HEA (as the previous government's 'internal market' values are dissolving across the NHS). We very much value the 'research partnership' approach adopted by Errol Walker and Julie Bull of the HEA research management team. It has enabled us to work constructively with our other research partners and the four participating trusts.

Our research partners, in addition to Errol and Julie of the HEA, were Linda Seymour (the HEA's 'field' worker) and the CHKS team of Linda Howard, Ian Campbell, John Smith and Andrea Williams. This has been a demanding collaboration – not always comfortable – and it afforded triangulation of findings from three very different arms of the research. This interactive research strategy has much to offer the HEA as it repositions itself in relation to the modernising NHS.

Four trusts participated in the main evaluation programme

After an aborted attempt to begin the evaluation with a single trust, which later withdrew from the project through other pressures on senior management time, we engaged with a wider group of four trusts (referred to later in this report as A, B, C, and D), in two groups.

Trust A is a semi-rural community and mental health trust offering a range of services through an increasingly devolved structure.

Trust B is a city centre acute trust and teaching hospital serving socially diverse communities

Trust C is a semi-rural acute trust serving a county town and a widespread rural community

Trust D is an inner urban acute trust in one of the most economically disadvantaged areas of the UK.

The first two acted as 'reference sites' with which we had interactions limited to selected interviews and meetings with a reference group near the beginning, middle and end of the evaluation period.

The second two constituted 'demonstration sites', with which we had more substantial involvement. In addition to our interview and reference group processes, the sites engaged with the HEA's field worker, initially to assist in making some of their HaW.NHS interventions. We too had more involvement with these sites than with the reference sites: through a wider range of interviews; a series of focus group meetings with those affected by particular local HaW.NHS initiatives of various kinds and scales; and greater involvement in local self-evaluation and reflection with the local HaW.NHS team. This approach was highly congruent with our philosophy of Developmental Evaluation (see also Ovtretveit 1998) which placed reflection and sharing learning at the centre of the project.

During the lifetime of this Evaluation a number of key reports have been published which focus on the health of the NHS workforce. These are reported in the new HR Strategy for the NHS (Dept. of Health 1998b):

> There is now research evidence from the NHS itself that poor staff management contributes to factors which damage the delicate infrastructure and networks that deliver patient care and in turn exacerbates staff turnover, low morale, and workbased stress and exhaustion.

We welcome the acknowledgement of these findings and hope that the evaluation report which follows contributes to improved health for the many committed NHS colleagues with whom we worked and their peers in the trusts and in the local networks of partner authorities and agencies.

Chapter 2

Background and rationale for the evaluation

In this chapter we explain the emerging rationale for the complex evaluation methodology and the reasons for choosing particular workplace health issues.

2.1 Initial assumptions

Our original proposals to the Health Education Authority rested on the following main assumptions:

- A centrally originated programme like *Health at Work in the NHS* (HaW.NHS) would encounter significant local sensitivities which would be different for every trust or health authority
- 'Hard' and 'soft' measures of input, process and outcome would be needed for an effective evaluation
- Trusts would face immediate/short-term needs in respect of workforce health which might conflict with the complementary goal of producing transferable learning for the longer term (and that this was an ethical issue)
- The vision (and rhetoric) of workplace health promotion can appear to contradict trusts' needs for focused, concrete deliverables
- The NHS is changing rapidly at all levels: paradigmatic, structural, systems, working practice and contextual (see Chapter 1)
- It is valid to treat trusts as open, complex systems (Morgan 1984)

A developmental evaluation approach fitted the context

In preparing ourselves for this work, we were very clear that we should develop an approach which took account of these factors by ensuring that the participating trusts and their staff experienced an evaluation which was intrinsically developmental. That is, we were explicitly not proposing an evaluation which attempted to provide an 'objective' cause and effect analysis of HaW.NHS. Instead, we developed – and are continuing to develop – a method which encouraged reflective practice

within workplace health interventions. The design was also intended to complement the research strategy of IES (Institute of Employment Studies), later replaced as research partners by CHKS.

Central to the design were two questions posed from the point of view of the trust and its HaW team:

How are we doing at becoming a health promoting trust?

What are we learning about learning to become a health promoting trust?

These questions were themselves later challenged, and modified, by the participating trusts themselves (see Chapter 5).

2.2 Evaluation in a complex environment

Our original King's Fund proposals assumed that NHS trusts can be treated as *open, complex and adaptive systems* existing in an increasingly turbulent environment (Wheatley 1995, Stacey 1996). This view, as opposed to the dominant structural-functionalist model which ostensibly underpins most trusts' organisational arrangements, enabled the team to identify the three key concurrent processes whose interactions need to be researched and understood if the impact and effectiveness of HaW.NHS *locally* was to be evaluated.

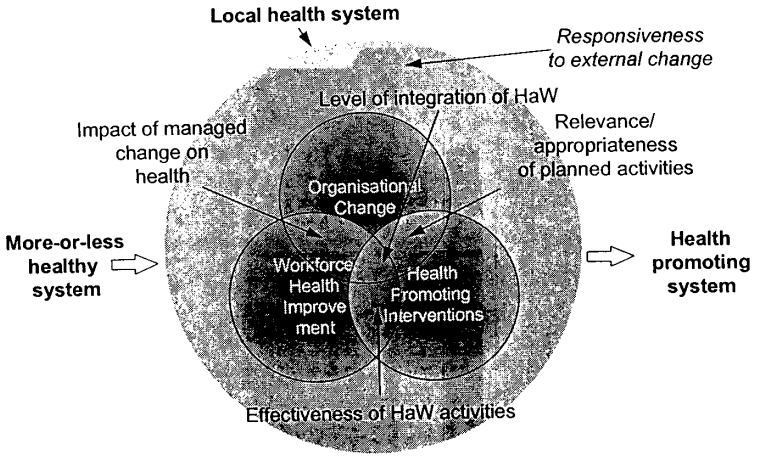


Fig 2.1 Interaction of factors affecting workplace health (theory)

We needed to develop evaluation practices which enabled us to work within this complex, changing system. However, as our colleague Eva Lauermann pointed out, the nice symmetry depicted above is in reality replaced by a very unbalanced picture in which the reality of organisational change dominates the other two elements by a large margin.

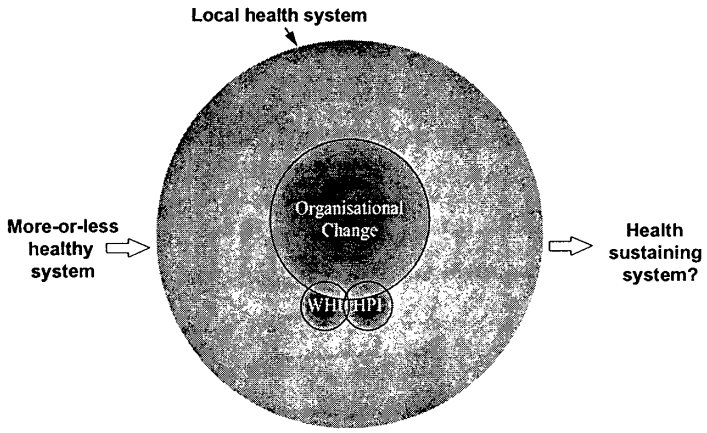


Fig 2.2 Interaction of factors affecting workplace health (reality)

2.3 National external stakeholder group

In order to test this model from the outset we established and facilitated a National Stakeholder Group process. This brought together colleagues from the HEA with a heterogeneous group of senior NHS colleagues whose roles gave them an overview of the challenge of workplace health in the contemporary context. They 'unpacked' the model identifying aspects of its complexity.

Box 2.1 The national external stakeholder group analysis of important factors affecting HaW

Culture: Incentives and rewards; rhetoric and reality; senior management commitment and style; risk sharing or denial; congruence and consistency; discrimination or encouragement; openness and trust

Communication: evidence of listening; methods and responses; feedback and impact; staff competence and effectiveness

Relationships: conflict resolution; diversity; (in)congruence; 'alliances' or 'tribalism'; horizontal/vertical; teams and individuals

Preventable Ill-Health: Sickness Absence policies and practice; physical and ergonomic environment; roles of Health Promotion and Occupational Health; mental health and staff (dis)stress; direct services and on-site facilities; response to dysfunction and injuries

Members of the Group saw a great deal that could be done to ensure that **the organisations** took responsibility for ensuring workplace health and that this goes well be-

yond health promotion events and preventive projects. As a result they produced a complex 'web' of key contributing factors.

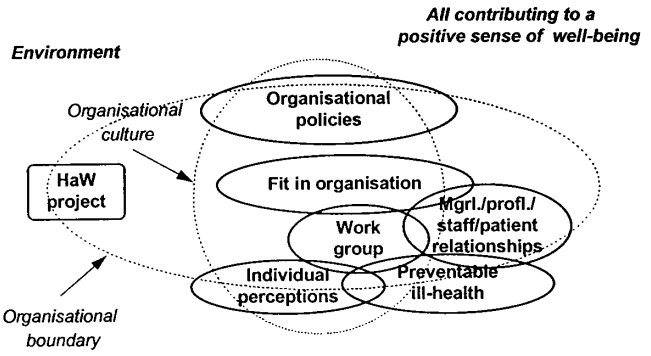


Fig 2.3 External stakeholder group — key constructs

Thus, they clearly took a view that workplace health could and should be managed and that it was a strategic responsibility. (In this they anticipated the new HR Strategy for the NHS by over three years — see Chapter 7.)

2.4 Methodology of our approach

The complexity that emerged from the above model justified the methodology we had originally proposed and, as Errol Walker noted:

> *Workplace health in our [original HEA] context may only be possible for organisations that are in a stable environment or where staff are really so vital they have to be rewarded...*
>
> Reflection on a Reference Group report, November 1996

Such instability as that experienced in NHS trusts during the period of the Evaluation — such continuous *and* discontinuous change (Handy 1991) — provides a rich environment for a methodology grounded in reflective practice. By encouraging colleagues in the trusts to *'reflect in action and on action'* (Schon 1984), during and after their planning and implementation of HaW activities, we anticipated achieving significant insight into the processes and practices of workplace health interventions.

A complex evaluation design was developed to fit the complexity of the context

To achieve this we developed a sophisticated design for the work of the evaluation which sought to engage relevant trust staff in the reflective process. This was to be achieved both by positioning a complementary set of methods within the complex adaptive system that is an NHS trust; and through regular reviews with our research partners. We shared our findings on an ongoing basis, both to aid reflection and to

ensure validation by the participants. This resulted in a complex implementation model which had to be negotiated with the two 'demonstration' trusts and the two 'reference' trusts.

The model summarised in Table 2.1 below sets out the framework and, unsurprisingly, evokes our third broad finding: that — **while an approach based on reflective practice is rich and helpful — simplicity, clarity, utility, *and* legitimacy are key criteria for the design of an evaluation process utilising this principle.**

Table 2.1 The evaluation methodology

Phase	Method(s) [2]	Participants	Key Questions/*Outputs*
I Preparatory *KF team + HEA Field worker[1]*	Local stakeholder process Local audit	HaW. NHS Group + internal & external stakeholders	'What are the key factors and requirements for HaW NHS in this trust?' 'What is the most feasible and relevant focus for HaW NHS in this trust?' ***Identification of HaW NHS priorities and implementation plans.***
II Planning	Reference Group I [3]	Diagonal mix of staff	'What is the current relationship between workforce health, workplace health activity, and change in the trust?'
HEA Fieldworker[1] assists planning process	Learning Diary I	Core HaW team [4]	As above, and 'What factors are helping and constraining our planning?' ***Initial analysis of trust baseline position before planned HaW interventions***
III Implementation	Local Data Collection	HaW Team KF Team	'What is relevant, useful and measurable in relation to our interventions?'
	Focus Groups		'What is working well, not so well, not at all, and why?'
	Learning Diary		'How are we doing? What are we learning? How can we improve? What happens next?
HEA Fieldworker acts as a resource to support implementation (See section 5.4)	Observation/ Reflection (with HEA fieldworker)		'What are we learning?' 'Can we begin to identify key implementation requirements and constraints?'
	Reference Group II [3]		'How is the relationship between workforce health, workplace health activity and change in this trust evolving? How do we know this (evidence?)?'
			Analysis of Haw NHS in action *(Chapters 4 and 5)*

Cont. next page...

Phase	Method(s) [2]	Participants	Key Questions/*Outputs*
IV Review	Learning Diary	Core HaW Team	As above (implementation)
	Interviewers	Key HaW NHS team members	'What is our experience of HaW. NHS in the trust?' 'How is it working and how can it be improved?' 'What are we learning?'
	Cost Benefit Analysis	Core HaW Team, KF Team	'What is our assessment?' 'What have we learned?'
	Reference Group III [3]	Diagonal Mix of Staff	'What is our assessment of the HaW NHS 'journey' and its relationship to change in the trust'
	Learning Diary	Senior staff debrief with the Core HaW NHS team	'What is our progress?' 'How do we know this?'
Debrief with HEA Fieldworker [1]	Executive debrief	Trust boards / executive	'What have we learned?' As above ***Evaluation Findings*** *(Chapters 5 and 6)*

Notes

1. The HEA fieldworker's action research is described elsewhere (HEA 1998). This tabulation indicates where the KF team reviewed progress and consolidated findings with her.

2. There were pre- and post-staff surveys conducted by IES then CASPE/CHKS (HEA 1995 1998) to assess the evaluation and impact of HaW.NHS in all fourteen pilot sites and the two demonstration sites and two reference sites.

3. Reference Groups were also run in the two reference sites.

4. The Core HaW Team consisted of those taking principal operational responsibility for HaW.NHS. in each trust.

The next chapter reviews the implementation of this methodology. We wish to acknowledge the high degree of co-operation *and* forbearance of colleagues in the trusts.

While we received a great deal of positive feedback on much of the work, we also acknowledge that it was an imposition in tough times and that our shared experience raises serious ethical questions about the negotiation and implementation of external interventions, their timing and project management.

Chapter 3

Implementing the evaluation

In this chapter we focus on the positioning and implementation of the evaluation and our use of qualitative and quantitative methods, including Cost Benefit Analysis.

3.1 Establishing the evaluation process

The initial phase of the evaluation – in which the first trust we had hoped to work with decided to withdraw from its intended role as the sole demonstration site – helped us to create the opportunity for a more developed research and evaluation design. We were able to 'signpost' the key issues and create a conceptual framework for our analysis. This learning was shared with the HEA's Advisory Group (February 1996) and we were encouraged to take this forward through the phased programme of work described in the previous chapter (Table 2.1).

In the two *reference* sites the relationship between HaW.NHS and organisational change was being monitored through a minimal intervention of a reference group process and limited interviews.

In the *demonstration* sites we were engaged in a continuous and much more significant process entailing negotiation about the substantive focus of the local HaW work. Internalisation of learning resulted both from Linda Seymour's support (the 'animateur role', see below) and the evaluative feedback. This *formative process* characterised our approach which clarifies evaluation as an intervention within negotiated terms of reference in specified local contexts. The use of Local Stakeholder and Local Audit processes in the preparatory phases both helped to clarify local workplace health priorities and to consolidate the scheduling of the evaluation activities.

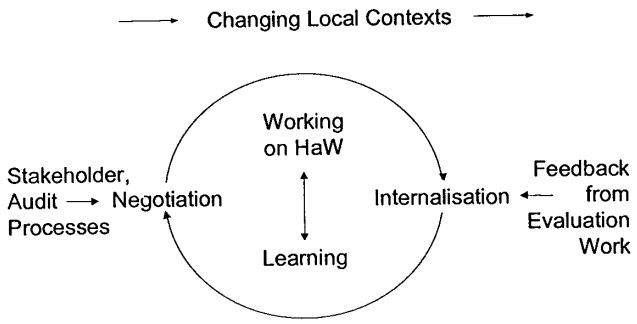
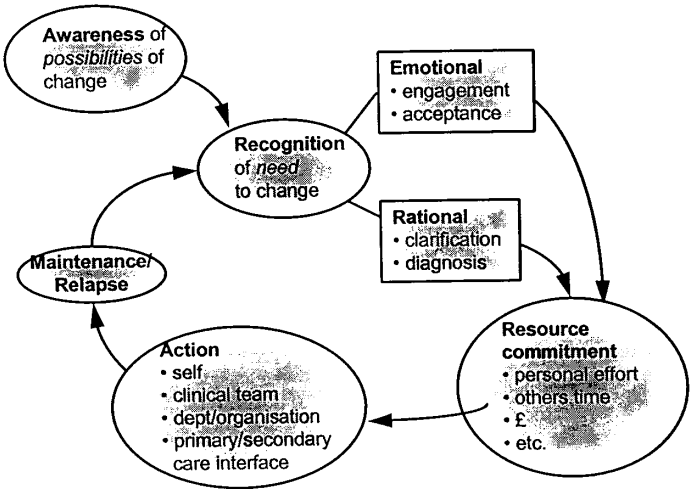


Fig 3.1 Evaluation as intervention

This mutual exploration was often uncomfortable as well as helpful, requiring constant attention to communications and co-ordination which, in an ever-changing context, are never perfect! We also knew from our initial work that behind this simple model lay a much more complex process, linking input (explicit use of resources, time, expertise, internal analysis, etc.) with desired outcomes: the tangible, and where possible, quantifiable changes that resulted from the HaW. NHS intervention(s).

This model acknowledges that at a trust level there is both a rational and an emotional process that have to be gone through if resource commitment is to be realised to support the programme.



Source: This model is developed from Prochaska and Di Clemente (1984)

Fig 3.2 The intervention process

Prochaska and Di Clemente's model has been adapted from their work with people who are addicted or habituated. Their recognition of the importance of the emotional

dimension of sustainable change - **for the whole service team** not just for the addict/habituee - applies just as readily to workplace health interventions and related organisational development work.

In the early phases of the evaluation it soon became apparent that while rational engagement with the proposed HaW.NHS programme was achieved in all four trusts, the *emotional* commitment was far less evident - especially outside the local HaW.NHS group. Thus, while a schedule of tasks might be developed (for example, relating to limited lifting) much less attention was paid to the emotional dimension of the work as it affected key internal groups and stakeholders.

In every case, as the work of HaW.NHS unfolded, it impacted at a number of levels :

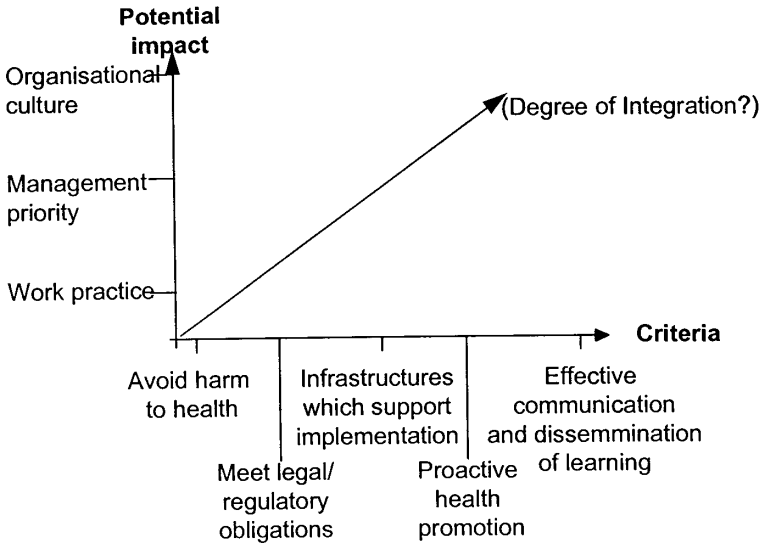
- work practice
- management priority
- organisation culture.

Each project, programme, or initiative could be seen to achieve a degree of integration that could be mapped in relation to the health outcomes. These would be later clarified (see next chapter) but the initial framework helped to provide a basis for assessing the 'direction of travel' of workplace health in the trusts:

- avoiding harm to health
- meeting legal/regulatory obligations
- infrastructures that support implementation
- proactive health promotion
- effective communication and dissemination of learning.

We later refined this framework and we also took account of the HEA's Advisory Group's advice to develop this model as a potentially useful model.

The risk in the NHS is to limit the use of this matrix by concentration on the 'Work-practice' element of each workplace health intervention. As we will show in the next chapter, the degree of management priority is critical if trusts are to embed practices which begin to characterise a **healthy organisational culture** – that is, a culture which positively values staff health through its management and leadership style. Such organisations constantly ask the question: ***'What shall we do if we really want to improve things round here?'*** Our reflective approach was designed to prompt this question in a variety of ways – particularly through the focus groups, interviews, and learning diaries – where the findings were shared with and validated by the participants. **There is no *a priori* reason why trusts and their management cannot do this for themselves.**



NB. The simpler, refined, model is presented later in Chapter 5

Fig 3.3 Assessing the 'direction of travel' of HaW.NHS

From the initial phase we also identified a set of constructs relating to the internal perceptions of HaW.NHS and its immediate organisational context. We used these later to interpret our findings – particularly from the two demonstration sites – as the evaluation project was implemented.

In all four trusts we noted behaviour that tended towards one or other end of the above spectrum which enabled us to begin to characterise the cultures in which we were working. The Reference Groups in particular helped us to build a cultural assessment and clarify the influence of significant external or internal change.

The above frameworks were put to use in analysing the material generated by the evaluation methods noted in Fig 3.4. Before we discuss these findings we reflect on the work of the evaluation itself and how well, or not so well, the various methods worked and what we learned from this experience. Again, we commend this framework for use in NHS organisations. Broadly, a shift from the left towards the right is typical of the shift from a traditional professional bureaucracy towards a learning organisation underpinned by reflective practice and open communications.

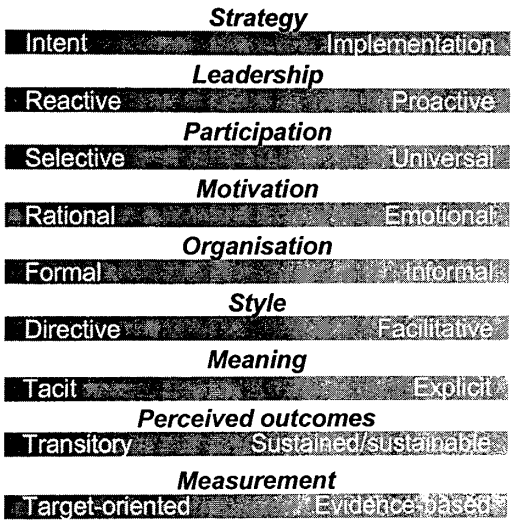


Fig 3.4 'Mapping' the Response to HaW.NHS

3.2 Implementing the evaluation

We discovered fairly early in our work with the trusts that our design was over-sophisticated and demanding, particularly for the two demonstration sites. Our goal was both to generate data for the evaluation and to stimulate and enhance reflective practice in the trusts. In this we complemented Linda Seymour's role as 'animateur' which focused on the substantive detail of HaW.NHS, while we were concerned with the processes of change and learning. (see Figs 2.1 and 2.4). That is, our intention was to understand *how* good practice in workplace health becomes embedded practice through the 'double loop' of learning:

> ***How are we doing at becoming a health promoting (sustaining) trust?***
>
> ***What are we learning about learning to become a health promoting (sustaining) trust?'***

As we explore in the next chapters, the reflective basis of our approach appeared to ensure that one of these fundamental questions was also challenged and rephrased! Indeed, a 'double loop' for us was that we learned about reflective learning in the NHS, and that our presumption of a culture that would engage fully with the proposed methodology had to be modified.

