Independent Review of Organisational Culture at British Columbia Emergency Health Services.

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1.0 Executive Summary

In undertaking this review of British Columbia's Emergency Health Service (referred to as BCEHS) organisational culture, a number of areas were explored which were identified as contributing factors in the prevailing culture in 2022, and included the concerns expressed by workforce in the 2022 staff survey.

Firstly, we should define what is culture? Harvard Business Review 2018 defines culture, as a group phenomenon. It cannot exist solely within a single person, nor is it simply the average of individual characteristics. It resides in shared behaviours, values, and assumptions and is most commonly experienced through the norms and expectations of a group—that is, the unwritten rules.

To provide context, this review was completed post enormous societal changes, emanating from 2020 which included a global pandemic, the MeToo movement which raised international awareness of sexual harassment as well as the Black Lives Matter movement which brought a focus on diversity and equality in society and these combined factors provide context for this review. In British Columbia work has also been done with regards to identifying and addressing Indigenous racism in health care. It is important to reference these changes as contributing to the recommendations at the end of this review.

Alongside the available quantitative data, and the comparison of recent international research, staff's lived experiences were sought through semi structured interviews. The reviewer focussed on exploring the following questions and encouraged staff to share the interventions they thought might support effective culture change from these identified issues.

What is the existing culture at BCEHS and what factors underpin it?
What does Bullying and Harassment look and feel like in the workplace?
What does Sexual Harassment look and feel like in the workplace?
What is your understanding of Diversity, Equality, and Inclusion (DEI) in the workplace and towards patients, and colleagues and what does this look like?
What are the strengths and motivators in the current workplace at BCEHS?

This review concluded that further work is needed on addressing the identified organisational culture shortfalls, through a systematic approach to making the culture more accountable, fair, and inclusive for both staff and patients.

One member of staff cited BCEHS as having s.22(1) [redacted] and this review created space for staff to share both painful and difficult experiences with the intention that by doing so long-standing change would be invoked

The breadth of sexual harassment activity reported, and the sense of frustration expressed by a number of female paramedics, as well as acknowledgement by male colleagues of its existence, requires urgent attention and a sustained focus on to reduce, by the organisation.

The damage that everyday sexism can have on working lives as shown by recent investigations and reports in Australia (Appendices 3.12) This review included references to other ambulance service studies identifying gender bias as a global issue, which are included within the literature review (Appendices 3 .7)

The low levels of DEI awareness and lack of sensitivity expressed by some colleagues around diversity of colleagues, and patients, is likely to be creating tensions in the workplace.

Limited leadership training and the variability of skills held by managers & leaders was also noted, and a review of how training is both delivered and evaluated for its effectiveness in terms of embedding behavioural change in staff, is required.

Within the recommendations, options are identified to contribute changes to BCEHS culture, to improve staff experience and a number of these were generated by BCEHS staff.

Furthermore, it would be helpful to develop and publish overarching organisational strategies, examples being a BCEHS People Strategy, a BCEHS Gender Equality Strategy and a BCEHS Diversity, Inclusion and Equality strategy, which would set out timelines, identify accountability, and articulate clear roles for staff involved in the workstreams.

Developing strategies to support culture change, would signify a recognition that staff concerns had been heard and responded too, which was a significant factor both within conversations held and the 2022 staff survey.

Organisational strategies also assist in linking the existing pockets of good work across the region and avoiding replication which promotes better budgetary management.

Engaging with staff to deliver long term change, might involve creating new roles such as diversity champions, developing staff with specialist knowledge in trauma informed practices, and holding many difficult conversations with staff, about sexism and racism and bullying, some which may result in disciplinary actions being undertaken.

This review recommends that better access to Human Resource metrics is provided, to predict organisational risk going forward and to introduce an audit cycle into workforce processes.

There was strong organisational memory and a number of staff engaging in this review had over 10 years' service and they were willing to consider new ways of working.

Overall, this review found, despite the many challenges that staff shared, staff were committed to team working and providing a quality service to their communities and there was a high level of goodwill expressed around culture change.

It would be recommended to regularly communicate with staff on any culture change programme planned and use their skills, experience, and knowledge, to pilot the changes needed to enable BCEHS to meet its stated values of being *an exceptional place to work.*

2.0 Introduction to the Review

2.1 The report author, Cathe Gaskell is an independent consultant with no prior knowledge or work history associated with British Columbia Emergency Health Services. This was to ensure objectivity and to provide a neutral examination of the existing organisational culture was undertaken.