This adjustment of our working principles emerged as the evaluation progressed and as our relationships with the trusts evolved. We were nowhere near as intensively involved as Linda Seymour, so our collaboration and debriefing with her proved to be a rich source of material too (see Chapter 5).

The trusts' evaluation of the evaluation was mixed, critical and developmental. A number of key factors in sustaining this approach are important to note for those wishing to take reflective, developmental evaluation further in relation to workplace health.

Box 3.1 Key factors in sustaining HaW activities

Basic administration. Ensure that the 'contract' is clear in establishing responsibility for setting up groups, interviews, etc.

Communications and Co-ordination. Clear, open lines of communication and verification are essential when working with and within busy trusts.

Language and Meaning. Key words and phrases (e.g. health promotion; occupational health) have different meanings for different people. Internal and external stakeholders may use the same words differently ... as might evaluators!

Competence and Capacity. Some people are not 'natural' reflectors, and in an over-stretched target-orientated system colleagues often lack the time and energy for reflective work.

'Box-Thinking'. The NHS culture encourages staff and managers to think in terms of structural and functional labels — *'Health at Work is an HR issue ... not my problem'*. We were fortunate to work with some colleagues who thought in terms of processes and who were culturally sensitive. Yet even they were often labelled and 'boxed'. Our approach fundamentally challenged this traditional paradigm.

Listening and Adapting. Responding sensitively to the realities of colleagues' working lives and ensuring that some measure of reciprocity is retained throughout the evaluation seemed to us to be a fundamental ethic of the work, which, often because of pressures in the trusts, we sometimes struggled to sustain.

At the outset of the project we had hoped to utilise a simple process — OARRs (agreeing Objectives, Agenda, Rules and Roles) — with the demonstration sites. In the circumstances such a concerted approach was not feasible. Instead we relied very heavily on the local managers who had taken (or been given?!) responsibility for HaW.NHS and its evaluation. These two individuals and their close colleagues were critical to the ultimate success of the work. (Yet the over-reliance on 'project champions' can be ultimately dysfunctional for workplace health - especially if there are fundamental challenges to be addresssed within the wider organisational culture which require the attention of the board. The difference between delegation and 'dumping' is often marginal!)

We believe that our evaluative approach was ultimately successful because it culminated in a set of key findings which make good sense. These findings 'triangulate' with the two perspectives offered by the other research partners and they have helped us develop some frameworks which support a more integrated, organisationally focused approach to developing workplace health. This learning forms the body of this report and it is worth reflecting on how the constituent elements of the evaluation contributed to this emerging 'picture'.

Elements of the evaluation in practice

We noted in Chapter 2 that a *national* stakeholder process enabled us to map out the wider context in which the evaluation was taking place. This process did entail use of the OARRs process (see above), as did the initial *internal* stakeholder process in the two demonstration sites.

Participants in the national group commented very positively on this process and its wider applicability. Essentially it can help any diverse group come to an agreement on priorities, goals, responsibilities and how they wish to work well together.

In the trusts the process did not work quite so well, principally because achieving a good mix of participants is difficult in busy trusts. People don't always turn up when they don't have to! The level of participation was sometimes a problem for the focus groups and reference groups also: especially where these depended on obtaining a 'diagonal' mix of staff from across corporate functions and direct patient services.

Our approach was, and is, explicitly participative and therefore risky in the current context. We did have to adjust to a falling off in participation over the life of the project: including last minute cancellation of interviews. However, we produced a substantial amount of data, all of which was validated by participants in the various methods deployed.

An overview of this data gives a picture of the structure and progress of the evaluation (Table 3.1).

All this work was conducted within the time frame of two staff surveys: the first conducted by IES; the second by CHKS. These studies provided a quantitative anchoring for our highly qualitative approach.

Feedback from the trusts reinforced our view that the methods were appropriate and helpful (with the exception of the observations and, to a certain extent, the focus groups where participation was uneven). Two powerful examples illustrate the positive points.

First, the writing up and sharing of the strategic level interviews facilitated an open dialogue about the deeply complex leadership challenges facing trust executives. Several interviewees commented on the inherent healthy value of this two-way process.

Table 3.1 The evaluation process model

Phase	Focus	Methods[1]	Data
1 Induction and negotiation	Trust priorities and inputs	Stakeholder Group Local Audit Learning Diary	Local Priorities Baseline and Criteria HaW Team[3] Review and Reflection HaW Project Team
2 Implementation and monitoring	HaW process and activity	Focus Groups Observation Learning Diary	'HaW Users' Experience Interest Groups[4] Perceptions HaW Team Monitoring
3 Review and analysis	Reflection and outcomes	Interviews[5] Learning Diary[6]	Key stakeholders independent analysis HaW Team Assessment

(N.B. Table 2.4 sets out the full schedule objectives and participants)

Notes

1. Reference Groups, involving a mix of staff, were run in all four sites and covered phases 1 and 3 in all sites, and phase 2 in three sites.
2. We endeavoured to include senior and operational staff, clinicians and support staff. Availability varied considerably as work pressures became more intense (see Section 1, above).
3. The 'project team' was the two or three key individuals who took responsibility for the HaW.NHS work.
4. Observations were almost impossible to organise, principally due to staff sensitivity to any perceived 'management agenda'. Where they were possible they provide a particular view.
5. 'Weighted' to obtain strategic management perspectives
6. The formal written recording by trust colleagues was not sustained, but regular review processes were held and written up.

Second, the reference groups were acknowledged to help staff in all four trusts shape an analysis of their own organisation and its change processes that was revealing and constructive.

In sum, we believe we began to develop an approach to evaluation that is inherently healthy. Next time we will improve it by paying greater attention to project administration, communications and the 'OARRs' in order to respond more effectively to the inevitable turbulence in NHS trusts.

3.3 Cost-benefit analysis: the quantitative dimension

Running alongside this qualitative work we collaborated with the two demonstration sites on two Cost Benefit Analyses (CBA's) (see Appendix A).

The project Steering Group felt it would be advantageous to be able to demonstrate that HaW interventions can be a cost effective use of limited resources as well as improving staff health. One of the things we were therefore asked to attempt was a cost benefit analysis of at least one Health at Work initiative in each of the principal sites where we were working.

We expected this part to be difficult, and it was – not to do in principle, but to demonstrate anything conclusive in practice. A review of the literature showed few previous successful examples of cost-benefit analysis of health promotion interventions in general, or of HaW ones in particular.

CBA played little or no part in initial decisions on investments in HaW

We also found that the decisions to invest significantly in HaW in the two trusts did not seem to have been very much influenced by expectations of cost-effectiveness. Decisions in both the cases where we have attempted CBA had already been taken before any solid information was available about likely *quantifiable* benefits, and with only limited information about costs.

Local skills to conduct CBA are patchy

We also found that local capability to undertake CBA is variable. In trust D, the Health and Safety manager completed a post-implementation audit for the Audit Commission of the trust's Lifting and Handling approach, which included most of the features of a cost benefit analysis, although that was not its major intent. We have extended it into the form of a CBA, with only limited additional need for information or analysis – mainly the ergonomics adviser's assessments of the amounts of staff time used, and its costs, in the training programme.

In trust C, where staff gym use was the subject, there was no one on site with the skills to design and implement a cost-benefit analysis, and no one could be identified in any local or related organisation with the skills, interest and time available to perform it. We provided most of the design input, and some more detailed sample design and questionnaire design advice, to enable the local personnel officer and the gym manager to implement the data collection, and we performed the data analysis.

Initial decisions were based on other considerations than CBA

In trust D, the decision to proceed with major investment was driven by a combination of a principled response to the legal requirements of the Manual Handling Operations Regulations 1992 and the determination of several senior managers to improve staff working conditions. The trust had themselves compiled most of the in-

formation about benefits retrospectively – mainly savings in litigation costs and claims for damages – and about the capital costs of equipment to support the policy. We have added an estimate of the staff training costs, based on information supplied by the lifting and handling advisor about the pattern and frequency of formal training programmes. Training was intensively developed, extremely well 'marketed' internally, and has become part of general and nursing management responsibility, and self sustaining. Overall, the investment will have paid for itself in financial terms in a very few years.

In trust C the subject of our cost benefit analysis was the provision of the staff gym. Again, the decision to invest in the gym was taken more on principled grounds of likely benefit to staff well-being, than of expectations of financial payback. It was (and remains) important that the net cost to the trust is largely covered by the modest membership fees charged (a fraction of the fees for equivalent private facilities). Space was donated and fitted out, and equipped initially, by a 'free' capital contribution from the trust. Ongoing fees should cover the cost of re-equipment when it becomes necessary.

We hoped to be able to demonstrate improvement in physical fitness indicators, and a reduction in sickness absence, for a random sample of gym attendees following their joining the gym. We were in the end unable to obtain 'after' figures to match the 'before' fitness indicators collected as part of the induction programme.

Variability in sickness absence rates was also very high between individuals and over time, so that such differences as there are have no reliable statistical significance. It would now be possible to design a larger sample which would provide a useful degree of statistical significance, but it is not something which attracted great interest in the trust, and seems unlikely to be attempted locally following the conclusion of our evaluation.

3.4 Implications of the evaluation design: catalysing reflective practice

A Hawthorne effect for all the fourteen pilot sites

It is important to recognise that from before the outset of this evaluation the HEA had, quite legitimately, been creating a 'Hawthorne Effect' across the NHS. By agreeing to be pilot sites the fourteen trusts involved altogether in the Research and Evaluation programme reinforced this effect for themselves. Linda Seymour's role in the two demonstration sites further amplified the effect.

We welcomed this on ethical and practical grounds. Our original proposals presumed that the evaluation would itself be an intervention: both for the trusts and for HaW.NHS programmes themselves.

The initial phase of our evaluation helped us to develop the models described above, and began to surface the issue of reflective practice in the trusts – the HaW.NHS 'learning loop'.

Essentially, by establishing evaluative processes which potentially closed the loop between strategic intent and HaW.NHS implementation, the trusts were obliged to reflect on what they were trying to achieve and how they were proposing to do it.

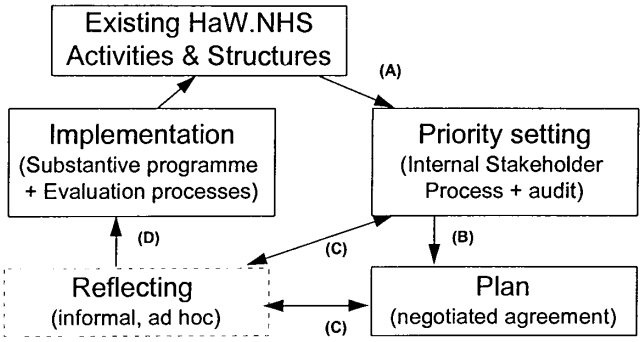


Fig 3.5 The HaW.NHS learning loop

Our involvement in the reference and demonstration sites helped staff to clarify what HaW meant for them

By explicitly working with the local HaW.NHS teams and the HEA's 'animateur' on steps (A) and (B) (see Fig 3.5), we ensured that everybody knew what was to be evaluated, how, when and – most importantly – why. This inevitably stimulated reflection in the trusts (C), and the point of the evaluative work which followed was to catalyse a shift from informal, ad hoc reflection, to a more explicit, positioned approach. Despite the practical and cultural difficulties noted earlier, we recognised that by the end of the evaluation process as a whole, those who took part in the various activities expressed a sense of forward momentum. In particular, the reference groups (on three sites), the learning diary process, and the key interviews all contributed to a deeper process of clarification which is central to achieving and articulating the embedded learning that underpins shared understanding and changed practice.

Key factors in the evaluation process

Four factors clearly contributed to the effectiveness of these processes in stimulating the process of clarification and the consequent learning :

- The organisational context and orientation towards workplace health. (NB See the CHKS typology which establishes a framework by which this can be assessed.)

- The skills and perseverance of the local HaW.NHS group
- The substantive contribution of the HEA: through their 'animateur', resources, and wider influence of the facilitation provided by the evaluations
- The sensitivity, flexibility and perceived relevance of the facilitation provided by the evaluation.

While we all learned to develop and improve as circumstances in the trusts changed, it also became apparent that the evaluation design had begun to catalyse greater reflection among the trust staff involved. This enabled a sharpening of focus, particularly through the means of the interviews with key managers and staff, and the reference groups. The themes which emerged and which were explored during these later stages of the work are addressed at length below (Chapters 4, 5 and 6).

Our baseline picture emerged from the initial phase of the evaluation

The initial work also enabled us to produce a baseline picture of the trusts which became central to the evaluation and grew in significance, both in our minds and in the thinking of key colleagues in the trusts. These can best be summarised according to the framework of Fig 3.6, which helped us to tease out the nature the relationships between changes going on in trusts and local HaW interventions. We have used it to develop the analysis of our findings from the four trusts (two reference and two demonstration sites) described in Chapter 5.

3.5 Using these evaluation tools in your own organisation

During the reviews of this evaluation and our draft reports we have been invited to make clearer the practical implications of our (highly conceptual) approach. Echoing Kurt Lewin on the usefulness of good theory, we would venture to suggest that the models contained in this particular chapter offer a great deal to those wishing to prepare for, plan and implement workplace health interventions in NHS trusts.

Indeed the recent Nuffield Trust report, *Improving the Health of the NHS Workforce* (Williams et al 1998) identifies the importance of addressing the factors we have noted above, particularly management culture, style and skills:

> *Our findings reveal the important influence of management style on staff health. The old competitive management culture has begun to change and must continue to do so. This will require action at all levels: leadership, commitment and investment from central government... For trust boards, commitment at board level is especially important. (p30)*

Dimension	Trust response	HaW.NHS implications
External factors	National agenda	Structural/programmatic
	↕	(and / or)
	Local priorities	Personal & cultural
Organisational change model	Transformational (radical)	Dominated by change agenda
	↑	
	↓	(and / or)
	Transitional (incremental)	Pragmatically adapted to context
Organisational leadership & learning style	Tactical — dependent	*'Leave it to Human Resources'*
	Tactical — pragmatic	*'Focus on deliverables'*
	Strategic — developmental	*'What are we learning & how can we improve?'*
Capacity/positioning of HaW.NHS programme	Professional model (subfunctional — marginal)	High dependence on specialist group (e.g. Occupational health)
	'Ad hoc' model (functional — instrumental)	Dependence by default on willing (available) interdisciplinary team
	Partnership model (integral — multicultural)	Interdependence achieved through cross-organisation teamwork.

Fig 3.6 The 'baseline' framework

The CHKS Self Assessment Tool (to be published by the HEA in early 1999) will provide trusts' management with a helpful baseline picture and an opportunity to clarify priorities internally and with their local health commissioners. Beyond this workplace health - recently prioritised by the Government who have clearly noted the above report - cannot be left reactively to small, committed local teams. Each of the models described above can be deployed to support the self-management and organisational learning processes that will begin a **sustainable** approach to workplace for local workforces:-

Figure 3.1: Evaluation as intervention

How will the trust, on the basis of evidence provided through stakeholder processes and application of self assessment, create a cycle which embeds learning from workplace health interventions?

We **recommend** that an internal network of workplace health facilitators, reporting independently to the Chief Executive or her/his nominee, provide regular feedback from cross-directorate focus groups of staff (say quarterly). These facilitators should be independently supported.

Figure 3.2: The intervention process

How will the trust board engage with this process and encourage its use to support the trust-wide workplace health programme? Try it, with a trusted external facilitator – then take the learning forward.

Figure 3.3: Implementing the evaluation

How can the local workplace health team use this matrix to monitor progress and take appropriate action? Each 'box' in the matrix can be given meaning, purpose and measurable criteria by use of the OARRs process and the outputs of the diagnostic processes. For example, take a sensitive issue like bullying. In the first 'box' – avoiding harm to health and work practices – a number of practical requirements emerge. First, identifying staff who are at risk in a safe and appropriate way. There is a growing body of literature available on this subject and about helpful methods – e.g., the use of a network of 'confidential friends', or a staff helpline.

The matrix does become more challenging vertically: 'What is there in the organisational culture that fosters bullying?' 'How can we address these needs?' But, if they are not addressed, the 'legal regulatory obligations' are increasingly likely to be costly (the next lateral 'box'), let alone the loss of good staff who experience harassment, discrimination and plain abuse. Each box in this matrix is worthy of analysis, assessment and, where necessary, investment.

Figure 3.4: Mapping the response

What does this framework tell trust management that it does not yet know about itself? Where does it wish to position itself in relation to this set of options? What are the implications for the workforce of such choices? Use of this framework will itself be a test of leadership style! Starting with a staff perception survey, or with a confidential stakeholder briefing, will help a trust to learn to see itself as others see it. Powerful and risky..... an essential for a healthy, health sustaining organisation.

Figure 3.5: The HaW.NHS learning loop.

Who owns these reflective process, and how will it connect with the trust business and strategic planning processes? Very simply, without this work being connected explicitly to the trust board's deliberations how will it achieve the workforce capabilities needed in an increasingly demanding context? This 'loop' was already in place in three of the trusts in the Health at Work study – out of fourteen.

Figure 3.6: The baseline framework

Where does your trust sit? In the next chapter we shall elaborate the meaning of this baseline analysis. Readers are encouraged to reflect on it in relation to their own organisation, and in relation to the CHKS classification of Marginal, Instrumental or Integrated approaches. This is a new kind of language for trusts in relation to workplace health.

Essentially,

Marginal trusts adopted a narrow programmatic approach to workplace health, barely addressing their legal compliances, and leaving the work to a few isolated professionals without any consideration of the cultural, leadership and management dimension of workplace health.

Instrumental trusts ensured that they met statutory obligations and focused on what could be reported about workforce health on the basis of professionally managed tasks and activities. They wrongly assumed a causal relationship between workplace health and reducing levels of sickness absence.

Integrated trusts had begun to relate workplace health to their organisational change strategy and management development. But, in trusts where a major (transformational) change programme was in process then there was an increasing risk of the HaW.NHS team becoming detached and marginalised.

Trust approach had nothing to do with resource pressures. Two with the most 'integrated' approach were among the worst resourced, according to national figures.

Chapter 4

The evaluation in action: learning from experience

The purpose of this section is to describe the learning from the use of the different methods applied during the evaluation in order to tease out the practical experiences of the four trusts.

4.1 Introductory comments: evaluation, reflection and action

In the next chapter we provide an analysis of our findings and relate the outcomes of our work to the CHKS research and to the fieldworker's role. This chapter attempts to help readers to develop a 'feel' for HaW.NHS in action in the four evaluation sites.

We offer three perspectives:

- That of the **local HaW.NHS teams** and their contribution to the **workplace health interventions** (sourced from the local audits, the learning diary process, interviews and Linda Seymour's work).
- That of **staff** and their sense of **workforce health improvement** within their local changing context (sourced from observation, focus and reference groups, and parallel CHKS work.)
- That of **trust management** with their responsibility for organisational strategy and staff development in a complex and rapidly changing context (sourced from interviews and debriefing with Linda Seymour and CHKS colleagues).

We want to acknowledge at the outset that all four trusts were well managed by any reasonable standard and each of them had achieved a measure of national recognition in respect of their performance or aspects of their performance. Also, we found exceptional and inspiring individuals throughout our work. Yet we were left wondering why work**place** health was struggling for an appropriately significant place on the leadership agenda and why, despite growing national concern about work**force** health, the system still relies so much on such individuals and small, committed, relatively marginalized teams?

4.2 The workplace health team perspective

The research and evaluation colleagues' introduction to the local HaW.NHS teams was negotiated through the process of clarifying local workplace health priorities and confirming that the implementation of local programmes was both feasible and capable of being evaluated in the available timescale. The notes of these meetings, including the local stakeholder process, and the subsequent correspondence, suggest a number of useful indicators for future work in all trusts.

Managing scope: Although an initial long 'shopping list' of candidate HaW activities was produced, once trust colleagues worked co-operatively towards clarifying priorities an initial consensus on which few should be evaluated quickly emerged. Our independent facilitation process engendered a sense of corporate responsibility which really helped to ease the tensions between internal interest groups, each with their own preferences.

Differential awareness and engagement: However, these initial processes also demonstrated a range of commitment that went from antipathy (based on mistrust), through apathy and lack of interest, through token engagement, to sincere, energised involvement. The local HaW.NHS teams have to live with the reality of this distribution and facilitate participation from increasing numbers of staff and managers. Making this analysis explicit, and quantifying the distribution - however crudely - is an important baseline setting activity.

Signposts: Even at this early stage organisational development, cultural and contextual factors were being identified. We all could have made more of this through an open, safe and confidential dialogue. It would have certainly aided process planning and risk management in support of the local programmes.

Trust: The mutual confidence and professional respect of the HaW.NHS team members, both internally and externally, was a key ingredient in getting started. This work cannot be given to just anyone, and in one trust where confidence in the HaW.NHS team was failing (for whatever reason) the momentum was rapidly lost.

Finally, it became clear at this early stage that trusts had adopted very different approaches to assembling and supporting their HaW.NHS teams. We reflect on this in the next chapter and **we believe the choices faced by trusts in respect of the leadership, structure, positioning and recognition accorded to the HaW.NHS team is crucial to their longer term effectiveness.**

Leadership of the team was delegated in all four cases, but the team led by an executive director clearly had the most coherence and influence at all levels in that trust. Where trusts left things to professional leadership alone (e.g., 'leave it to occupational health') the work was marginalised and made relatively ineffective. Equally, where the trust relied on relatively junior and non-expert leadership, even with direct accountability to a board director, the HaW.NHS process remained vulnerable throughout the period of the evaluation.

Structures based on tight, multidisciplinary working, that brought together expert members with committed senior managers, created a sense of commitment and purpose that 'underwrote' the work programmes.

Positioning, both in relation to internal communications and senior staff awareness, was critical to sustaining momentum. In the two trusts that made the most progress the HaW.NHS agenda was supported by excellent dissemination which continuously linked the programme to trust priorities. In these trusts the Chief Executive and the project leader developed a shared appreciation of the workplace health agenda and the trust strategic priorities.

Recognition: Credibility and pride in an important job to be done shines through: even in very hard-pressed organisations.

As the programmes progressed in the demonstration trusts so we noted new individuals being drawn into the work. For example, as 'stress' and 'violence and aggression' emerged as issues, so occupational psychology and security staff had a role to play. This was an uneven, ad hoc process which added to the pressures on the core teams. The intensity of work pressures and the usual functional boundaries made it very difficult for the core team to retain an overview. The evaluation process was both a positive and a negative for HaW.NHS teams at such times: positive because it helped to sustain focus on agreed priorities; negative because it required the local team to rebalance in light of new perceived needs.

Quite apart from us the HaW.NHS teams had much more to deal with.

- **The impact of structural change** which often resulted in a change of management style in key directorates. Team members who really **know the organisation** and carry high legitimacy are critical in such times because they gain rapid acceptance in such times.

- **Uneven communications** were a real issue - each trust had its 'black box' areas where managers were resistant to workplace health, including matters of legal compliance.

  Health and Safety is worse than in the bad old days of the Unions.

- **The lack of strategic organisational and management development** created a highly task-focused culture where staff needs and responses to change were seen in terms of targets and numbers.

  The 'tick box' mentality of our trainers is not helping us to get to the managers we need at the coal face.

  Who is left dealing with the people who have genuine problems...?

  Does our organisation really have a conscience?

- **Energy and risk are in continuous tension.** The HaW.NHS teams were, and are, in effect, change agents caught up in a demanding work programme, where they had to be continuously sensitive to the risks to staff and to themselves. This is potentially energy sapping, despite the real job satisfaction gained as key projects and activities were completed. However, a shared perception of the degree and nature of risk was largely missing at the top of trusts. The team's risk was that their energy and credibility would both run out and that they would fall victim to the 'blame culture'.

Indeed, by the end of the evaluation period it is fair to say that these teams, who had been pivotal, were in need of a break. One had been effectively disbanded for local, structural reasons; one had been restructured and was under review as the trust moved into its next phase of development; and two were reflecting on their next phase of development in the context of further major structural change.

HaW.NHS has a fragile future in such circumstances and we are drawn to the conclusion that too much is expected of such small teams, especially when they are not empowered to address some of the fundamental factors which impact on workforce health.

4.3 The staff perspective

Time and again in our work with staff we were struck by their relatively low, reasonable expectations; and by the gap between what they experienced as good practice and some of their appalling experiences. Trusts are multi-cultures housed in facilities of very variable quality. Staff know when they are valued and supported in their workplace, and they know the managers and professionals who recognise this and respond positively.

The CHKS survey has provided an analysis of shifts in staff awareness and our qualitative analysis clarifies some of the significant underlying issues that mattered to the people we observed and worked with in confidential groups.

Several issues stand out.

The impact of HaW.NHS

CHKS have shown that there has been a differential impact across the fourteen trusts involved in the whole study. Our qualitative assessment in the four sites reflects their detailed findings on a site-by-site basis. **Where there was real measurable progress the staff we worked with acknowledged evidence of improved workplace health.** They were much more ambiguous in the trusts which had been uneven in their implementation - reflecting many of the characteristics of the variable experience of the local teams described in the previous section.

In all four trusts staff appreciated visible, accessible investments in their future health at work. For example, staff gyms which were professionally run and eco-

nomically priced were seen as a **symbol of good intention**. (The CHKS work shows that actual take-up and use of such facilities was inconsistent across staff groups). The most effective interventions acknowledged by staff were the highly focussed, professionally supported projects addressing particular **expressed needs**: the 'team briefing' and 'lifting and handling' projects that we debriefed.

The meaning of HaW.NHS

In Chapter 6 we address the different meanings of workplace health that surfaced during the evaluation. It is fair to say that the programme as a whole had little direct meaning although, as we have noted above, some constituent elements of the programme were highly valued. More important by far was the **workplace as a healthy context**, particularly:

- **The physical environment.** Clear, well-lit, reasonably spacious, and safe were the basic criteria that really meant something to staff. The range of experience was enormous: from the up-tuned box in a dirty, narrow and dark corridor which formed the only space for a break for medical records staff from their overcrowded office; to the spacious, clean and airy private dining room for consultants .... Staff really appreciated regular cleaning, 'a lick of paint', natural light – **'Little things mean a lot'.**

- **Investment in equipment and facilities.** Examples included the installation of floodlighting in staff car parks; comprehensive deployment of hoists and other lifting aids; refurbishment of ageing offices and wards; and the use of CCTV. All these all meant a great deal to staff. Yet their experience was uneven:

  > *The lifting and handling programme is running into the ground because we have to share equipment. So, in practice it's never there when you need it.*

  (Our cost benefit analysis shows how short-sighted this particular financial strategy was and is!)

  > *They have really thought about our new buildings, although it's hard to get time to yourself in these smaller more dispersed units.*

- **Being recognised, informed and involved.** For staff this is all about change, anxiety and even fear. It really meant something to be continuously and reliably informed in a context of constant restructuring, rumour and media hype (especially in the local press), and insecurity about jobs.

  > *For a while everyone felt at risk, then it turned out that no jobs would be lost ... this time.*

  > *We really appreciate all the efforts made to keep us properly informed; but some managers just don't bother, especially when it comes to feeding back our views into the system.*

The need for an effective, objective, two-way process of informed communication which enabled staff to assess their situation and their contribution was substantiated throughout all our work (see also Lloyd 1998).

- **Patchy experience of management.** Even in the 'best managed' trusts, staff experience in relation to their health at work was profoundly affected by examples of poor management practice and behaviour. Staff also recognised that this was often a 'two-way street'.

  Some individuals and groups just do not want to change no matter how hard our managers try to help them.

  We believe our managers really care about us so we want to work with them, but some managers in this place are only interested in their own empires and that makes it really hard for us to work with them. It causes all sorts of problems.

  These quotations came from staff from different trusts but they could have come from any one trust. Staff clearly felt that management style was a critical factor in the maintenance of their own health at work. How managers enabled them to deal with change was central to this, including their capacity to deal with staff who were disruptive and/or resistant to change. The staff perspective surfaced those key tensions concerning the **management role in workplace health**.

- **The manager as facilitator or 'boss'.** As the evaluation progressed so staff expressed the need for more involvement and dialogue, really appreciating managers who helped them to manage themselves through change. However, other staff wanted their managers to make decisions for them and retain the hierarchical, dependent relationship that inevitably results in 'win or lose' situations. For example, in one trust HaW.NHS was seen by one group as an opportunity to blame 'management' for lack of progress while, at the same time, other groups were acknowledging improvement and offering advice on further development. Many managers appeared to prefer to be 'the boss' and remain appropriately distanced from staff and from the HaW.NHS programme. This clearly led to a 'stand-off' which blocked workplace health developments. Yet concurrently, staff talked about managers who acted on a range of workplace health needs treating it as integral to service delivery and development.

- **The manager as 'friend' or 'foe'.** Change is very, very personal and it was very clear that some fortunate staff experienced managers who were empathetic, informative, sensitive to personal and workplace needs and the relationship between the two. These counted as 'friends'. There were also some managers who plainly dumped their own fear and anxiety on staff, who were (understandably?) task and target-focussed, and who appeared to have no awareness of the effect of their behaviour on others' health. These were more like 'foes'.

  Over the two-year period the beneficial effect of the former and the deleterious effect of the latter was evident. We found little evidence that this duality, with its contradictory effects on staff, was being addressed as a workplace health priority.

- **The 'open manager' and the 'manager in denial'.** While openness was appreciated by staff it was also clearly perceived as weakness by at least some members of the diverse trust sub-cultures. Being open by sharing the ambiguity and uncertainty created by constant change appeared to make staff feel valued and insecure at the same time. Their need for a measure of certainty and direction and for a sense of a better future could not always be met by managers who were trying to be open and honest. Staff recognised that such managers tended to work extraordinarily hard in order to try to achieve their objectives and address colleagues' needs. As the evaluation progressed so did stories about 'burn-out' and chronic over-working among valued managers. Their denial about their own health and well-being gave – and continues to give – a confused message to staff about workplace health as a priority. It was also evident that managers who were closed and who avoided working with staff on the consequences of change caused even more concern and anxiety. Their level of denial was pre-emptive and prohibited dialogue.

In sum, our work with staff revealed the deeper challenge of workforce health improvement. NHS staff are only just managing to cope at work. The benefits of well-managed workplace health interventions can be risked by critical contextual factors, such as the quality of the physical environment, and plain poor management. Staff themselves can contribute to the problems by adopting a dependent and negative stance to change.

Traditional health promotion activities which focus on personal lifestyle change are peripheral to these deeper organisational and cultural challenges. A good baseline can be set by focusing on key ingredients:

- Planned, supported and sustained interventions that are capable of measurement and improvement
- Continuous audit of the conditions that staff work in which result in straightforward practical improvements
- A shift towards a communicative management culture which fosters increasing staff involvement.

This is not a complex agenda. It requires no new knowledge and it certainly would meet the reasonable expectations of most trust staff. Yet as the previous section indicates, the local HaW.NHS teams faced a considerable challenge. In the next section we offer insights into the managerial challenge and the uncomfortable perspective of senior staff.

Certainly, we were left as independent evaluators asking the seemingly naïve question:

> ***If 'merely' sustaining workforce health is such a tough challenge in the workplace, how much harder will it be to achieve an NHS workforce that is thriving?***

4.4 The management perspective

First, a reflection on process. All the managers with whom we worked commented that they valued the opportunity to reflect constructively with someone acting as an independent listener. They were all, without exception, over-occupied and over-preoccupied. With the exception of the local 'champions' of HaW.NHS and work-place health in general - usually the same person - and despite good intentions, the programme and its evaluation were continually forced to the margins of their thinking and energies. One senior colleague has talked of 'time deprivation' and another reminded us *'you need to understand the difference between who is managing and who is controlling this trust'.*

We observed and/or heard about the personal strategies that individual executives adopted in dealing with the triple pressures of work intensity, time management, and leadership ambiguity. All were working in a climate of mistrust and damaging personal history resulting from recent conflicts about contracts and internal market restructuring:

> *I do not know if I can be part of the solution because I am very much part of the problem too.*
>
> *If I open up about these issues I worry that staff will lose confidence in my capacity to lead the trust.*
>
> *I really worry that the latest 'strategic plan' will do real harm; but most of my colleagues are too tired to address it ... they have just left it to the 'X' director and he is not up to it.*
>
> *We have just spent 95% of the total negotiation time on 5% of the contract value. I was here nearly all weekend.*
>
> *Some of our consultants are great. Others still run things the way they have always wanted to...*
>
> *I am ashamed of our lack of progress (on workplace health); but we are making enormous strides elsewhere.*
>
> *Bringing Occupational Health, Health Promotion, Health and Safety, and Health at Work together in one directorate gives us a better chance for the future.*
>
> *We are monitoring; we are practical and responsive; we are doing some excellent work; we will continue to invest in the health of our people; but how much more can we ask them to do?*

These quotations, and our experience, did not reveal a defensive out-of-touch generation of senior managers - far from it. However, they did reveal a leadership culture that remains encumbered by real, serious historical constraints.

'Box Thinking'

First and foremost, 'box thinking': the relentless attachment to organisational restructuring based on functional and clinical specialisation is at the root of many of the problems and constraints that we observed. All the trusts we were working in

were trying to address this cultural impediment with varying degrees of success. So, why was workplace health so 'boxed in', even where a more integrated approach was being developed?

Preoccupation

Secondly, executives are legitimately preoccupied. The new reform agenda is of such a scale and scope that untangling past constraints, and creating new, better futures in an over-stretched present is an inevitable challenge. How can they also implement workplace health as part of the strategic human resources agenda that is now called for?

Overload and lack of support for top managers

Finally, who takes care of the health (*not* illness) of senior managers? We observed the effects of overwork and anxiety in many senior colleagues. A national programme such as HaW.NHS inevitably creates a sense of exposure among senior staff. Some (a very few) delegated and ignored the programme, the majority acknowledged its importance and tried to fit it in to their ever lengthening *'horizontal priority lists'*; and a few took the responsibility very personally and exhibited a raw sensitivity to external evaluators and researchers.

We address the issue of leadership on the final chapter. Here we note the significance of personal style and the tension between openness and denial that senior staff exhibit in relation to their own health and the effect of their behaviour on the health of others. Some executives appeared to be entirely unaware of the effects they had, others were extremely sensitive to these issues and ensured that they were addressed, in confidence, at executive away-days. In the latter cases, and despite extraordinary workloads, workplace health remained a strategic priority and the HaW.NHS programme was much more connected to the wider change process being managed in the trusts.

So, to respond to the three issues identified:

The challenge of 'box thinking' relates to the systems of incentives (financial rewards and career recognition) that exist in the NHS. The high performance 'high anxiety' trusts identified by CHKS were completely re-ordering these frameworks and associated structures by restructuring the work of staff in accordance with patient/client processes and pathways. In these **transformational** organisations the top team were beginning to invest significantly in **transitional** leadership development. Traditional HaW.NHS suffered as a result of serious long-term investment in clinical and service leaders. This was a brave choice which resulted in significant short to medium term pain. The next step will be to develop workplace health as an **integrating process** enabling staff to work with managers on the continuous improvement of working practices, communications, physical amenities and personal developments. Will boards adopt this approach too? Certainly this emerging model of a process-oriented organisation creates the potential to position the skills of the work**place** health team

to support programmes based on principles of continuous improvement (see also Dunphy and Griffiths 1998).

Herein lies the response to our second issue. Several trusts were completely reappraising their investment in leadership and management development. Traditional management qualifications and competence-based, assessment-driven programmes were and are beginning to be challenged. In-house, independently facilitated, action-learning programmes focusing on intra-personal and inter-personal development, and on constantly reviewing the changing context of the trust will begin to create cadres of **change facilitators** who will support legitimately over-preoccupied strategic managers in sustaining their trusts.

This is long-term, fragile work more akin to community development than traditional change management (see also Beaty and McGill 1996).

We have partially addressed our third issue. Unless and until boards work reflectively on their own *health* (not illness) and consider, as they learn, the effects of their style and styles on workforce health, then successful implementation of HaW.NHS will remain blocked. We acknowledge the courage and openness of those who had started down this road, and (in common with many people we interviewed) we remain frustrated and deeply concerned by those who are not even aware that this is an issue. This poses a real dilemma for those charged with delivering the new Human Resource Strategy for the NHS. Workplace health improvement is essential but it cannot be imposed. The best management action that we found during this evaluation does help us all see the beginnings of a way forward. This path-finding work is as much a matter of will as it is a matter of skill and expertise. The will to be open, personally and professionally, to feedback and the search for incremental improvement.

4.5 Signposts for the future

In the remainder of this report we step back from the immediacy of these findings and begin to develop some models and frameworks intended to underpin future development. The next chapter explores the four trusts as case studies and elaborates our observations on the importance of the independent external help provided by the HEA's fieldworker. Then we reflect on the HaW.NHS programme as a whole, and finally offer our own suggestions and ways of thinking about the challenge of delivering workplace health. All of this is grounded in our experience of the evaluation described above.

As we have reflected and synthesised from this experience and all the primary data we obtained we have begun to see the inter-relationship between the three central processes:

- the HaW.NHS process itself championed and supported by small multidisciplinary teams.

- the trusts' change processes emerging in very diverse contexts
- potential workforce health improvement supported (or not) by the people, practices and material resources available to management and the HaW.NHS teams.

As our exploration of these processes and their inter-relatedness has progressed, three straightforward messages have emerged.

- A great deal can be done to improve the quality and inherent safety of the staff experience of the workplace. This is a matter of assiduous, practical day-to-day monitoring where small improvements are constantly sought - 'a lick of paint', 'better lighting', 'clean tables and comfortable chairs', 'regular health and safety checks'. To reiterate: little things do mean a lot and everyone can be given permission to take action.
- Openness to change goes along with an open management culture that fosters dialogue and genuine two-way communications. Audit from the bottom-up and unblock the blockages.
- Workplace health cannot be left only to the HaW.NHS team. They are a rich resource to be supported in choosing and addressing meaningful priorities while everyone else continues to share responsibility for the fundamentals. If staff are not evidently thriving in their work ... ask 'Why?'

Chapter 5

How are trusts doing at improving health at work?

This chapter provides an assessment of the findings from the evaluation fieldwork focusing on the four sites.

5.1 Improvement in the face of the 'almost intractable'

In Chapter 1 we identified the complex, seemingly intractable agenda facing NHS trusts. Yet throughout this evaluation we had the opportunity to work with NHS colleagues who retained an unfailing ability to demonstrate that much could be achieved despite the growing pressures. Indeed, they demonstrated a talent to turn the *in*tractable into the *'almost* intractable' and used that latitude to achieve some measure of success in relation to workplace health.

Just to sustain workforce health in the current context is a success and any evaluative commentary which follows must be seen in this light. To do otherwise would be to devalue the endeavours and integrity of colleagues from the four trusts. There has been too much unhealthy 'blame' around the NHS culture in recent years.

This section echoes Ian Cunningham's helpful evaluative framework drawn from his work on 'strategic learning' (Box 5.1).

Box 5.1 Learning to Improve

What have we achieved?

What have we learned?

How can we improve?

What shall we do next?

Source: adapted from Cunningham 1994

Before we move onto an analysis of the work in the four trusts, it is important to offer a general observation about the organisational – as opposed to the systemic – context of NHS trusts.

The ostensible goal of the 'internal market' reforms was to create organisations which would compete for purchasers' (Health Authorities, GP Fundholders, etc.) business within a contracts management culture. Performance would be judged against criteria of price, activity, and quality. Central government regulation of the market would ensure public accountability for NHS resources, principally through the regional offices' performance management functions. We found that a change of Government does not cause this to be swept away overnight. Indeed the 'internal market' culture has created significant barriers to workplace health in the NHS.

The pressure cooker effect

We found that, in all four trusts, it has resulted in a general sense of embattlement and anxiety: what we came to call the 'pressure cooker' effect. The objective causes of this effect are easy to identify: cash-limited budgets; compulsory efficiency gains; ever-increasing activity levels; built-in unfunded cost increases (e.g. salary scales); and mounting capital costs. Add to this the wider systemic context (see Chapter 1) and, most significantly, the local style of contracts management, and there emerges a sense of attrition with little or no hope or remission.

> *We have got to get away from this 'unit of production' model of management*
>
> Chief Executive
>
> *Relationships (with the purchasers) have been so damaged that there is little or no basis for trust and cooperation*
>
> Trust Director

Fundamental tensions for NHS trusts

Any evaluation of workplace health interventions must take account of this immediate organisational context. Rumours about mergers, further cuts and reorganisations pervaded the climate in all four trusts – with good reason, given recent experience and media 'hype' (local and national). For local management this also reflected an uncomfortable set of tensions between their *legitimate source of authority*, where expectations of significant local autonomy were increasingly disappointed as central control grew; and their adherence to the *values of public service* as they come into uncomfortable tension with *internal market values* as they have been interpreted within the NHS.

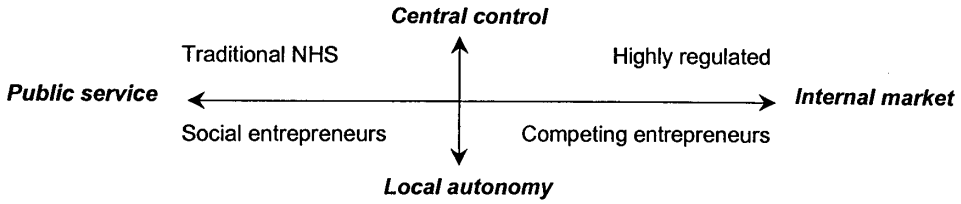


Fig 5.1 Fundamental tensions for NHS trusts

These tensions are reflected in staff groups too, and the reference group process was particularly helpful in identifying a residuum of 'traditionalists'. While the days of the competitive entrepreneur are numbered, managers and professional leaders, in particular, enjoy social entrepreneurship; yet a high degree of regulation is emerging with the new White Paper and its proposed centralist institutions (see New and Klein 1998).

Learning to respond to both social entrepreneurship and regulatory pressures

In reviewing the local organisational context in this way we found that these recent changes have created a highly ambiguous situations for a centrally initiated programme like HaW.NHS and for the HEA as a Special Health Authority. In commercial terms this could be seen as a complex, shifting market segmentation. But oversimple commercial concepts are no longer viable.

What we found in broad terms was that the trusts were learning to respond to both the social entrepreneur model and the regulatory model. The latter is being given increasing emphasis by the proactive work of the Health and Safety Executive. Certainly, the animateur role developed by Linda Seymour worked very well in situations where the former model pertained and, through her substantive expertise, she could help significantly with the latter. This surfaced another dilemma for the trusts in setting reasonable priorities within constrained resources and available energy: to which should they give priority?

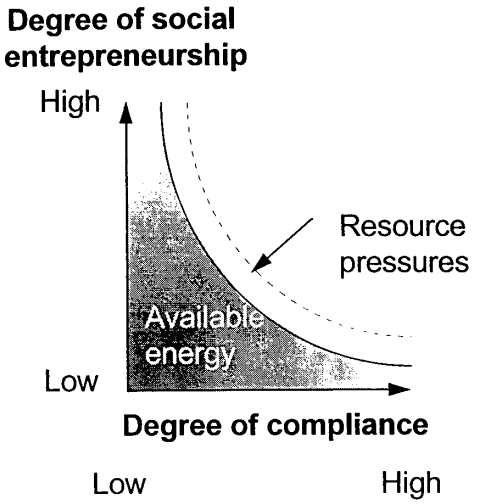


Fig 5.2 The HaW dilemma

'Social entrepreneurship' was being (and is still being) demonstrated by individual practitioners, local multidisciplinary HaW groups, senior managers, and so on. But Chief Executives can be sacked for failures in compliance. This is a dynamic and highly context specific dilemma and we hope that the preceding two models will be of value in helping others to 'map' priorities within a deeper understanding of local cultural tensions. They can also aid monitoring of the otherwise implicit choices trusts often make in relation to their investment in workplace health. We believe that **energy** is a key human resource that will require sustaining and nurturing as central to both workplace and workforce health in the NHS.

For example, in one trust there was (and is) a concerted attempt to link the regulatory compliances of the Health and Safety Act and the day-to-day practice of operations managers. In other words, *as risks to staff health emerged, so there was an explicit attempt to share leadership responsibility throughout the organisation: at a corporate level, through the HaW.NHS group, and through management development.* (This energising of the whole system was responded to positively by staff surveyed in the later CHKS work.)

Inevitably, this is an uneven process. Trusts are ever-changing multi-cultures and the overall process of improving/sustaining workplace health takes time. The CHKS research (HEA 1998) maps out staff perceptions of this change over the period of the evaluation, and our work has begun to clarify the constraints and opportunities that managers and professionals must address as they engage with this challenge.

Above all, we want to make it clear that we found no right or wrong answers and no magic remedies. Each trust started from an historically defined position which created its own limitations and potentials for development. Every management team

faced a 'horizontal priority list' in the face of growing demand for direct patient services.

Our role, together with the other research partners, is to offer some frameworks and principles that help trusts become the best employers they can be in relation to workplace health. In relating this to *the self-improvement of trusts as they learned to develop sustainable workplace health interventions* we identified four key areas of development that were critical.

Box 5.2 Four key areas for development of HaW

Organisational design and development

Workplace health capability

Capacity for reflection and self evaluation

Intervention planning and monitoring

Each trust (reference and demonstration) contributed significantly to our findings, so the analysis which follows is not comparative but affirmative, and to an extent challenging.

5.2 Trust characteristics and direction of travel

In Fig 3.3 we provided a generalised framework which elaborated the four trusts' responses to change and the implications that this had for the local implementation of HaW.NHS. These responses are valid within the reality of local conditions and available resources. They also demonstrate the choices (explicit and/or implicit) made by management in relation to sustaining workplace health. Through triangulation with the work of Linda Seymour and CHKS, we are fairly confident of the analysis and prognosis of 'direction of travel' that we have identified for each of the four trusts.

In particular, our analysis mapped directly with the CHKS typology of Marginal/ Instrumental/Integrated approaches to HaW by trusts.

Trust A has for some considerable time seen workplace health as **integral** to its organisational development strategy and had built a multidisciplinary approach to HaW.NHS involving both specialist staff and line managers. However, during the evaluation, the need surfaced to develop an even more sophisticated approach as the pressures of the trust change programme intensified. This was acknowledged by senior staff, including the Chief Executive, during the final review of our work. It will entail a detailed assessment of the management development and workplace health implications of the next phase of the trust's programme.

Table 5.1 Trust characteristics and direction of travel on four important dimensions

Organisational design and development	
Characteristics	**Direction of travel**
Trust A	
Long-term, transitional model sensitised to local conditions	Increasingly strategic and addressing more persistent organisational needs
Trust B	
Transformational model in response to national agenda	Need to address tactical-functional limitations in face of new needs
Trust C	
Predominantly structural response to local and national factors	Reactive, pragmatic response mediated by internal process champions
Trust D	
Strategic-structural response in tension with more tactical-cultural approach	Increasingly process-orientated and integrated

Workplace health capability	
Characteristics	**Direction of travel**
Trust A	
Partnership model linking HaW professionals with line management and range of interventions	Increasing focus on middle/operational management development to 'unblock' deeper cultural tensions
Trust B	
Potentially blocked by historic structural-functional arrangements	Integrated approach to encourage shift from professional model to more responsive internal partnership approach
Trust C	
Enriched 'ad hoc' model restricted by 'box-thinking' in key areas placing limitations on available skills	Perseverance resulting in shift towards more integrated team approach and greater strategic emphasis
Trust D	
Professional model linked explicitly to a strategic-developmental approach	Extending awareness and training into management development agenda

Capacity for reflection and self-evaluation

Characteristics	Direction of travel
Trust A	
Highly aware, reflective approach linking assessment of personal needs (whole life) to organisational strategies and processes	Recognition of need to enhance and extend self-improvement philosophy to tackle residual dependency culture
Trust B	
Highly reflective at a strategic level, but patchy at an operational level; especially where change is resisted	Use of internal contracting to make performance requirements and monitoring explicit
Trust C	
Significant at strategic level, but capacity for assessment and monitoring limited in operational management	Cross-organisation working and external regulation (HSE) stimulating recognition of need to improve, especially in relation to management development
Trust D	
Considerable tactical capability linked to growing capacity for self-monitoring and assessment	More reflective, less task orientated approach emerging: remains blocked in certain areas of the management culture

Intervention planning and monitoring

Characteristics	Direction of travel
Trust A	
Multidisciplinary approach linking three levels of HaW.NHS (see Chapter 3) to other trust initiatives	Increasing focus on integration with OD/MD agenda and implications for 'whole lives' of staff. (e.g. Modelling healthy behaviours).
Trust B	
Dominated by trust-wide change process	Increasing focus on integrating HaW.NHS intervention with service development processes
Trust C	
At risk of being constrained by relatively isolated position of HaW.NHS team	Create opportunity to work with cross-organisation 'change' team and local multidisciplinary team
Trust D	
Highly skilled respected team with considerable tactical awareness	Greater integration with strategic change process and with management development process

Trust B was and is engaged in a major transformational process entailing replanning and redevelopment of all its clinical services. Concurrently, the workplace health capability, which was significantly externally 'owned', has been subject to radical review. This has left trust B exposed in relation to workplace and workforce health –

especially as the current tactic of relying on internal contracting is likely to continue the relative marginalisation of the HaW.NHS professional capability.

Trust C has been feeling its way from an instrumental towards a more integrated approach. The original motivation ('reduce sickness absence significantly') has been increasingly replaced by recognition within the HaW.NHS that the dominant leadership style tended to disrupt the priority given to workplace health ... until Health and Safety Executive (HSE) compliance became an issue. Linking with a cross-trust organisational development initiative offers the best hope of progress, provided that the capacity to measure progress is strengthened.

Trust D was always determined not to be 'marginal'. The values of the Executive Directors and the HaW.NHS team were very clear in this respect. The trust developed an increasingly integrated approach, building on some highly professional 'instrumental' interventions. Evidence-based learning and a renewed commitment to change management development characterised this trust, which made the most progress in the perceptions of its own staff (as evidenced by the CHKS study).

In each of these trusts we identified a 'point of departure' where the HaW.NHS intervention risked becoming disconnected from the change management agenda:

Trust A was endeavouring to reconnect, through reflective evaluation

Trust B had created a real fracture that will take much to heal

Trust C was and is struggling to stay connected

Trust D is moving towards measurable integration, despite enormous atypical pressures.

5.3 The four trusts in perspective: key lessons for HaW.NHS

What did we learn from working with the four sites?

Each made its own significant contribution. The reference trusts helped us to achieve a perspective on the impact of change across the 'field', and the demonstration trusts enabled us to delve much more deeply into HaW.NHS as a process intervention.

TRUST A — Social entrepreneurial style

This trust provided remarkable insight into the management of change, and how **a deeper appreciation of workforce health can aid the management of change by enabling local leaders to develop more appropriate responses to staff needs**. In this case the work of the HaW.NHS group can be seen as integral to the policies and practices of sound change management. As the evaluation progressed it became clear that the long-term service development programme of the trust was beginning

to come into increasingly acute tension with the morale and motivation of some staff – and that this was a health issue, at least in part. Even in a trust where change management had been assiduous, intelligent and sensitive over a long period of time, the members of the Reference Group recognised that the vulnerability and ill-health of some colleagues indicated deeper problems:

> *Change has become very, very personal.*
>
> *When you change your work-**place**, you also change your work-**mates** just when you need them most.*
>
> *Staff and clients are growing old together. Is that healthy?*
>
> *It's hard to find time and space for yourself in the new services.*

This was, and is, a trust characterised by 'social entrepreneurship' and well used to developing innovative services of acknowledged high quality and responsible efficiency. It was also a trust where there is a culture of openness and honesty in a sector which, when it comes to workforce health, is pervaded by avoidance and denial. This culture had been threatened by fear and uncertainty which was felt more intensely by those who were resistant to change and who had been more comfortable with the dependent culture that had existed when the trust's services were more centralised. Also, in common with other trusts, all staff felt the pressures of the increased workloads resulting from new demands and required efficiency gains. Anxiety about the future added to this stress. This was reinforced by a highly troubled local economy characterised by historically high levels of structural unemployment.

In this trust senior management had responded quickly and appropriately to these needs by developing and improving information sharing and communications. But the development of the trust will require a further shift in the transition from dependence towards self-improvement among the increasingly dispersed work teams. The complexity, intensity and sensitivity of the work will grow, requiring even greater attention to the risks faced by staff in relation to their health and well being. Working together, the Reference Group identified the key skills of management in contexts where change has become *'very, very personal.'*

Box 5.3 Key skills of management during personal change

Noticing when individuals are unsettled, unwell or distressed

Preparing for a dialogue that enables colleagues to share sensitive and difficult issues

Initiating appropriate conversations and actions that are supportive and that provide the opportunity to make positive changes

Encouraging colleagues to be open and self-determining

Courage in facing deeply sensitive staff issues 'square on'

'Growing' staff by facilitating self-improvement and engagement with health activities

Reflecting constructively on the consequences of their own actions for others, including the behaviours they 'model'

This is a management development agenda that the Chief Executive described as *'honest'* ... and it is congruent with the culture of trust A; principally because it is recognised that this is an area for continuous learning and improvement.

TRUST B — High performing, high anxiety

This trust is beginning to develop a similar emphasis on continuous improvement through the evolution of self-managing teams. This follows a period of considerable transformational change, where every aspect of the trust's performance was reviewed and reshaped – including the workplace health organisation infrastructure. As in trust C, the Human Resources (HR) directorate is seen as providing leadership and co-ordination in relation to HaW.NHS.

At trust B, we found that this set of inter-relationships was being reformulated and re-established during the period of the evaluation. This coincided with what one staff member described as the 'after-shock' of the major transformational change programme.

This raised an important set of questions that are still being addressed at trust B:

- What process leadership capacity and competence is needed to support sustainable workplace health interventions in an organisation undergoing major structural and cultural change?

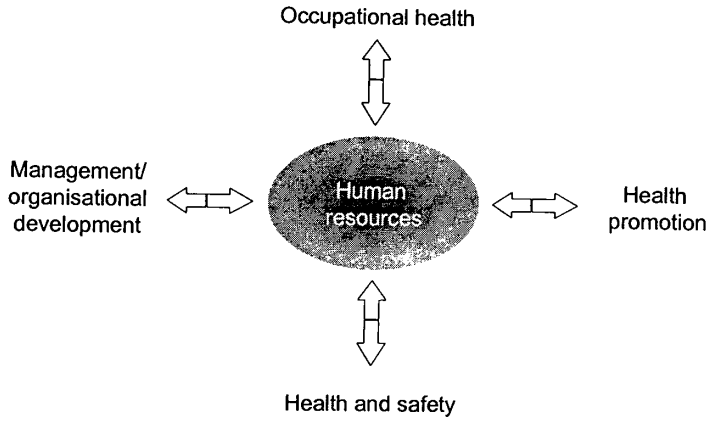


Fig 5.3 HR department as the co-ordinator

- How, in a developing organisation, will the appropriate balance between corporate authority and personal responsibility for staff health be clarified and implemented? (i.e. how will the risks inherent in workplace health be clarified and shared beyond the minimum legal compliances?)

- Given the key role of HR as enabler, how will the transition towards a more integrated approach be managed and resourced?

Our sense of trust B is of a high performing, high anxiety organisation. Transformational change has been largely successful, but inevitably uneven in its impact. And, as new workplace health issues emerge – especially violence and aggression, and stress – so the need to sustain the workplace health agenda and the associated change management processes become more significant. trust B has initiated a series of responses to this challenge:

- Further development of a culture of multidisciplinarity, which will extend from direct patient services into the corporate function

- Leadership development of doctors and senior nurses based on principles of self awareness, self-reflection and continuous evaluation and improvement

- Growing sensitisation of senior managers to the need for open, two-way, 'blame-free', communication

- Collaboration with the network of external agencies who have the ability to contribute to internal process improvement (e.g. the police, local authorities, GP's etc.), especially in relation to staff safety and security.

Not all of this is 'seen' by staff members, who experience on a day-to-day basis 'bastions of resistance' and 'lateral disconnections' between departments/patient processes. Also, the continuing unrelenting pressure of work create a sense of 'flaky stability' and little time to stop and think. (Staff bringing their lunch into meetings is a

very observable symptom). The new formal lines of accountability remain hard to implement: colleagues are still learning where they 'fit', and some middle and operational managers still adopt a 'tokenistic' stance towards the change programme. All-in-all, this reflects a trust undergoing a profound cultural change which resonates with the wider transition of the NHS from a traditional 'Acute' model (functionally specialised, reactive, fast and innovative) towards a 'Chronic' model (proactive, process-orientated, adaptable, providing continuity).

Box 5.4 Five elements of workplace health to sustain the transition from 'acute' to 'chronic' management models

Invest in leadership development of clinicians and process managers

Ensure that compliance with all the basic Health and Safety requirements really works — a responsibility for all managers

Provide the resources that enable all individuals to take appropriate personal responsibility for health

Pay attention to personal security, and to 'little things' in the working environment that demonstrate management attitudes to individual working environments

Improve two-way communication as a means of sustaining commitment and reducing anxiety; especially as the trust's services continue to devolve

This trust's lack of 'ownership' of workplace health capability was historic and fundamentally impaired its ability to develop to integrate workforce health as a dimension in its transformational programme. It is at risk of remaining stuck in an 'acute' mindset when it needs to shift towards 'chronic'.

Trust C — Becoming more two-way communicative under a charismatic style of leadership

This trust focused, *inter alia*, on the issue of communication. This remained an issue for staff throughout the period of the evaluation. Achieving effective, two-way, communications in a large, complex, multi-cultural, ever-changing context is a significant challenge, and our work showed that progress was uneven and the impact was patchy within an overall sense of helpful improvement.

Trust C was, and is, characterised by a charismatic leadership style, where the strengths of the local leadership are well recognised. But the beneficial effects of distinctive executive management are limited and, in this case, mediated by a traditional hierarchical structure and quite a strong sense of embattlement which had

created a climate of disempowerment among operational staff and their immediate managers. Consequently, despite an investment in substantive workplace health needs and in improving two-way communications, the residual culture of dependency on 'strong leadership' created an inertia that was hard to shift. Implementing HaW.NHS surfaced risks and tensions which became more fully appreciated as the evaluation progressed and as new staff health needs emerged. At the outset of the work we identified a framework of desired outcomes and associated risks which characterised trust C. (Table 5.2)

HaW led mainly by HR department

This 'agenda' was seen as primarily the responsibility of the HR team who continuously facilitated workplace health at four levels (and all this in addition to the usual HR agenda!).

- Monitoring and assuring the Sickness Absence policy and processes across the trust as it was devolved to line management (and having to take it back when line management began to fail)
- Acting as integrator for the various substantive workplace health activities and policies (as in trust B, above) including 'Lifting and Handling'
- Providing leadership in relation to the development of two-way communications across the trust
- Enabling change management at all levels in the trust through management development, advising and participating in key groups (including those external to the trust), and taking responsibility for internal change agentry.

Throughout the evaluation work (focus and reference groups, interviews and observations) we identified the critical significance of this corporate contribution. The evaluation also identified a number of factors which exacerbated the risks noted above:

- A persistent anxiety among staff about the future of the trust and, by implication, their jobs
- Suspicion about the management agenda, including concern about the role of HR, especially in relation to change
- Partial take-up of resources, such as the subsidised gym
- A constant feeling about the lack of attention to the working environment and the physical conditions under which staff – particularly lower-paid grades – worked.

Table 5.2 Trust C risk assessment

Desired outcomes	Risk factors
Line management ownership of Workforce Health as a priority	Lack of resources committed for implementation of HaW.NHS
	Constantly changing management structure
	Deficit in people management skills
	Limited range of management styles (dominant task orientation)
	Uncertain (volatile) external environment
Staff feel more valued	Expectations will shift upwards and become unaligned with goals of the HaW programme
	Growing cynicism/scepticism
	Morale dropping
	Lack of interest/commitment
	Impact of external perceptions and 'politics'
Demonstrable relationship between staff health activity and quality of contribution to patient care	Pay seen by board as a more important motivator
	Not perceived as a workplace issue (boundaries)
	Absence of managerial leadership
	Tokenism (another 'add on')
	Perceived as taking resources from direct care (whose subsidy?)
	Targeted at interested groups only (divisive)
Executive level (and non-execs?) demonstrate that they really do value staff and staff health	Preoccupation with politics, targets and the 'Task List'
	'Lip Service'
	Not an investment opportunity
	You show *us* the 'value for money'!

'Little things mean a lot' referred to the importance of cleanliness, fresh paint and half-decent rest facilities away from crowded offices or busy wards. (In this trust, more than in others, we were left with a sense of the 'class divide' in the NHS, with the HR team facilitating inclusion as best they could.)

All staff directly involved in HaW.NHS also identified two persistent features of the trust which inhibited progress: the 'blockage' at operational management level which limited the value of communications exercises such as team-briefing; and the insufficient awareness at board level of the statutory implications of the Health and Safety legislation. HaW.NHS was being developed in quite a strongly 'dependent' culture whereby it was left to the committed few to focus on the priorities. Despite this, there was recognition that in relation to the gym, healthy diet and other activities which supported self-help in relation to personal health, the trust was moving forward as an employer that demonstrably cared about staff health. Similarly, the lifting and handling and team-briefing exercises elicited much positive recognition.

Thus, in relation to the first evaluation question, *How are we doing at becoming a health promoting trust?'*, the answer was *'Reasonably well'.*

In relation to the second question, *What are we learning about learning to become a health sustaining trust?* the answer would be qualified *Not well enough ... yet.*

The reasons for this are partly historical and partly to do with explicit management choices about organisational approach and leadership style.

Limited substantive expertise available

Insufficient substantive expertise and senior management commitment was brought to the key HaW.NHS activities. This was partly because of the constraints on staff time, but also because 'box thinking' inhibited the development of a core team which had both the knowledge of the organisation and the skills to sustain an integrated effort. Thus, the HEA's 'animateur' had a great deal to contribute to the design and support of the work.

Ambiguity in the management culture

There was, and is, an ambiguity about the management culture in a climate of continuing anxiety and uncertainty. This is being addressed through the creation of further opportunities for organisation and management development. However, there appears to be no map indicating the 'direction of travel.' This reflects, perhaps, wider cross-county uncertainties.

In sum, trust C is learning about learning to improve workforce health. However, while the leadership at three levels – corporate, process and operational – remains only partially engaged with the challenge, the full potential of HaW.NHS will not be realised. Workplace health is not yet perceived as a positive driver for change at trust C – more a problem to be tackled. Where it has been tackled positively the rich potential for the trust and its staff is becoming apparent.

Trust D — Social entrepreneurship in an ever-demanding environment

This trust is historically under-funded, yet has consistently met increasing performance targets while also achieving 'efficiency gains'. The constant sense of pressure experienced by the great majority of staff was captured in one of our group discussions.

> *In effect this trust is never out of crisis.*
>
> Reference Group member

Throughout the period of the evaluation it was evident that senior management paid constant attention to this intensity of pressure and its effects. They also responded to new, emerging needs

Box 5.5 Emerging HaW needs

Staff Stress: reflected in over-working, 'presenteeism', lunch taken into meetings or at the desk, persistent weekend working, and so on. There was a growing awareness of managers' responsibilities in monitoring the effects of undue stress and in reflecting on their own behaviour: both as role model and as facilitator of others' needs.

Communications were also key: especially style of communications where 'good' managers listened a lot and held frequent useful meetings, ensuring that staff were kept up-to-date and 'rumour-free'. They saw communications as a clear, unambiguous, management priority. Others added to stress by relying on 'trickle down' of information or, worse, by holding onto information as a source of power. (NB. we found a high level of awareness of 'good and bad' managers and an increasing willingness to address the challenge – especially where 'bad' amounted to intolerance or even bullying).

Security: the threat and/or incidence of violence and aggression towards staff grew over the period of the evaluation, and the trust management responded helpfully in a variety of ways; CCTV; training; security staff, etc. It was recognised that the skills needed in dealing with (potentially) violent patients and visitors were of a different order (e.g. dealing with visitors endeavouring to bring drugs into patients who were also addicts).

Thus, while the overall message was of a trust that was generally well managed and which did a great deal to sustain staff health in demanding circumstances, there was a general sense of pressure exacerbated by pockets of poor, uncommunicative management. In trust D, sound practice was also exemplified by the outstandingly well managed 'Lifting and Handling' programme (see below).

As the evaluation unfolded, the issue of the persistent sense of crisis was addressed in various ways in a number of the key interviews. There existed key factors which made this difficult to unblock.

- Attrition in the setting of the trust's contracts exacerbated by negative, or even punitive, attitudes towards the trust by purchasers
- An uneven response to the new pressures from the doctors: some responding positively; others resisting change. (Ironically, the most helpful consultants also generated the most work as they toiled to meet both elective targets and rising emergency admissions)
- A paper-driven contracts and performance management system which valued activity and costs over people, and took up a very high proportion of senior management time.

- Deliberately 'planted' rumours about cuts and mergers in the local press, which staff found constantly unsettling
- The discontinuities and dysfunctionality inherent in a split-site organisation
- The continuing willingness of staff and managers to over-work and carry ill-health at work.

Sustaining HaW is becoming recognised as a top management priority

At trust D senior management were beginning to come to grips with these complexities, and recognising their key role in creating a context in which staff could sustain health. By working analytically (assessing trends and developing an evidence-based approach) and by being prepared to be pragmatic/opportunistic, they had begun to create an integrated approach which was exemplified by the 'Lifting and Manual Handling' project.

> *Health and Safety is crucial in giving a positive impetus to workplace health because it is so pervasive and so obviously focused on staff well-being*
>
> Executive Director

(This perception of H & S as being of value 'beyond compliance' was not shared by all managers. In this trust the H & S manager was a valued member of the HaW.NHS team, yet he had to address internal resistance in some directorates).

The programme of work at trust D is built from developing a set of compliances focusing both on personal responsibilities for health and on the employer's statutory obligations. In order to make this work for 'Lifting and Manual Handling' a number of key elements were implemented (see box 5.6). This on-going programme demonstrated the real benefits of such an integrated, strategic, approach.

Another project which was not so effectively integrated – especially with regard to cultural sensitivity in respect of certain staff – was only partially successful, illustrating the concentrated effort and high level of skill needed to sustain any significant HaW.NHS initiative in busy NHS trusts. This related to 'Stress Management' which had been asked for by some key groups of staff. In the pilot stage the programme worked very well for clinical service staff, but failed almost completely for a group of administrative staff. In the latter case it was clear that some members of the project team were unaware of the sensitivities with which they were dealing. At Director level a great deal is now being done to remedy this situation.

The emergent cultural challenge

Nevertheless, we identified that trust D is at a key turning-point. The current management culture is not sustainable, despite its considerable merits, and the risk is that further *structural* attempts will be made to address the challenge when a deeper *cultural* challenge is emerging.

Box 5.6 Key elements in lifting and handling initiative

Leadership for the programme provided from within the appropriate directorate, providing both project management and substantive expertise

A small interdisciplinary team of specialists respected for their experience, expertise, and professionalism was responsible for the whole process

A budgeted plan was created entailing capital and revenue expenditure and including training and on-site monitoring of the newly trained staff

Cultural sensitivity to support cross-trust implementation in all directorates was seen as key

Measurement of costs and benefits was implemented, leading to a shared, meaningful assessment of the return on investment was implemented

Like trust B, trust D is struggling with the shift in emphasis from 'Acute' to 'Chronic' models of care: the latter being characterised by more process-orientated, whole health system models of conceptualising care and treatment. For example, in the 'Chronic' model, 'Rehabilitation' becomes a core integrating process, not a bounded functional department. This emerging realisation raises more fundamental issues than those originally noted at the commencement of the research and evaluation.

In trust D, senior management have begun to feel their way towards a more process-orientated, integrated approach whereby workplace health is not impeded or constrained by traditional structural boundaries or by the 'macho' management agenda which was stimulated and sustained by the internal market reforms.

Management are beginning to admit to their own and others' vulnerability

The phrase 'managing vulnerability' – of self, of others, of services, of contexts – began to surface, facing senior colleagues with a conundrum. Would explicit attention to these issues be seen as a sign of weakness, thus increasing the vulnerability felt by others? By beginning to model new behaviours (e.g. less 'presenteeism') and by developing a more process-orientated internal management development programme, it was hoped that a start could be made. An adaptation of the 'Stress Curve' (Teasdale & McKeown 1994) helped to explain the problem.

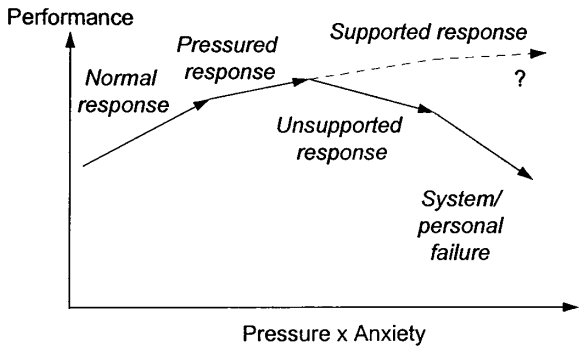


Fig 5.4 Performance under pressure

Our colleague, Eva Lauermann, points out that *not* investing in nurturing and support is equivalent to killing the geese that lay golden eggs – i.e. NHS staff. The 'Lifting and Handling' project at trust D was a good example of a well supported response, leading to sustained improvement under increasing pressure. Will future management development programmes be underpinned by similar principles? In trust D the Chief Executive and Directors are struggling with this personal challenge of shifting leadership style – despite resistance from some individuals and a continuing adversarial context locally.

5.4 The emerging role of the 'animateur'

Central to the HEA's research and evaluation strategy was the appointment of a field-worker to work with the demonstration sites' HaW.NHS teams in support of their implementation process throughout the period of the evaluation. The field-worker Linda Seymour embodied the NHS-wide 'Hawthorne effect' of the HEA's promotion of HaW.NHS. She was in effect an action-researcher with a substantial, legitimate interest in the research project.

Linda's interest is also substantive. She is a highly skilled and experienced research and development worker in the fields of health promotion and workplace health. She also has significant insight into the NHS through her previous role as a health authority non-executive director and her current responsibilities as a non-executive director in a community trust.

Moreover, Linda collaborated with the evaluation team in both the national and local steering groups and in the local audits, which together helped to define the terms of reference of HaW.NHS interventions within the trusts. After all, we all had to be sure that these programmes of work were realistic, appropriate and capable of being evaluated. Linda's own record is reported elsewhere (HEA 1998b). (In her report she explains the evolution of her multifaceted role. 'Animateur' is our term - not hers - describing the kind of change agentry we now perceive to be necessary in workplace health.)

The purpose of this contribution is to reflect on the learning from her role which we shared formally and informally as the programmes progressed. We have chosen the term *'animateur'*, which is taken from the community arts field, because it reflects someone who brings life to a programme both through their expertise and through their abilities as an enabler of others' practice and development. This is fairly long-term 'catalytic' work depending very much on the quality of the relationships established in the field and the degree of legitimacy accorded to the role and its holder by key protagonists.

Initially, as 'animateur' Linda brought a number of key skills to the local trusts.

Box 5.7 Key skills of the 'animateur'

Expertise in the methodologies required to achieve effective implementation of organisationally based workplace health initiatives (e.g. questionnaire design, running groups and interviews, planning activities, establishing monitoring and reporting processes)

Project and programme management skills

Information skills and access to up-to-date sources

Educational skills (especially with regard to the design and dissemination of materials and educational programmes)

Strategies and tactical awareness in relation to the changing NHS

Excellent, relevant networks

All these qualities were and are necessary, and complemented the available skills in the trusts to a significant extent. The idea was that colleagues would learn *from* Linda by working *with* her, and this did happen. Deep experience, an eye for detail, high professional standards and genuine, evident commitment all enhanced the HEA's contribution to the trusts. (This is a transferable model which could be much further developed by the HEA by building on its current educational programmes.)

Moving on in the role presents challenges — of trust capability, and of style and integrity of the animateur

But there are two 'Buts'. It also became evident that there were two opportunities for learning that emerged as the work progressed. The first relates to capability and recognition; the second to style and integrity. They were not predicted. They raised uncomfortable issues in the trusts for the HEA, and for Linda they created powerful learning for the future.

Working as an external 'change agent' is hazardous at the best of times which is why the big consultancies operate on the basis of their 'brand' and a 'pre-packaged' ap-

proach to diagnosis and implementation. While the diagnostic process for the local HaW.NHS projects was explicitly managed, the hidden 'mutual diagnosis' was ongoing and informal. By learning to 'live' with the trust's culture and dominant style Linda had to gain legitimacy in both trusts, both at the strategic organisational programme (process) level, and at the operational (embedded practice) level.

While the initial stakeholder and audit processes conferred a degree of legitimacy for the work, she had to establish her own legitimacy at each level as a change agent. Thus, recognition of her substantive skills was important; but this directly contradicted the other aspect of the animateur role — the need to facilitate ownership of grounded workplace health practice at all three levels of the intervention. The animateur's role is also to facilitate a transition from an organisational culture of *dependence* through *autonomy* to *self-improvement.*

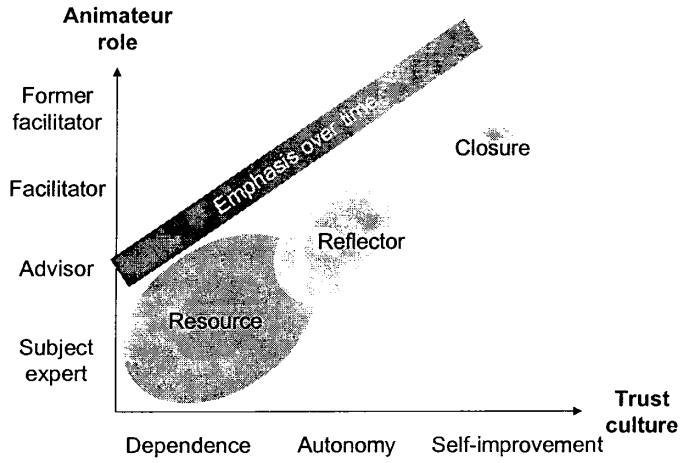


Fig 5.5 Animateur's changing role and relationship

Assessing progress within, between and beyond these phases is a challenge in itself. Each can be a 'long slow bake' depending on the conditions in the trusts themselves and the degree of support available to the animateur. We shared Linda's concern at the 'reflector' phase where it was not at all clear that anyone else recognised its significance and long-term importance. (Linda has developed her own model to explain this evolutionary process.) Anxiety about the need to do something — overemphasising the action in the action research model — was also a pressure that was experienced at critical times. But Linda was very clear about the requirements:

> *Everybody has got to know the ingredients and there needs to be equal involvement of the members of the internal team.*

Forthrightness and clarity are also prerequisites in this messy environment. We all found that while the 'Resource' role/phase was demanding, facilitating and staying with the 'Reflector' role was even more so — both emotionally and in terms of energy.

Some HEA colleagues found this considered, process-oriented approach difficult too and the central pressures to move to 'Closure' and then 'product development' were considerable. (This culture is changing – across the NHS and within the HEA – but there is still widespread impatience with reflective practice.) There was no doubting the animateur's capability, but achieving recognition as the process evolved was unrelenting hard work for the reasons noted above.

This inevitably put pressure on the integrity of the animateur's contribution. It is easier to give stakeholders, especially funders, what they want rather than what you believe they need! In addressing this challenge the issue of personal style became central.

Personal style, and support for the animateur role

There are as many personal styles as there are change agents and animateurs. We have noted the following minimum requirements for support and development of the animateur – especially one who like Linda in reflecting on her chosen style, determines not to 'feed the beast' but to ensure that sustainable development does occur, within the constraints and opportunities of each local system.

In traditional professional hierarchies, change agents are always at risk of being caught between cultures. When they are working with two or more such organisations these risks multiply. Yet they often are best placed to monitor congruence between the purpose of the workplace health intervention, its implementation, and evaluation. Thus, Linda's report forms an important connecting piece within the Research and Evaluation as a whole. From observing the consequences of her work and as a result of debriefing interviews, we were able to identify the critical support needs for this role which are generic for this kind of 'animateur'.

It is clear that this project would have been barely feasible without the animateur – especially in one trust where her depth of experience and expertise was invaluable in the first, resource, phase. Inevitably this created tensions as the initiative proceeded and the shift from the safety of dependence took all participants into the really difficult challenge of delivering sustainable workplace health.

This is where the HEA's tripartite Research and Development strategy paid dividends and offers an important model for future national interventions a workplace health.

Box 5.8 Support required for the animateur role

Independent support/supervision. This is potentially an isolated role and quite lonely despite its high level of activity. On-going, regular support through a mentor or learning set seems essential

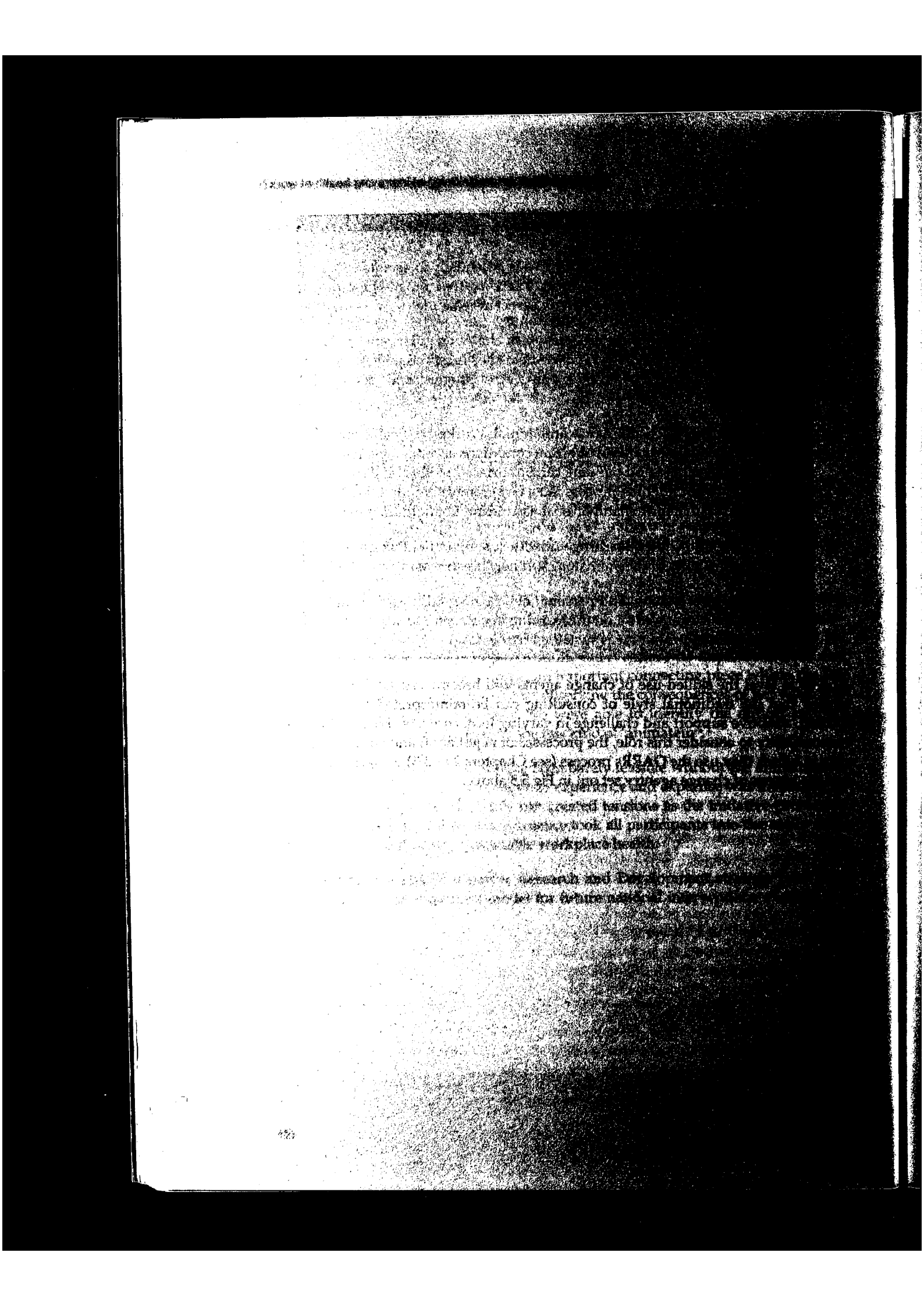
A collaborative monitoring process which enables regular reflection and review with the 'sponsor' and the field sites is essential. For example, using Fig 5.4 above to enable a mapping of progress and the implications for relationships

Dealing with conflict, avoidance and denial. Workplace health raises uncomfortable home truths about local conditions and management practices (even abuse and bullying can be surfaced by this kind of work). A safe, confidential process must be agreed and defined that enables the animateur to hand on such issues and not hold them

Networking and shared learning with other, similar 'field workers' is a key responsibility of the animateur and her/his sponsors

Continuing professional and personal development. The opportunity to conceptualise and reflect on the learning in a structured way is valued by animateurs...(and was sustained in this case)

At a local level the skilled use of change agents will become crucial. Linda demonstrated that the traditional style of consulting can be reinterpreted to provide informed, adaptive support and challenge in varying local contexts. Trusts will have a responsibility to consider this role, the processes of negotiation and support, and the way in which they use the OARRs process (see Chapters 2 and 3) to clarify and manage the phases of change agentry set out in Fig 5.5 above.



Chapter 6

What is important to NHS Trusts and their staff about HaW, and how could they learn to improve HaW?

The purpose of this chapter is to clarify our overall learning and to link our findings to those of CHKS in order to focus the key messages of the research and evaluation programme. We raise some fairly fundamental questions about the meaning, purpose and value of workplace health in the NHS.

6.1 Diversity and confusion about the meaning of HaW is widespread

We found much diversity of view about what is meant by Health at Work, with several groups and individuals saying they wished there were a clearer, and more widely accepted, description. Because so many interpretations are possible, confusion can easily arise when one person or group uses the phrase with one meaning, and another person or group 'hears' their own meaning which can be very different.

Greater clarity about the meaning of HaW is important

We identified three partially overlapping levels at which HaW can be interpreted:

- **Prevent harm:** Prevention of injury or harm to staff health from the organisation's activities (mostly felt to be linked to Health and Safety issues, but also related to the pace of work and pressures for change, and to the emerging and increasing risk from violent and aggressive behaviour by members of the public)
- **Promote individual health:** Positive promotion of individuals' understanding of their own health, and influencing it for the better (mostly linked to 'traditional' Health Promotion ideas and actions)
- **Integrate HaW with Strategy:** Development of an organisational culture which sees HaW increasingly as integral to the strategy of the trust (broadening much beyond the established role of Occupational Health, to become much more diversely influenced, particularly by Human Resources and senior managers collectively or individually).

Pictorially, these could be represented as:

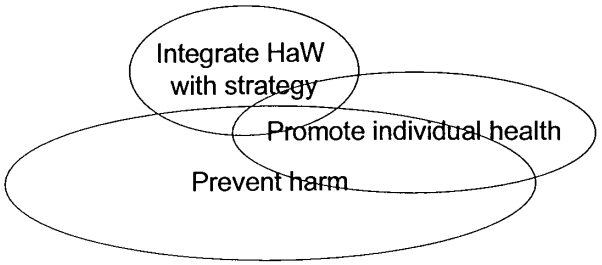


Fig 6.1 Levels at which HaW can be interpreted

The meaning is rapidly changing to recognise issues of staff *mental* health, as well as physical health – particularly as recognition grows of the high levels of stress measured in the NHS as compared with other organisations, and staff concern about it as an issue for them (Borrill et al 1996, Patterson et al 1997 & Williams et al 1998).

Organisationally induced stress – from the pressures of work and the pace of organisational and service change – was widely felt to be important by staff, and action should sit partly in the first level (prevention of harm) but can certainly be most influenced by the third level. (This is now acknowledged in the new HR Strategy for the NHS.)

Overlapping initiatives also could be interpreted as related – for example, the Health Promoting Hospitals initiative, and to a lesser degree the Healthy Cities movement – although some people drew clear distinctions between these and HaW as they interpreted it. For every trust, their workforce is a key part of the local health economy and of the local economy. As skill shortages become more critical, experienced and potential new staff will re-assess their value in this wider context.

6.2 Implications for a new style of leadership and personal responses

Because of the increased perception, and the reality, of the impact of organisational change on staff health, we believe there are important implications for leadership style at the top of trusts, for the HEA, and for the NHSE.

Top managers, professionals, and boards need to give careful re-consideration to where responsibility and accountability lie, if they are to secure widely desired improvements in Health at Work. As the risk of harm to staff rises from organisationally induced or organisationally preventable causes, the responsibility for action needs to move away from the individual (with whom it is predominantly now assumed to lie) towards a clearer management and organisational responsibility. And

as the *nature* of the risk changes, the responsibility for action needs to move to where it can best be dealt with – at individual, workgroup, trust, regional or national level.

We have seen this responsibility taken up and delivered exceptionally well in trust D in relation to manual handling of patients (and more recently, extending into other manual handling activities, and VDU use). After initial dependence on the manual handling specialist, the approach has succeeded in making this a clear, continuing, and effectively delivered responsibility of senior and middle managers throughout the organisation. Accountability is discharged through the general and professional management lines. It is taken seriously at the highest level of executive management, and by the trust board. The same issue is taken seriously, but less successfully or wholeheartedly implemented, in another trust.

Leadership styles which are more communicative and participative have been shown to be associated with lower staff stress levels (Borrill 1996), and are gradually becoming more widely accepted in principle. They are encouraged in training programmes and management development processes. However, rising day-to-day pressures can cause 'reversion' to more centralist and authoritarian styles even if that is not intended (see Chapter 4).

The HEA's emphasis at policy level is already changing to recognise the developing agenda. This will need to be carried through into a different kind of relationship with, and practical help to, hard pressed managers and professionals in the field, not just through provision of training and materials to health promotion and occupational health staff. The involvement in our study of an HEA funded 'animateur' or field worker has provided some important pointers to how this might be done differently in the future (Seymour 1999).

Given the pressures on senior staff from NHSE and political change requirements, the NHSE too must be prepared to change its expectations and behaviour if serious damage to staff health is to be avoided. Implementation of their new HR strategy will connect closely with the outcomes of this evaluation and the associated research (see Box 6.2).

6.3 Confusion arises because activities take place on widely varying scales

We found (as did CHKS in a larger sample of trusts) many examples of HaW related activity, on a wide range of scales. They could cover a whole spectrum from individual projects to (still partial) strategic integration.

Staff or managers didn't always see the first three sorts of activities as part of any concerted 'HaW initiative', although their potential impact was appreciated, where it was known about.

Box 6.1 Different scales of HaW activity

Individual 'projects' with relatively finite lifetimes (e.g., a health fair; staff attitude survey; health or fitness checks) – some of which might turn into ...

Individual ongoing activities (e.g., a staff counselling service; a staff gym; healthy eating options in the restaurant; no smoking policies and support for staff trying to give up smoking; alcohol and drug abuse policies; long-term sickness/ absence follow up; regular newsletter to improve communications)

Processes which fostered improved health at work in particular areas of the trust (e.g., improved security, and training for staff at risk from violence or aggressive behaviour in A&E department)

Linked programmes of activity (e.g., widespread investment in lifting and handling equipment and training to reduce risk of staff and patient injury; team briefing to improve communication)

Strategic consideration of HaW which connected with the overall priorities of the trust, organisational and management development

On the whole, trusts corresponding to CHKS's *marginal* categorisation will be likely to have activities mainly towards the project end of the spectrum, *instrumental* trusts to have a mixed picture, and *integrated* trusts to have developed a more principled, programme-linked and/or strategic view of HaW (HEA/CHKS 1998).

6.4 HaW can be addressed functionally or strategically

Like many other activities in the NHS, HaW can be tackled with some success at a tactical level, and we saw many worthwhile examples at that level. It is more difficult, but ultimately, even more successful, if it can also be addressed strategically.

Demonstration trust D and reference trust A were striving to make HaW an active and more nearly integral part of their overall trust strategy, and beginning to succeed in that. It was much less clear that this could be the case soon in demonstration trust C or reference trust B.

Making connections between initially separate activities which can be linked to HaW can be a useful intermediate stage. It raises the profile of HaW in staff perceptions, makes it easier for individuals with lead roles to feel supported, and can strengthen management/staff relationships.

Box 6.2 Mechanisms to increase integration of HaW activities

Bringing together individual initiatives under the umbrella of a small working group

Designating related activities as part of a larger programme of activities with guidance from an overall steering group

Overlapping memberships of working groups or steering groups.

Where the scale of activity warrants it, incentives and organisational support can be added, if activities are progressively included in individuals' or team objectives and built in to the performance review system

In part, our involvement as 'developmental evaluators' stimulated or reinforced such conceptual links by our inclination to see things as connected, where sometimes others did not, or had not previously. On one or two occasions, however, we were brought up short when trying to take the connections *too* far. One sharply delivered reminder was:

> *This [HaW] is not trying to turn us into a Health Promoting Hospital — stop using the phrase 'How are we doing at becoming a health promoting organisation?'*
>
> Project Leader

Changing the name, membership, and remit of steering group(s) or working groups can signal significant shifts in organisational emphasis between the three levels of HaW, and mark progressive 'connectedness' on the spectrum from individual projects to coherent trust-wide strategies. (*'Joining up solutions to connected problems'* – an active, intellectual process which does overtly challenge 'box-thinking' such as: *'leave it to the Health and Safety Adviser.'*)

6.5 Mismatch between staff expectations and perceptions of HEA HaW emphasis

Individual health issues are important, but not top of the list for staff

The HEA's role, if recognised at all by staff, was seen as emphasising the promotion of individuals' responsibility for their own health, and focused mainly on physical health. Most activities for which HEA training and supporting materials were available were seen to be concerned with individual projects and ongoing activities, and targeted for use mainly by health promotion and occupational health services. However, the involvement of the HEA field worker catalysed a shift in perception in the trusts where she worked (see Chapter 5).

Staff welcomed the attention paid by their trusts to physical health matters such as 'healthy eating' menus in the restaurant; no-smoking policies and help for individuals trying to give up smoking; drug and alcohol policies designed to support staff with those problems; and health check-ups offered either at 'health fairs' or as a routine activity. However, the CHKS 'second wave' analysis shows an uneven and inconclusive response to such initiatives over the three year period of our work.

Employees valued other trust initiatives such as staff gyms and counselling services, both for their own sakes and for their symbolic significance. Counselling services were initially available to staff in hard pressed areas, but later their scope broadened to all staff. *'It shows the trust are trying to care for us, and we appreciate that'* (or some variant of it) was a commonly expressed view in focus and reference groups in the four evaluation sites. *'In such turbulent times, even little things mean a lot'* — the effect on wider perceptions could be much larger than the direct impact of particular activities, even quite small scale ones. **A sense of being really cared about was much more important than specific initiatives which focussed on personal responsibility for health.**

Health and safety matters concern staff as well as regulatory bodies

Staff expectations (as evidenced by our reference and focus group discussions, and the staff attitude surveys done by IES and CHKS) were predominantly concerned with health and safety issues in the workplace; and with the impact on their stress levels and mental health of increasingly rapid organisational change, layoffs, and other factors such as poor communication. These were all matters which boards and line managers could reasonably be expected to address.

Communications and how organisational change is handled were top of the list of staff concerns

When it came to issues of stress and general mental health, 'improved communications' were high on people's list of suggestions for improving (mental) health at work.

Organisational change was a significant inducer of stress and gave rise to a real concern about how management were handling such sensitive issues. When it comes to one's own future role, let alone continued employment in the organisation, *'change is very, very, personal'* said one respondent. It mirrors the sometimes intensely personal interaction between a patient and the clinician involved in treatment or care-giving, however 'professional' the relationship.

Staff told us that they paid more attention to what senior managers and professionals *do* than to what they *say*, especially if the two are perceived to be different.

This means that the *manner* in which organisational change is carried through (and not just how it is talked about) makes a huge difference to people's ability to handle it well and constructively, and not see it as something that positively damages their personal mental health and well-being.

If British Airways' experience is anything to go by, staff who are treated well can in turn treat their patients dramatically better (or their customers, in BA's case). Being 'treated well' meant in BA that front line staff were given a strong, shared and explicit value base, clear leadership with a few firm rules, and wide discretion to act in accordance with the espoused values. The reverse – asking staff to treat patients (or customers) well, while they themselves are being treated badly – is not impossible, but a lot harder. (Of course, even in BA's case, 'dirty tricks' on Virgin could undermine staff belief in the reality of the value base. This example is very relevant to both demonstration sites where a recent history of adversarial relationships characterised the local context and continued to undermine staff confidence in a better, healthier future.)

New issues emerged over the period of our study

Over the period of our study, this gap in expectation began to be closed at a policy level, as the HEA took on board the importance of organisational behaviour on stress levels and staff mental health, and as other 'harm-prevention' issues emerged upon which local management took action – for example, reducing the incidence and effects of violence against health service staff, and reinvigorating team briefing to improve two-way communication and reduce staff uncertainty and stress about change.

Organisations' ability to respond not only to particular issues as they emerge, but also to address the more general process of continuing *organisational learning* is central. There is a need to learn to *expect* such change, and plan not only around each individual issue, but also to plan how to recognise and adapt to continually emerging further new issues (see Chapter 7).

6.6 A systemic, authoritative approach is a growing priority for trusts

We found that preventing a deterioration in staff health was a significant and important achievement, and hard to manage even in those trusts which were doing most to promote HaW.

A 'force field analysis' of factors favouring HaW and those opposing it would be heavily weighted towards the latter – for example:

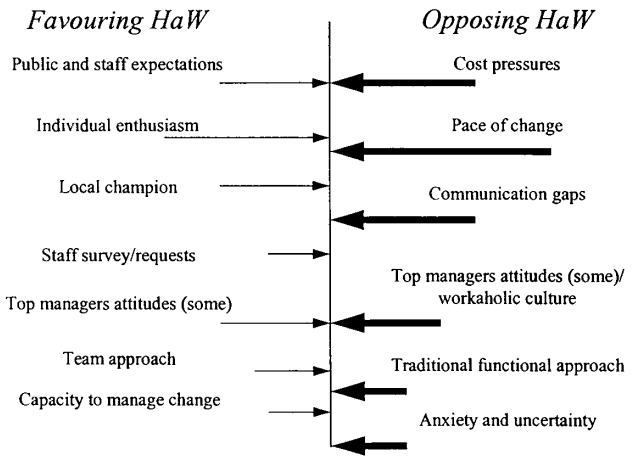


Fig 6.2 Forces favouring and opposing HaW

Given that the future for trusts is becoming even more challenging than the recent past, continuing in the same style may become unsustainable. One chief executive recognised this in his reflection on the contrast between what he believes to be necessary to meet central NHSE expectations of his organisation, and how his actions are perceived by local staff.

> *The tension is becoming too great for me to ignore.*

Undertaking such a force field assessment will greatly aid this Chief Executive and his board in analysing their current situation, identifying serious imbalances, and taking appropriate action. Engaging staff in such a process will help even more.

Hindering factors need to be reduced for HaW to become a reality in most trusts

A recognition seems to be growing that without modification of some of the hindering factors on the right of the above diagram, achieving the higher aspirations with which we started for HaW will be difficult to achieve on any widespread scale. Trust

managers cannot do much at present about some of the factors – for example, cost pressures, the pace of change – which are driven by demographic and political trends and national health policies (see Chapter 1). They can, if they choose, change the approach to some of the others – and we saw examples where this has been successful.

In some of the trusts we worked with, and others with whom CHKS have been working, communication has been significantly improved through (for example) better implementation of an existing Team Briefing process, with greater two-way communication (not just top-down conveying of information from management).

Improving HaW is a complex dynamic with shifting emphases

Breaking down the barriers of too-restrictive demarcations between functions also helps. We saw the beginnings of trusts using the term 'Health at Work' to draw together Occupational Health, Health Promotion, and Health and Safety work, and connect it with general development of managers and senior professionals. HR departments can use their influence to foster and sustain some of these connections. In reference trust B this need had been recognised and the HR director was taking a lead in recreating a more integrated needs-led system to support workplace health.

6.7 Links to key findings of the IES/CHKS surveys

Through our collaboration with IES and CHKS we identified five potential types of indicators, relevant to staff perceptions of what matters to them in HaW:

- the organisational context
- physical and psychological well-being
- sickness absence
- (changing the behaviour of) high risk groups
- stress.

These link well with our national external stakeholder group's perceptions. A healthy workplace, in their view, would have consistent:

- organisational policies
- individual perceptions (ideally, of a positive sense of well-being)
- activities directed to reduce preventable ill-health
- managerial / professional / staff / patient relationships
- (good) 'fit' between workgroups and the organisation

While there isn't quite a one to one correspondence with the previous list, there is strong congruence.

Communications and the culture of the organisation were also given high prominence by the national external stakeholder group, with particular emphasis on reducing stress through good communications, by congruence between words and actions, support of risk taking (vs. blame for failure), and by a reduction in workaholism of senior staff (the last more an aspiration than a common reality). In this they predicted some key findings from the Nuffield Report by some three years!

Sickness absence measures proved problematic for the wider group of 14 trusts, because meaningful figures were not obtainable at all in a majority of them. Even where they were obtainable, they were often only for very recent periods, not wholly consistent across different departments, or very limited in their analysis of causes of sickness absence.

The trusts we worked with were selected, in part, because they had good sickness absence records, actively reported and used. One trust had developed a coherent, rigorous and supportive approach to managing and monitoring sickness absence, run centrally by an HR manager, which was working well early in our evaluation period. When the trust tried to devolve accountability for managing and monitoring sickness absence to departmental line managers, they found that the reliability and rigour of the process deteriorated over the period of the evaluation. The trust is now having to consider re-centralising the process at least in part.

In some trusts, developing the capability to sustain effective workplace health interventions is not just a *rational* challenge, but also an *emotional* one (see Fig 3.2). 'Relapse' can occur if the emotional commitment is not sustained. The unrelenting nature of change in the modern NHS can readily result in marginalisation of HaW as 'just another initiative'. As the pressures continue to build, and evidence from other sources accumulates, it seems to us that work**force** health is becoming *the* change management issue.

This convergence — between change management and workplace health — is creating a new significance for HaW.NHS, suggesting that workplace health will not only change the *skills* needed to sustain it, but also the *will* to address it as a strategic issue. This is a key message for those concerned with implementing *Working Together* - the new HR strategy (Dept. of Health 1998b).

6.8 How could trusts learn to improve HaW: running up a down escalator

In the present climate of rapid organisational and clinical service changes, for an NHS trust to prevent its staff's health from deteriorating is a significant achievement. So *realistic expectations* and a more *ethical base for action* are two factors which can help the organisation to respond constructively.

Realistic expectations

Even the senior management groups in the trusts we worked with did not have a wholly consistent view of what 'counted' as HaW, so it is not realistic to expect staff to see different strands as being connected, or to expect strategically directed action connected to the trust's overall strategy.

As one reference group put it

> *[We] didn't know how much was covered by Health at Work... We learnt more from the Reference Group meeting than from the [HaW] programme itself... but we need to see something tangible to keep up momentum.*

Given the continuing pressures on NHS management and senior clinical staff, it is probably more realistic to promote a *few* projects or programmes *really well* than to try to make a difference across the board. We also learned that achieving this level of focus will continue to require constant board level attention and executive leadership (see Chapter 7).

Ethical base for action

Principled action to respond to whatever are legal requirements or important local staff concerns is more likely to have a real effect than 'token' actions on a wider front.

Trust D (in our view, and the local staff's) had done exceptionally well in implementing manual handling improvements throughout the trust. *Every* part of the implementation programme had had (after some minor initial setbacks) thorough and motivated support from all levels of management and staff within the trust, under the overall leadership of the ergonomics advisor. No single aspect was in itself exceptional, but it is still too rare to find such balanced, principled, and effective action taking place so coherently, over a whole trust, and becoming so well embedded in 'the way we do things here.' Plans are in place to follow this through and sustain the return on investment (see Appendix A – Cost Benefit Analysis).

Recognise the shift in the HaW agenda in setting organisational priorities

As noted elsewhere, both the realities of the environment and staff preferences are shifting the agenda beyond the traditional focus on Health and Safety, Occupational Health, and Health Promotion. Emerging issues already include:

- reducing unnecessary organisationally induced stress by managing change more sensitively, using multiple and frequent channels of two-way communication with staff, and *demonstrate* by action that staff mental health matters
- complying fully, and not just in a token manner, with legislative requirements to minimise risk of harm.

- pay attention to improve staff security, and training to defuse potential physical or verbal assault, and to other issues as they emerge, in addition to traditional areas such as manual handling, hazardous wastes and chemicals.

Use a systematic analytic method of identifying HaW needs and priorities

With our research partners, the HEA and CHKS, and using concepts proven by King's Fund Organisational Audit (KFOA, now Health Quality Service, HQS), we developed an approach and validated checklists which organisations can use to assess their performance in addressing HaW issues. This, or some other systematic method or methods of identifying the issues that matter, and taking action to address the highest priority ones, may help both to give HaW a higher profile, and to strengthen co-ordination between different and perhaps hitherto unrelated projects or activities (see HEA 1999).

Develop organisational capabilities and relevant skills

We found three key areas where improved skills and organisational capabilities can markedly contribute to improved HaW:

- substantive HaW skills
- reflective, evaluative, responsive management
- management development and people skills.

Substantive HaW skills

Subject knowledge in relevant areas is of great value, particularly in the more 'traditional' areas of HaW such as legislated health and safety matters, knowledge of what has been found to be effective in promoting individual health for a workplace population, and in managing occupational health hazards. Our research partner's field work role brought some of these skills to her work in the participating trusts, and enabled them to taken action with greater speed and confidence as a consequence (Seymour 1998).

Reflective, evaluative, responsive management

The pressures and current culture of NHS management and senior professionals tend to squeeze out time for reflective practice. The more successful practitioners made sure at least in some important areas to make the time for reflection, and to learn from both successes and mistakes.

Evaluative skills, particularly quantitative ones, were less in evidence. Trust D regularly quantified and analysed progress on Health and Safety matters, and extended much of the same approach into managing and monitoring progress on

manual handling policies. Both were accompanied by a successful style and pragmatic approach which engaged with managers at all levels, and with a wide range of staff, to ensure the transference of attitudes, approaches, and commitment throughout the organisation. Unfortunately, the importance of such analysis, let alone the availability of people locally with quantitative and analytic skills, is not now widespread in the NHS. Recent calls for 'evidence based management' have highlighted this need (eg. Peter Homa and Stephen Thornton at the 'NHS 50th Anniversary' conference).

We were happy to find managers willing to respond to the concerns of staff in all four of the trusts with whom we worked. Serious attempts were made to frame appropriate responses, even if they were not initially able to be applied everywhere, or appeared fragile in some places. Strong differences of style did emerge, both between different parts of the same trust, and between trusts, in the degree to which action was able to make the desired impact – ranging from substantial success, to occasional staff reactions of

> *its just tokenism' or 'they say this matters, but when it comes to it, other things take priority and [this activity — HaW or — usually — some more specific named topic] gets squeezed instead.*

In the next chapter we explore some more congruent and sustainable models for managing workplace health as a response to this fragility and patchiness.

Management development and people skills

We met, and admired, individuals doing excellently in developing other people and fostering HaW through strong personal example on particular projects and some ongoing activities or programmes of work – in counselling people with recurrent problems of sickness absence; in manual handling; in improving staff communications; in establishing and sustaining much welcomed staff gyms; in reducing hazards from sharps, chemicals, equipment or the building environment, among many. However, with the exception of manual handling of patients in trust D, we have yet to see these become firmly embedded within mainstream management processes and priorities, measured routinely, and linked directly to the trust's overall strategy.

As CHKS found, the biggest single concern of staff, and our commonest observation, was that the way change is managed currently has the biggest impact on staff perceptions of their health at work. All the trusts we worked with were facing significant organisational change in response to a whole range of (mainly external) factors – clinical service reconfiguration, technological development, financial constraints, professional practice requirements, site reconfiguration, and a whole host of others. Dealing with this sensitively, or even adequately in current circumstances, needs a significant increase in *organisational* as well as *personal* development. There are no simple answers, but changing attitudes at the top, and diffusing different methods of behaviour in organisations, can help. This evaluation has begun to clarify the 'signposts' for this emerging agenda of personal and organisational development work.

Planning for improvement using our emerging frameworks

The self assessment framework mentioned above, derived from work by CHKS and KFOA (now HQS), can help trusts not only to see where they are now, but also to plan for improvement. By highlighting and summarising the present pattern of activity, it can help trust managers to see what they are doing more as a whole, and not just as isolated fragments of the HaW jigsaw. By some of its more specific suggestions for how organisational infrastructure to support HaW might be shaped, it can stimulate change in the focus, linked membership and terms of reference of key steering or working groups concerned with activities related to HaW.

The HEA is considering a development of the checklists which would link them more closely with their ten priority areas. Together, the checklists and actions derived from applying them could help to sharpen the focus and improve the trust's performance on HaW.

Chapter 7

Evaluating the evaluation

In this final chapter we review our learning and identify signposts for future work.

Our key finding

HaW.NHS can enable trusts to clarify and develop interventions that sustain workplace health and improve their capability to respond to major change

Failure to address workplace health, through initiatives like HaW.NHS, is a risk which trust leaderships increasingly need to address

7.1 A reflection on the approach to evaluation

Our role has been to develop and test an approach to evaluation of workplace health which can act as a bridge between analysis and implementation. Our colleagues from CHKS, through their analytic and quantitative work, have created and substantiated a framework and indicators that will enable trusts to assess their own position in relation to workplace health. Linda Seymour's story provides a grounding through two in-depth case studies which explore the challenge of implementation over a significant period in the two demonstration trusts.

Our approach, reflective developmental evaluation, provides some useful frameworks

Our approach, reflective developmental evaluation, establishes some frameworks which can aid thinking and planning of workplace health in the context of complex and demanding change agendas within distinctive local environments. Because we see evaluation as an opportunity to learn through reflection-in-action and through reflection-on-action (Schon 1984); and because we firmly believe that summative evaluation serves formative evaluation – that is, *'what have we learned'* serves *'what are we learning'*. We also believe that our contribution is to offer some frameworks, principles and practices that aid process design. (For example, see Chapter 3.) By process design we mean the thoughtful, collaborative and explicit choice of a way, or ways, forward.

Box 7.1 Process design for implementation should be...

Purposeful, with stated, measurable objectives

Meaningful, based on an informed agenda

Ethical, using ground rules which are negotiated and monitored

Responsible, in which the participants agree roles and contributions – through an inclusive process

Resourced, to provide the means (time, energy, talent, facilities) to ensure implementation

The implementation of processes is messy, ambiguous, uncertain and riven with 'politics'. They cannot be pre-specified as pathways or protocols – but they do facilitate relationships, innovation, continuous learning and, hopefully, improvement. Our simple, generic process model (OARRs – making explicit Objectives, Agenda, Rules and Roles) underpinned all this work and enabled us to share the two evaluative questions with a variety of willing participants :

How are we doing at becoming a health sustaining trust?

What are we learning about learning to become a health sustaining trust?

Note that the participants changed these questions from the originals we set out with in Chapter 2.

Three key words — risk, emergence, and leadership

What we learned about workplace health and change ultimately boils down to three words.

Risk

Emergence

Leadership

All three are very current: risk (Giddens 1997); emergence (Stacey 1994); leadership (Mant 1997). But until now, they have been loosely inter-related – through sociology, organisation development and management development – and, in this case, they are grounded in the experiences and reflections of our colleagues in the trusts. Moreover, they have not previously been so explicitly connected to the sustainable development of the health and well-being of the employees of large organisations – let alone public sector healthcare organisations.

Three inter-related processes

We initiated this work by proposing a structured exploration of three inter-related processes – change management, workforce health improvement, and HaW interventions (see Chapter 2). By developing a qualitative and varied methodology, and experiencing its strengths and weaknesses (see Chapter 3), we have shared a process of learning began to clarify the links between these three processes, and the CHKS framework:

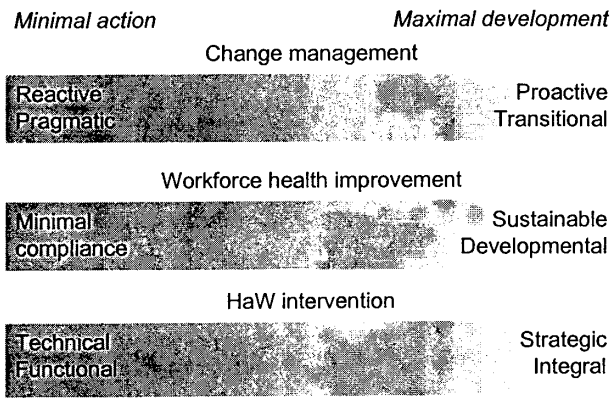


Fig 7.1 Processes affecting workforce health improvement

At any time a trust's mapping against each of these processes will reflect the current stage of practice: by managers, HaW.NHS groups, and workplace health specialists (see Chapter 5).

The principal contribution of the evaluation has been to tease out this framework.

This framework surfaces the choices faced by trust management and professionals.

> ***How do we wish to position ourselves — minimal action, or maximal development?***
>
> **Or**
>
> ***What do we do if we really want to improve workforce health?***

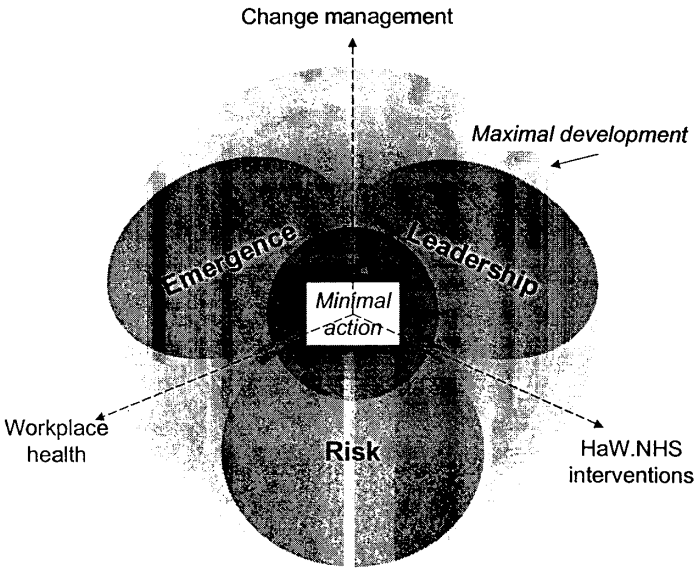


Fig 7.2 The '3D challenge' of workplace health

This highly conceptual framework sets up some important practical steps:

1. An evidence-based approach will inevitably require some form of monitoring process which extends well beyond the minimal, more-or-less reliable use of sickness absence data. Regular (six-monthly?) monitoring from a baseline created by the CHKS Self-Assessment Tool will provide managers and the HaW.NHS team with the data they need to address persistent and/or emergent needs.

2. Staff involvement exercises focusing on communications, appraisal of management style(s), responses to change and change management etc. will have the double benefit of addressing key workplace health issues and meeting one of the key requirements of the new HR Strategy for the NHS. Surveys, focus groups, internal consensus conferences – all **co-operatively designed** with a degree of independent facilitation – offer well tested means of providing trust leadership with information about the relationship between management capability and emergent workforce health needs.

3. The HaW.NHS team can begin to develop their own force-field analysis (Fig 6.2), and review it iteratively in relation to the outputs of (1) and (2) above, to provide an on-going risk assessment of the priorities for planning and action. In support of planning, in-trust responses can be developed using the guidance contained in boxes 6.1 and 6.2 above.

4. Appraisal of the HaW.NHS team, its strengths and needs, can be achieved through both a peer review process and a regular (say six monthly) debriefing with the Chief Executive and other board nominees.

As trusts engage with this evidence-based, reflective approach so they will develop their own methodologies and tools in order to work incrementally towards an integrated, maximal development approach.

7.2 Responding to emergent workplace health needs

Almost every decision and every consequent action in organisations has implications for staff health ... and managers are staff too.

In Chapter 6 we identified the three levels of meaning for Health at Work:

- Prevent harm
- Promote individual health
- Integrate HaW with strategy.

In Chapter 5, we summarised the learning from the four trusts as they began to address new and emergent health needs in the workplace. As the evaluation proceeded, so two issues emerged which have been substantiated elsewhere: 'stress' and 'violence and aggression'. Both have significant physical and mental health effects, and both require attainment of a 'direction of travel' as defined in Fig 3.3 if an integrated, informed and strategic approach is to be achieved. Each trust was achieving a measure of success in relation to sustaining staff health in the face of considerable change. Each trust was also 'blocked' in its response and the mapping framework (Fig 3.4) helped us to interpret our findings in this respect.

When asked *'How?' – 'How can we more forward in addressing workforce health in such a rapidly changing context?'*, we refer to Figs 3.2 and 3.3, and note that, quite apart from understanding the local context (the situational aspects), attention needs to be paid to the emotional and reflective aspects of the intervention, not just its rational aspects. The challenge is multidimensional, but we have identified three issues which put trusts at risk, if not addressed via their staff and accountable executives and non-executives.

Workplace health skills are critical to longer term organisational success

In relation to working practice it is very clear that, at a time when occupational health and health promotion are often marginalised in local health systems, the **substantive skills of workplace health professionals are as important as the clinical skills of other health professionals.** There will never be enough 'animateurs' to go around and the meaningful implementation of workplace health needs to extend beyond narrow functional interests.

The facilitation of substantive workplace health expertise within the structures of trusts and the creation of valued inter-disciplinary teams is critical to longer term success. All four trusts were endeavouring to achieve this from very different start-

ing points. 'Box thinking' by management and by the health professionals themselves was the biggest blocker, creating an organisational developmental challenge for the HaW.NHS teams and the 'animateur' alike.

Managerial priority for workforce health is central

In relation to management priority we refer again to the growing substantial body of evidence (Williams et al 1998) that indicates that **'management priority' is *the* issue**. The management development agenda identified within trust A was echoed by the Reference Groups in all four sites, and confirmed by Linda Seymour and CHKS's work.

Workplace health is fundamentally a personal development priority reflecting person centred management values, and their impact on staff motivation. In the trusts a degree of sophistication was emerging that helped colleagues identify and respond to the effects of management behaviour. Two 'blocks' – traditional hierarchical structures, and the sheer scale and complexity of the trusts – provide a persistent challenge to this approach. We hope that the mapping tools provided in this report can help colleagues to continue to develop their approach in an objective, blame-free way.

Making the shift from an 'acute' mindset to managing 'chronic' conditions

In relation to organisation culture we have begun to establish and clarify the nature of the relationship between the three processes identified in Fig 7.1 above (change management, workforce health management and HaW intervention). This initial mapping confronts senior management with the choices they face about the relationship between managed change and workforce health and the risks they are prepared to take with their own and others' health and well-being. Behind this set of choices lies a deeper crisis: that created by the contradiction between the inflexible hierarchical professional bureaucracies and the growing demands of a population whose epidemiology is increasingly characterised by complex, variable, disease processes. In trust D the Chief Executive and his service directors worked at this tension constantly as they began to unravel the tensions between their own acute and chronic sectors of provision.

The role of leadership

We firmly believe that the leadership shown by colleagues in the four trusts offers an insight into the way forward: a way forward that has been teased out by all three 'arms' of the research.

Leadership works at a number of levels within a trust, each of which is relevant, in different ways to sustaining workforce health (see box 7.2).

Box 7.2 Levels and roles of leadership for workplace health

Corporate leadership establishes the context in which health at work either grows or become marginalised. By ensuring that the basic legal requirements are explicitly and authoritatively promulgated, and by investing in programmes and facilities which facilitate personal responsibility for staff (e.g., healthy diet, internal communications, staff gyms) corporate leadership fosters a climate in which staff health can be seen as integral – 'the way we do things round here'

Process leadership is a form of professional internal change agentry whereby individuals become increasingly proactive in recognising and addressing staff health needs, to a point whereby they become integral to the responsible line management of staff groups and teams across the trust's functions and services. (e.g., revitalising two-way team briefing)

Leadership for improvement and self-improvement, a desirable characteristic of all managerial roles (functional, professional, medical, corporate) which moves beyond just meeting legal requirements towards self-managed improvement through continuous learning and development (e.g., managers ensuring that the principles and training for Lifting and Handling become embedded practice)

However, these are not panacea. Research and experience tell us that high levels of performance are impossible to sustain indefinitely without support. This is why the 'Health Promoting Hospitals' initiative seemed such an imposition to our trust colleagues. In its own context each trust sustained a remarkable record and there remains great willingness to learn and improve within high professional standards. Sustaining workforce health and achieving some improvement in key areas is a major achievement in the current circumstances. As the 'Stress' projects in trust D indicated, it is a fragile context in which to work, demanding a high price from those who take on the risk of leadership, especially where the overlap between sustaining staff health and managing change is so significant. Then workplace health leaders begin to uncover both the comfortable and the uncomfortable truths about the effect of colleagues' behaviour on staff health. This is where the real test of managing for improvement begins.

7.3 Beyond the Evaluation: A Contribution to Theory?

Context is (almost) everything

(Sang 1998)

Early on in the evaluation we shared with Linda Seymour a concern that our work might have been expected to become 'product development' for the HEA. Working

together with the animateur, we would have identified the ingredients of successful workplace health interventions and reproduced them as generalisable, transferable products for 'sale' and use across the sector.

We knew that the trusts could not be treated as a 'field' for positivistic investigation and analysis. As we have explored in Chapters 2 and 3, our original design was both naïve and over-elaborate, but it did create the opportunity for significant learning.

First, Linda Seymour's 'story' stands up in its own right and offers significant learning to be shared with the future external and internal process leaders.

Second, each case study – including the CHKS case material – stands up within its own context.

Third, in this summative evidence-based reflection, we have begun to develop a set of frameworks that, with further intellectual work, will offer a fresh basis for exploring workplace health within rapidly changing and uniquely complex organisational contexts.

Fourth, others are already moving beyond the limitations of our frameworks and have begun to address this challenge from a whole system (locality) perspective (e.g. Kelly 1997). Thus, our contribution to theory, which will be developed collaboratively following this report, will endeavour to focus on the key findings from our work about evaluating complex processes in complex organisations.

Conditions for the process to work

Reflective developmental evaluation can help trusts to create a sustainable set of workplace health interventions... *provided that*:

- there is sufficient substantive Workplace Health expertise and reflective capacity available within the trust
- senior management explicitly choose to share the risks associated with taking on HaW.NHS in order to prevent relapse to prior conditions (see Fig 3.2 especially)
- the cultural/emotional dimensions of change are addressed as part of an overt shift from traditional rationalist models of change.

The 'three tiers' model of workplace health (Chapter 6) is sustainable if the work practice, management development and organisational development implications are articulated, analysed and addressed. Cost Benefit Analysis is a potentially helpful tool in this analysis when it is linked to all three levels of development (see Appendix A.)

Health at work is integral to our understanding of the 'risk society', and within this managing emergence in creative, sensitive and meaningful ways is critical to linking sustained staff health to change management.

Three styles of leadership practice have been clarified which address the needs of organisations undergoing the transition from traditional functional models of bureaucracy towards process-orientated models mirroring the individual health journeys of patients, and the personal transitions of staff (Bridges 1995).

Conclusion

This evaluation has created a platform for further research and development in partnership with the trusts, the HEA and the wider networks of colleagues who recognise the fundamental importance of workplace health in the national agenda.

Our work has begun to explain the necessary convergence of the processes of purposeful organisational change and workplace health improvement. The HEA's programme has stimulated this 'healthy convergence' in some trusts by chance; in others by design. We believe that HaW.NHS research partners contributions taken together and developed further will continue this important systemic change.

Finally, three key questions:

1. For chief executives and their boards:

What is your risk assessment of the relationship between the state of trust work***force*** health and the attainment of operational and strategic objectives?

2. For HR directors and their 'allies':

What is the relationship between your HR strategy and sustainable work***place*** health in the trust?

3. For the HaW.NHS team and its champions:

What will you need most to continue your important work? And, depending on the answers to questions 1 and 2, what is your prognosis for health at work in your trust?

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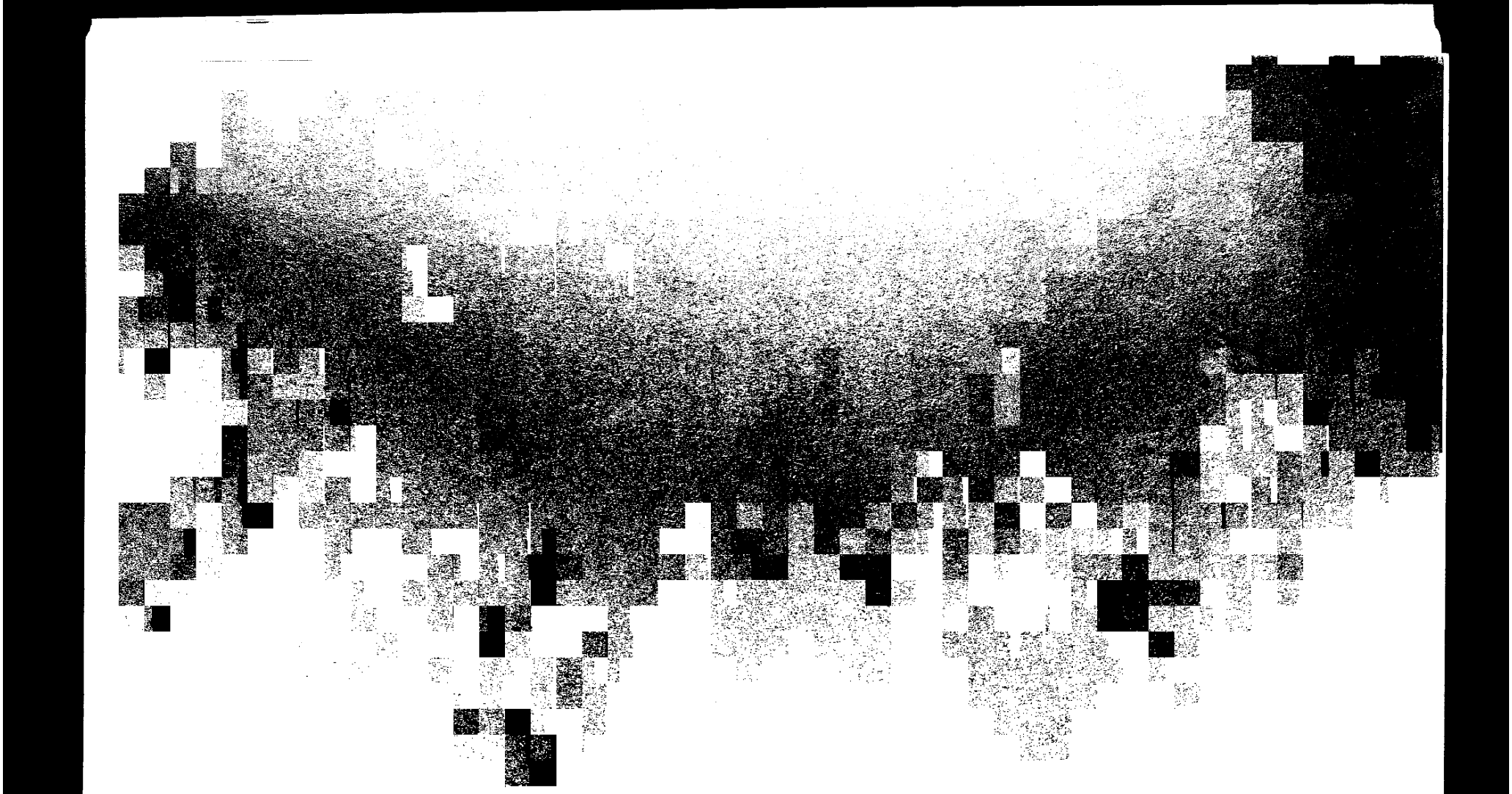
Appendix A

Cost Benefit Analysis – Application



Appendix: Contents

Appendix A

Cost Benefit Analysis - Application

A1. Introduction

One of the often asked questions from hard pressed managers and professional staff about Health at Work is some version of "Does it pay?"

Given the importance of this question, it is disappointing to find little UK-based evidence in the literature, or from knowledgeable researchers, on Cost Benefit Analyses (CBA) for Health at Work. (Some data is available for the US context, which yields a qualified "Yes" answer for some traditional health promotion and disease prevention subjects.)

We were asked to attempt to include topics for which it appeared in advance that adequate data and useful results might be obtainable within the time and resource constraints of this project, for subjects of potential interest to other Trusts.

A2. Topic selection

Topics selected had to meet several other criteria as well as the actual or potential availability of data which would enable CBA. They had to be:

- on a significant enough scale so that the potential impact would be detectable, and would affect a significant fraction of the Trust's total staff
- have started since the launch of the HaW programme by the HEA
- have impacts that could be measured with little additional effort, based where possible on routinely collected data supplemented if necessary by staff surveys
- have likely impacts on important dimensions identified by the External Stakeholder group, such as induced stress levels affected by communications with top management, perceived job insecurity, and physical well-being.

Two topics were chosen at the demonstration sites which seemed potentially able to provide sufficient information to enable at least a roughly quantified cost benefit analysis.

They were:

- Lifting and Handling (Trust D)
- The impact on staff sickness absence of use of the Staff Gym (Trust C)

Our aims were:

- to define the conceptual basis for CBA for these topics, if possible in a generalisable way for use on other topics
- to see if adequate data exist to enable CBA to be done on an individual Trust scale, for these topics
- if so, to see to what extent the Trusts needed help in formulating and completing the analysis
- to draw conclusions, if possible, on the balance of costs and benefits, and to describe what would be needed to apply CBA more widely in Health at Work.

A3. Conceptual basis

The basic general concepts of CBA are well known, and in essence very simple. The difficulty lies in putting them into practice in particular cases.

In general, one compares the 'benefit stream' over time resulting from an activity, project or programme with the corresponding cost stream. To account for differences in the timing of costs and benefits, one uses some form of 'discounted cash flow' to take account of the greater importance of immediate than more distant future benefits and costs. It is also important to calculate the benefit and cost streams relative to some 'baseline' of what would otherwise have happened.

CBA should also be *relevant* to the organisation's priorities, consider *significant* benefits and costs, identify those which are *measurable*, and where possible translate those measurements *usefully* into monetary values, and make them even more *meaningful* by using 'discounting' to allow for the lessening importance of benefits and costs further into the future.

Benefit stream

The benefit stream should be identified in a four stage process:

- describe qualitatively the **types of benefit** to be considered, and **to whom they are attributable**
- decide which types of benefit are **both important and quantifiable**
- for these, estimate the **quantitative amount of each** in appropriate 'natural' units (e.g., numbers of people, lengths of time affected, strength or severity of effect)
- where possible translate from 'natural units' into **monetary values over a range of time periods.**

Then **'discount' the monetary values** occurring at different times to calculate a 'present value' which allows for the lower value of benefits occurring further into the future than benefits achieved now.

Types of benefit and who obtains them

Benefits of interest will generally include

- improvements in individual or population health (care may be needed to define the population benefiting), reduction in individuals' risk of illness or injury, levels of pain, discomfort, disability, stress, or fear of illness, which in turn may lead to more directly measurable benefits such as
- better staff morale and productivity
- reduced time off work
- lower support needs from others (e.g., cover for staff off sick, reduced need for statutory or unpaid carer support).

They may accrue to individuals or groups (sub-populations), organisations, or society at large, and a choice needs to be made about which level is most relevant for a particular analysis. In many cases (and in ours here) the focus will be on benefits accruing to the employing organisation. However, for some purposes the focus may more appropriately be on specific population subgroups (e.g., those at risk of developing cardiovascular disease, or stress related psychiatric illness), and in other cases on society at large.

Important and quantifiable benefits

Two filters can be applied to select which benefits to analyse in further detail - how *important* are they, and how readily can they be *quantified.*

Deciding on importance requires judgement, and a sense of the relevant criteria to apply. The criteria may include perceptions by different stakeholders of their *beliefs* and *values* which define for them what is worth looking at. The sheer *scale* may also be important - the more people are affected, and the more dramatic the *impact* on their health, the more importance one is likely to attach.

Quantification is partly a matter of principle and partly a practical matter -- how clearly can the identified benefits and beneficiaries be described and counted? -- and how much skill and effort would be required to measure the effects reliably enough to be useful? Again judgement is needed, balancing the availability and sources of skills, and the effort to gather and analyse relevant data.

A4. Data availability and analytic capability in the trusts

Both trusts D & C had high levels of senior management commitment to improving staff health at work. They differed significantly, however, in the availability and

application of substantive expertise to both implementation and evaluation of the impact of their interventions.

In trust D, both the intervention (a limited lifting and handling policy for patient handling) and its evaluation benefitted from locally available expertise and staff with substantial dedicated time for this issue.

In trust C, by contrast, there was very limited availability of management time for evaluating the staff gym investment, and no locally available evaluative expertise.

Lifting and handling

Trust D had already completed the majority of data collection and analysis needed for cost/benefit analysis after the introduction of its Limited Lifting and Handling policy, and prepared a report for Trust Management and the Audit Commission (see below for details of data obtained and used). However, the cost side of their analysis did not include explicitly the time costs of the ergonomics adviser who spearheaded implementation, nor the time costs of the very successful and extensive staff training programme which she initiated. We have attempted to include approximate allowances for these, based on judgement and notes from interviews and focus groups about the nature, duration, and extent of these training events in the study period.

Gym use

At Trust C, the management were concerned to provide the gym at minimal net ongoing costs to the trust, after the initial donation of space, its refurbishment, and initial equipment acquisition. In discussion with trust HR staff, we agreed to try to supplement this with a special data collection exercise to assess the impact on staff fitness indicators, and on their sickness/absence record.

We first selected a quasi-random sample of just over 50 gym users, then wrote to them seeking their agreement to obtain data about their gym membership period and initial fitness status assessment from the gym manager, and their sickness absence record from trust personnel records. We had also hoped to conduct a second fitness assessment at the end of the analysis period, but other pressures on the trust at the time made this infeasible.

We were given very considerable assistance in survey implementation and data collection by staff in HR, but it is noteworthy that the trust had no access to the analytic skills needed to plan and design sample surveys, nor to analyse the results of data collection. No one within the trust, nor in related or neighbouring organisations (such as a local university), had the combination of skills, time available, and interest needed, so we had to perform most of these tasks ourselves.

A5. Balance of costs and benefits: case studies D & C

Lifting and handling (trust D)

Trust D is an acute trust with nearly 3,000 staff. For this trust, an extremely well implemented programme of investment and training in patient lifting and handling has paid handsomely - a return on investment of over 30% pa for the first four years alone. The rate of return should increase further if the benefits continue at the same rate, and after the initial investment, recurring costs to maintain the training and equipment should remain relatively low, unless the present low staff turnover increases markedly.

Broadly speaking, identifiable costs had been recovered by about three years into the implementation of the trust-wide policy. Future costs will be much more than outweighed by savings if the experience of the first few years is continued.

The main benefit has been the virtual elimination of serious injury to staff arising from lifting and handling patients. Financially, this has resulted in dramatically lower (almost eliminated) litigation costs and anticipated damage claims. Before implementation of the policy, these were running at a (variable) level of around £200,000 pa. Nearly £100,000 pa further savings resulted from staff needing less time off work as a result of serious injury.

Initial capital costs of around £150,000 were incurred over two years for equipment, the greatest part on patient hoists with an anticipated lifetime of many years, and minimal annual inspection and maintenance costs. Other less costly equipment such as drawsheets and patient slides will need replacement more frequently as it wears out, but ongoing costs are relatively low.

Training costs are hard to estimate reliably, but we have calculated them as approximately £107,000 for initial training of all relevant staff (mainly, but not exclusively, nurses, porters, radiographers, and physios), spread over two financial years. Now that all relevant staff have received initial training it is a matter of maintaining expertise for existing staff, and providing training for newly recruited staff, and this is now built in routinely to the trust's management and training processes at an annual cost of around £47,000. Most initial and ongoing training was and is provided by a pool of 180 'key trainers' who were in turn trained by the ergonomics adviser. The pool is kept topped up by training replacements in a similar manner (about 30 in one recent year).

It is particularly noteworthy that the ergonomics adviser was extremely successful in generating enthusiasm and support from nursing management and ward nurses themselves - a great tribute to her approach and attitude throughout a long process.

Had this not been the case benefits would not have been so great, nor so extensively obtained as virtually to eliminate staff injury from patient handling. The trust's experience demonstrates the value of learning to *'do it all the time, everywhere'*.

The calculations which follow demonstrate a real success which was underpinned by highly effective leadership, executive commitment and substantial expertise. Without those, the ratio of benefits to costs elsewhere cannot be so favourable, but even a less dedicated approach should pay handsome dividends.

Table A-1. Lifting and Handling Cost Benefit Analysis

All amounts in £000	*Before*		*After*		
	No.	*Value*	*No.*	*Value*	*Annual saving*
Benefits - reduction in outgoings					
Staff injury claims - number (note 1)	4		0		
Staff injury claims - anticipated settlement costs (note 1)		200		0	200
Cost of staff absence through L&H injury (note 2)		100		10	90
Net annual benefit					**290**

		Cost in year ...			
Costs - programme setup		*1*	*2*	*3*	*4*
Initial investment - equipment (note 3)		75	75		
Initial training (from training cost analysis)		53	53		
Additional equipment (note 4)				25	
Costs - ongoing					
Annual training costs (from training cost analysis)				47	47
Equipment replacement - not costed but small - say					5
	Total				
Total costs, by year	**380**	**128**	**128**	**72**	**52**
Net benefit	**200**	**-128**	**-128**	**218**	**238**
		Annual multiplier			
Annual discount factor (note 5)	8%	*100%*	*92%*	*85%*	*78%*
Discounted benefit (= benefit in year x annual multiplier)				245	226
Discounted costs (= cost in year x annual multiplier)		128	118	61	40
	Total				
Discounted net present value	**124**	**-128**	**-118**	**185**	**185**

(years 1-4 only - increases over longer period)

Return on investment **33% after only 4 years**

Notes

1. Trust claims history, and legal service estimate of average settlement (just over £50K)
2. Trust Lifting and Handling Audit
3. Internal note and discussion with ergonomics advisor
4. Discussion with ergonomics adviser - mainly remedying gaps in initial equipment coverage
5. Annual multiplier = (100% - Annual discount factor)**(No. of years after first year)
   hence second year (100-8)% = 92%; third year 92%*92%= 85%; fourth year 92%*92%*92% = 78%
   Annual discount factor - taken as typical UK Treasury discount rate for public sector CBA

Table A-1. Lifting and Handling Cost Benefit Analysis (cont)

Training cost analysis

Staff time:	*Number of people*	*Days each*	*Times per year per person*	*Person days*	*Rate (note 4) £/day*	*Initial Setup Cost £000*	*Annual Cost £000*
Of ergonomics advisor (note 1)							
Initial training of ward trainers (first year only)	1	173	1	173	130	22	
Specialist training (ongoing)	1	23	1	23	130		3
Selected new staff, agency & temporary staff, and isolated department staff	1	0.5	40	20	130		3
Of trainers (note 2)							
Training of original ward trainers	180	4	1	720	78	56	
Initial training for new trainers	30	4	1	120	78		9
Annual refresher	100	0.5	1	50	78		4
Of staff (notes 3 & 5)							
Ward staff, physios, radiology, et	2150	0.4	0.5	430	65	28	28
Total, staff time at normal daily rate						**£107K**	**£47Kpa**

Notes

1. Assumed payroll cost of £30,000 pa
2. Assumed payroll cost of £18,000 pa
3. Assumed payroll cost of £15,000 pa
4. Daily rates are calculated as (annual payroll cost)/(no. of workdays a year) - assuming 230 workdays/yr
5. For some staff, the training is fitted into quiet periods, and does not directly result in additional cost to the Trust, but we have not allowed separately for this

Impact on sickness absence of use of the staff gym

After the initial costs of setting up the gym in a disused linen room had been borne by the trust, the net running costs have been managed to be near-zero.

Staff in focus groups report feeling better about themselves, and about the trust for having made the investment in the gym on their behalf.

Have there been additional benefits to the trust in terms of reduced sickness absence of gym users? Not measurably so, although this may be simply because of the high variability of individual sickness absence patterns over time, and the practical limitations placed on sample size.

The table *Percent Absence Before and After Gym, by Individual* on the following pages shows by individual the pattern and percentage of sickness absence before and after the gym opened, and in the period in between opening and individuals' joining. The individuals are grouped into six bands (labelled 0-5) depending on their total days of sickness absence in the analysis period from 1 April 1994 to 31 December 1997.

There is no straightforward interpretation of the data. The *lack* of pattern is however consistent with the CHKS finding that trusts can make a systematic difference to organisationally induced staff ill-health, but *not* on most measures of individual lifestyle-influenced health indicators, including sickness absence. This is also consistent with earlier studies of sickness absence in the NHS (for example, Seccombe and Turner, 1995).

Table A-2. Percent Absence Before and After Gym, by Individual

Absence Band (note 1) Age	Total days sick	Before Gym Opened: Days Absent	Before Gym Opened: Weeks Employed	Before Gym Opened: %Absent (note 2)	Before Joining Gym: Days Absent	Before Joining Gym: Weeks Employed	Before Joining Gym: %Absent (note 2)	After Joining Gym: Days Absent	After Joining Gym: Weeks Employed	After Joining Gym: %Absent (note 2)
5										
61	166	0	196	0.0%	0	3	0.0%	166	135	17.6%
51	183	0	196	0.0%	0	0	0.0%	183	138	18.9%
50	187	3	196	0.2%	184	44	59.7%	0	94	0.0%
37	209	80	196	5.8%	0	27	0.0%	129	111	16.6%
50	**745**	**83**	**783**	**1.8%**	**184**	**75**	**41.1%**	**478**	**478**	**16.7%**
4										
55	94	86	196	6.3%	0	0	0.0%	8	138	0.8%
52	88	26	196	1.9%	41	10	56.2%	21	128	2.3%
42	71	67	196	4.9%	0	17	0.0%	4	121	0.5%
38	84	14	196	1.0%	0	1	0.0%	70	137	7.3%
47	**337**	**193**	**783**	**4.1%**	**41**	**29**	**23.9%**	**103**	**524**	**3.3%**
3										
60	48	21	196	1.5%	0	6	0.0%	27	132	2.9%
57	32	14	196	1.0%	0	54	0.0%	0	84	0.0%
54	33	0	196	0.0%	31	43	10.3%	2	95	0.3%
42	29	8	196	0.6%	6	41	2.1%	15	97	2.2%
38	21	4	175	0.3%	16	63	3.6%	1	75	0.2%
35	21	11	196	0.8%	3	39	1.1%	7	99	1.0%
33	38	29	196	2.1%	0	0	0.0%	9	138	0.9%
26	23	3	175	0.2%	0	1	0.0%	20	137	2.1%
43	**245**	**90**	**1524**	**1.0%**	**56**	**248**	**3.8%**	**81**	**858**	**1.6%**
2										
53	18	3	196	0.2%	12	56	3.1%	3	82	0.5%
50	9	0	196	0.0%	0	0	0.0%	9	138	0.9%
49	14	2	196	0.1%	0	6	0.0%	12	132	1.3%
43	20	4	196	0.3%	0	5	0.0%	16	133	1.7%
39	10	0	196	0.0%	5	61	1.2%	5	77	0.9%
36	8	1	196	0.1%	0	8	0.0%	7	130	0.8%
34	9	5	196	0.4%	0	1	0.0%	4	137	0.4%
34	17	5	196	0.4%	0	20	0.0%	12	118	1.4%
30	8	0	196	0.0%	3	68	0.6%	5	70	1.0%
28	18	7	196	0.5%	1	39	0.4%	10	99	1.4%
40	**131**	**27**	**1957**	**0.2%**	**21**	**265**	**1.3%**	**83**	**1117**	**1.2%**

Absence Band (note 1) / Age	Total days sick	Before Gym Opened: Days Absent	Weeks Employed	%Absent (note 2)	Before Joining Gym: Days Absent	Weeks Employed	%Absent (note 2)	After Joining Gym: Days Absent	Weeks Employed	%Absent (note 2)
1										
50	3	3	196	0.2%	0	25	0.0%	0	113	0.0%
42	6	4	196	0.3%	0	0	0.0%	2	138	0.2%
41	7	5	196	0.4%	0	8	0.0%	2	130	0.2%
39	5	5	196	0.4%	0	2	0.0%	0	136	0.0%
36	5	0	196	0.0%	2	64	0.4%	3	74	0.6%
34	4	0	196	0.0%	2	57	0.5%	2	81	0.4%
28	3	0	196	0.0%	0	0	0.0%	3	138	0.3%
26	6	2	196	0.1%	4	64	0.9%	0	75	0.0%
37	**39**	**19**	**1566**	**0.2%**	**8**	**221**	**0.6%**	**12**	**885**	**0.2%**
0										
57	0	0	196	0.0%	0	2	0.0%	0	136	0.0%
52	0	0	196	0.0%	0	1	0.0%	0	137	0.0%
51	0	0	196	0.0%	0	99	0.0%	0	39	0.0%
47	0	0	196	0.0%	0	9	0.0%	0	129	0.0%
46		0	196	0.0%	0	4	0.0%	0	134	0.0%
46	0	0	196	0.0%	0	0	0.0%	0	138	0.0%
44	1	0	196	0.0%	0	68	0.0%	1	70	0.2%
43	0	0	196	0.0%	0	80	0.0%	0	58	0.0%
41	0	0	191	0.0%	0	0	0.0%	0	138	0.0%
41	2	0	196	0.0%	2	3	9.5%	0	135	0.0%
39	2	0	196	0.0%	0	20	0.0%	2	118	0.2%
39	0	0	196	0.0%	0	51	0.0%	0	87	0.0%
36	0	0	196	0.0%	0	21	0.0%	0	117	0.0%
33	1	0	42	0.0%	0	10	0.0%	1	33	0.4%
32	0	0	144	0.0%	0	1	0.0%	0	137	0.0%
26	0	0	126	0.0%	0	53	0.0%	0	74	0.0%
42	**6**	**0**	**2852**	**0.0%**	**2**	**422**	**0.1%**	**4**	**1680**	**0.0%**
Grand Total:										
42	**1503**	**412**	**9466**	**0.7%**	**312**	**1259**	**4.1%**	**761**	**5542**	**2.3%**

Notes

1. Banded by total number of days off sick in whole analysis period (second detail column in table)
2. Based on 6-day "benefit week" - but note that short absences count work days only; longer absences spanning weekends include non-working days as "absent"
3. Before gym opened - from 1 Apr 1994 (start of analysis period) or start of employment (if later) to 9 May 1995 (gym opening date)
   Before joined gym - from gym opening or start of employment, if later, to date individual joined the gym
   After joining gym - from date joined the gym to end of analysis period (31 Dec 1997) or end of employment if earlier
4. "Weeks employed" are displayed to the nearest whole number, but stored as fractions to the nearest day. Totals shown therefore may not agree exactly because of internal rounding
5. Lines in bold type are averages of the detail in each Absence Band above
6. The opening of the gym approximately coincided with a strong drive by the Trust to manage sickness absence much more proactively

A6. Lifting and handling - specifics

Identify and attribute types of benefit

Types of benefits in lifting and handling could include:

For patients

- reduced risk of injury from inappropriate lifting and handling: (e.g., tissue damage which could result in extra length of stay; pain and suffering; overt musculo-skeletal injury or even death) *

For individual members of staff:

- reduced pain, discomfort, disability and time off work due to inappropriate lifting and handling of heavy loads (whether people or - in later exetensions of the programme in trust D - inanimate objects such as heavy boxes of patient records)*
- reduced concern about lifting and handling

For the Trust

- reduced risk of injury to patients, and hence less time off work, fewer claims for compensation**
- better working conditions for staff
- reduced time off work of staff affected by injury caused by inappropriate lifting and handling, and also fewer claims for compensation**
- lower need for additional staffing to cover for staff off work due to lifting and handling injury*
- less management time taken dealing with the consequences of the above*
- lower needs for legal services*

Identify important and quantifiable benefits

Items starred (* or **) above are *in principle* both important and quantifiable. Those considered *in practice* in the Trust's own analysis have a double star (**).

Quantify in natural units

Patient time off work can be counted, and attributed a degree of severity (for example, as a minimum, the duration of disability); or classified in various ways beyond that.

> Typical problems include inadequate or incomplete recording systems, missing or doubtful classification details, and limited information about the severity or duration of disability.

Staff time off work can be totalled by staff grade (and optionally, by department or responsible manager)

> Typical problems again are incomplete, unreliable, inconsistent, or unclassified data, limited or inconsistent information about staff grade, department, or manager. For example, in the twelve Trusts included in the CHKS research data, only four had reasonably comprehensive and accessible sickness absence recording systems, all introduced only in 1995 or later, precluding longer term analysis with any validity.

The need for staff cover for injured staff can be estimated using a combination of quantification of the amount of time off work from this cause, records of the total use of agency, bank, or replacement staff, and judgement about the extent to which the former required the latter.

> Data on staff absence may not be classified by cause in a way which makes it easy (or even possible) to extract only that due to lifting and handling injury. Agency and bank staff usage is usually available at least in total, although it may be harder to access from any central source. Judgements by experienced staff for a selection of departments or directorates may be needed to estimate what proportion of absence due to lifting injury is in practice covered by additional staff, or absorbed by existing staff. Individual cases of long-term sick leave, requiring replacement, may need to be analysed to uncover these costs where a replacement 'post' is needed rather than temporary cover.

Cases requiring legal services can be analysed by cause and counted, the time required from legal advisors can be recorded (for internal staff) or directly estimated as monetary amounts paid to external legal staff employed.

> If legal services are contracted internally, staff time records may provide required information. If legal services are externally contracted in, accounting records or more detailed departmental records may need to be examined to identify those relating to lifting injury cases.

Claims for compensation from patients or staff can be counted and classified by expected likelihood of settlement, expected cost of settlement, etc.

> Usually, the number of such cases per Trust is small enough to allow manual analysis and classification of individual cases.

Express in monetary values

Translating the quantified benefit stream into monetary terms involves making some further judgements. First, what ***conversion rates*** should be used - how much is each natural unit worth? Second, against what alternative is the cost to be estimated - what is the ***baseline*** for comparison? In most cases, the baseline is the *current or recent past* actual or estimated level of benefits and costs, and the comparison is with the *projected or now current* level of benefits and costs following the introduction of a Health at Work programme - in this case, to improve Lifting and Handling.

Patient time off work will not cause a cost to the Trust unless a claim for compensation is made and paid. If it does result in a claim, its costs will be picked up under that heading.

Only if social cost benefit is being attempted will there need to be an estimate of cost made directly under this heading, and in principle it should take account of the patient's current and anticipated income loss, for as long as the injury has an effect. For retired people, and others not in paid employment, other and more difficult considerations arise, not covered here.

Staff time off work can be valued *either* at the 'worth' of the time paid for but not available, *or* by the cost of staff employed to do the work instead (see below), *but not both.*

Minor variations in conversion rates will be caused by decisions on whether to value the time at the average pay rates for the staff grade or actual pay rates for individuals, and whether to include or exclude proportionate allowances for 'normal' levels of public holidays, overtime, sickness, vacation, maternity leave, etc. Allowances need to be made too for related employer's payroll costs - National Insurance, pension contributions, etc. Finance and payroll departments can usually provide helpful advice on reasonable assumptions to make.

The need for staff cover when quantified using judgement can be valued similarly to staff time, but the basic pay rate will usually be significantly higher.

Some of the same considerations apply as for costing internal staff, except that any allowances for NI, holiday, sickness, and maternity cover are normally included in the rate paid, as will commonly be an agency fee.

Cases requiring legal services can be costed either in total (based on analysis of historical records of legal fees paid for legal services related to lifting and handling injuries) or by counting cases of different complexity and estimating the impact of reduced injury on the total number and proportions of future injury cases.

Compensation claims can be estimated historically, and compared with actual or estimated reduced costs of claims after the introduction of the lifting and handling programme.

Future estimates can be based on experience elsewhere of the degree of reduction expected or experienced in claims of different severity. Estimating the likelihood of existing *pending* claims being paid in future may require analysis of past *settled* claims, or even the services of an actuary or legal expert. The Medical Defence Union may have estimates available of the average compensation awards of 'similar 'cases.

Cost stream

Principal elements in the cost stream are:

- equipment purchase
- staff training
- management and audit time

Equipment purchase

In Trust D, a wide range of equipment was purchased over two financial years, to enable the present Limited Lifting and Handling Policy to be implemented.

The biggest element of the purchase was patient hoists - one for each ward and A&E, and for a few outpatient areas and other departments which were not close to a ward from which a hoist could be borrowed quickly when required.

Other patient movement-enabling equipment includes patient slide sheets, draw sheets, 'banana boards' and other slides/turntables (for moving patients e.g. between bed/chair/wheel-chair/toilet seat etc.), support platforms for use at the bedside, foot supports for bed-ends, and armrests for bed heads. Some slide/turntable equipment originally designed for ambulance road-accident rescue was tested, and acquired for in-hospital use (it is now being re-marketed as such by the manufacturer). Some special sheet slides and drawsheets are being made in existing hospital sewing facilities, for no more outlay than raw material costs (typically £5-£15 per sheet, depending on design).

Staff training

Staff training has involved all nursing and some other patient-handling staff, and is now a routine responsibility of departmental managers. The staff time taken can be estimated, and costed in the same way as for staff time off work described above. Initial training was provided by the ergonomics adviser, and a proportionate amount of her time can be estimated and costed similarly.

Management and audit

The staff training programme, and the overall process of managing the Trust policy on lifting and handling, is audited regularly. This involves annual documentary review and audit, and a more frequent but less formal series of meetings of nurse managers and key trainers to review progress, develop procedures for uncommon or new lifting and handling requirements, and suggest improvements to the way in which patient movements are dealt with.

In principle, the time involved could be estimated and costed. This has not been attempted so far, as the information is not systematically or centrally recorded.

A7. Use of staff gym - specifics

Identify and attribute types of benefit

Types of benefits in use of the staff gym could include:

For patients

- improved mobility, fitness, and reduced risk of cardiovascular disease or symptoms (not the main focus of this analysis)

For individual members of staff:

- improved fitness and general health, leading to better quality of life, sense of well-being, and less time off work. Possible reduction in perceived individual stress levels, and improvement in physiological health risk factors such as resting and exercising heart rate, blood pressure, lung capacity and peak airflow, muscular strength, body mass index etc.

For the Trust

- reduced patient mortality and morbidity following treatment (the gym in one trust is used for patient rehabilitation treatment, as well as by staff)
- better working conditions for staff leading to improved morale and recruitment/staff retention*
- fitter and healthier staff?**
- reduced time off work of staff**
- lower need for additional staffing to cover for staff off work**
- less management time taken dealing with the consequences of the above*

Identify important and quantifiable benefits

Items starred (* or **) above are *in principle* both important and quantifiable. Those considered *in practice* in the Trust's own analysis have a double star (**).

Quantify in natural units

Staff fitness factors are assessed on joining, and could in principle be monitored over time for a sample of members and perhaps non-members. This was not in the end possible in this study, owing to time and resource constraints on the gym managers.

Staff time off work can be totalled by staff grade (and optionally, by department or responsible manager), contrasting gym users, interested potential users, and non-users.

Typical problems again are incomplete, unreliable, inconsistent, or unclassified data, limited or inconsistent information about staff grade, department, or manager. For example, in the twelve Trusts included in the CHKS research data, only four had reasonably comprehensive and accessible sickness absence recording systems, all introduced only in 1995 or later, precluding longer term analysis with any validity. In practice, we were only able to obtain information for existing gym users, and analyses by department or profession were possible, but not used owing to the high variability of individual data and small overall sample size.

The need for staff cover for staff absent due to illness or injury can be estimated using a combination of quantification of the amount of time off work, records of the total use of agency, bank, or replacement staff, and judgement about the extent to which the former required the latter. It would be useful if possible to contrast gym users, potential users, and non-users for matched groups of staff, but in this study only gym users could be surveyed.

Data on staff absence may not be classified by reason in a way which makes it easy (or even possible) to extract only potentially relevant effects. Agency and bank staff usage is usually available at least in total, although it may be harder to access from any central source. Judgements by experienced staff for a selection of departments or directorates may be needed to estimate what proportion of absence due is in practice covered by additional staff, or absorbed by existing staff. Individual cases of long-term sick leave, requiring replacement, may need to be analysed to uncover these costs where a replacement 'post' is needed rather than temporary cover.

Express in monetary values

Translating the quantified benefit stream into monetary terms involves making some further judgements. First, what ***conversion rates*** should be used - how much is each natural unit worth? Second, against what alternative is the cost to be estimated - what is the ***baseline*** for comparison? In most cases, the baseline is the *current or recent previous* actual or estimated level of benefits and costs, and the comparison is with the *projected or current* level of benefits and costs following the introduction of a Health at Work programme - in this case, the availability of the gym.

Patient time off work will not cause a cost to the Trust unless a claim for compensation is made and paid. If it does result in a claim, its costs will be picked up under that heading.

Only if social cost benefit is being attempted will there need to be an estimate of cost made directly under this heading, and in principle it should take account of the patient's current and anticipated income loss, for as long as the injury has an effect. For retired people, and others not in paid employment, other and more difficult considerations arise, not covered here.

Staff time off work can be valued *either* at the 'worth' of the time paid for but not available, *or* by the cost of staff employed to do the work instead (see below), *but not both.*

Minor variations in conversion rates will be caused by decisions on whether to value the time at the average pay rates for the staff grade or actual pay rates for individuals, and whether to include or exclude proportionate allowances for 'normal' levels of public holidays, overtime, sickness, vacation, maternity leave, etc. Allowances need to be made

too for related employer's payroll costs - National Insurance, pension contributions, etc. Finance and payroll departments can usually provide helpful advice on reasonable assumptions to make.

The need for staff cover when quantified using judgement can be valued similarly to staff time, but the basic pay rate will usually be significantly higher.

Some of the same considerations apply as for costing internal staff, except that any allowances for NI, holiday, sickness, and maternity cover are normally included in the rate paid, as will commonly be an agency fee.

Cost stream

Principal elements in the cost stream are:

- building conversion and equipment purchase
- gym staffing
- running costs
- income - membership fees and grant used to offset running costs
- management and audit time.

Conversion Equipment purchase

In Trust C, which has around 2,000 staff, the gym was converted from a former linen store, and equipped with a range of exercise and fitness measuring equipment by an initial donation from the trust.

Gym staffing

A private company which operates a range of gyms and other leisure facilities in the area was contracted to operate the gym and provide advice and guidance for patients and staff using the facilities. Two salaried company staff members provide on-site instruction and hands-on gym management. Eight trust staff members were recruited as part-time instructors, and paid small salaries as part of the contract fee.

First year contract management costs were just under £39,000 for the 11 months of operation.

Running costs

In addition to the staffing and management costs paid to the management company, there are relatively small charges for maintenance and utilities, and minor additional equipment purchases. Replacement and upgraded equipment will be necessary from time to time. In the first year, total costs under this heading amounted to £2,200.

Income - Membership fees and grants, other

Staff pay quarterly for membership, mostly by deduction from their wages or salaries. Membership fees also entitle members to use some related private facilities operated by the gym management company locally.

Other types of memberships include about 10% of members who are patients taking exercise 'on prescription' by their local GP, and junior doctors who received free membership in the gym's first year. A £10,000 grant was made by the Region in the first year to pay for the junior doctors. It ran out in the summer of 1996. Other minor income is obtained from T-shirt sales and fitness testing fees.

Total income was just over £46,000 in the first financial year (11 months from opening in May 1995 to the end of March 1996), including three quarters of the regional contribution for junior doctors which covered only 9 months of the financial year.

Membership peaked at nearly 600 members in the first year after the gym opened, and about half of the members reported that they had not previously been regular participants in physical activity. Drop out rates (at 15% in the first year) are said to be well below half of the private sector industry average (30-50%). For various reasons, including the loss of the regional grant for junior doctors, membership subsequently (in 1997) fell to below 500. Very recently (1998) the management company has been asked to explore ways of increasing membership back up to around 500 staff. Effective capacity is around 550 active members.

Overall, the trust management have as a matter of policy set the fees and contract costs to achieve as near as possible a 'no net cost' position, in which membership and other income matches identifiable running costs. Fees are less than half those of private exercise centres in the area.