2.2 Cathe Gaskell has an extensive background in report writing and investigations and reviews, she specialises in organisational development working in the fields of bullying and harassment and conflict resolution within the National Health Service and wider healthcare settings within the United Kingdom.

2.3 Cathe Gaskell has prior experience in listening to staff stories and recording them to facilitate an understanding of existing beliefs, challenges, and strengths that contribute to an organisations culture. She holds a BSc Hons in Professional Issues in healthcare as well as being a registered nurse.

3.0 Methodology

3.1 This review was undertaken remotely, using a range of information to diagnose the current culture.

- Conducting semi-structured staff interviews with employees from across many parts of BCEHS, using staff lived experiences and stories, garnered via online interviews
- Multiple staff sent additional supporting information to the reviewer
- Speaking to paramedics with direct experience of being involved in BCEHS investigations involving allegations of Bullying and Harassment and the application of existing policies
- Speaking to paramedics with direct experiences of sexual harassment in the workplace
- Reviewing relevant policies and procedures including internally produced reports
- Reviewing current training programmes content
- Reviewing the findings of two staff surveys undertaken in 2018 and in 2022 with a focus on the 2022 findings
- Meeting with members of Women in Paramedicine Special Interest Group and discussing their published articles and research and plans
- Analysing the workforce data that was available
- Reviewing literature on bullying and harassment in ambulance services globally

3.2 This review also includes references to best practices in organisational culture development, which are included in the appendices.

3.3 This review also references academic reviews on sexual harassment and gender bias, in the ambulance service produced in Australia and Canada which are included in the appendices.

3.4 The staff interviews were not recorded, nor transcripts taken, but staff were asked to comment, knowing their comments would not be attributable to them as individuals.

3.5 The reviewer relied corroborative information such as the most recent policies and relevant information being made available to include in the review.

3.6 Staff involvement was voluntary and not linked to any disciplinary process or individual investigation of concerns.

3.7 All conversations were confidential, the notes taken at the time from semi-structured interviews, which were used as an aide memoire have been destroyed. This was completed to ensure that individual participants confidentiality was maintained, and that staff were free from the fear of reprisals which allowed for transparency in what was shared, with the reviewer.

3.8 A list of the documents referred to during this review are included at the end of this report.

3.9 A glossary of terms used is included at the end of this report.

3.10 A culture checklist is included at the end of the report for information purposes.

4.0 Terms of Reference

The scope was commissioned by BCEHS HR Services and Recruitment.

4.1 Complete diagnostics to assess the existing culture at BCEHS and identify the current culture from an employee point of view whilst identifying contributory factors that impact on the existing culture within the workplace.

4.2 Review organisational materials, examples include leavers experiences, hard data such as internal audits, whistleblowing feedback, sickness, and turnover statistics, and reviewing language in key policies and training materials.

4.3 Understand and report back on the needs of minority health ethnic groups in the region to ensure they are treated with respect and dignity by colleagues working at BC Emergency Health Services.

4.4 Understand workplace experiences which could be described as bullying and harassing, and with a specific focus on identifying sexism, sexual harassment, and bias, in language and actions, evidenced by female colleagues in the workplace

4.5 Identify hotspots and priorities for cultural change though developing recommendations that are both evidence based and support long standing culture change.

5.0 History of British Columbia Emergency Health Service

5.1 The ambulance service in British Columbia has roots dating back to the early 1900s. At this time, emergency medical services were provided by a wide range of commercial and municipal operators, some functioning from funeral homes, others partially subsidized by municipalities, some based with volunteer fire departments and others existing on paid subscriptions from the public.

5.2 This diversity in providers resulted in great variations in response times, a lack of control over staffing levels or staff qualifications, inconsistencies in service delivery and differences in the quality of ambulances and equipment. Staff training and patient care standards were also virtually non-existent, as they were largely determined by the financial health of the providing agency or company.

5.3 The British Columbia Ambulance Service was created in the 1970's to provide a provincial public ambulance service in British Columbia. In 2012 BC Emergency Health Services was created as part of the Provincial Health Services Authority (PHSA). PHSA has a unique role in British Columbias's health authority system: to ensure that British Columbia residents have access to a coordinated provincial network of high-quality specialised health care services.

5.4 PHSA works in partnership with the province's health authorities and health-care professionals to improve access to evidence-informed practice closer to where people live and to effectively promote health, manage chronic conditions, and reduce the burden of illness. As Canada's first provincially operated ambulance service, the BC Ambulance Service (BCAS) provides emergency pre-hospital treatment and transportation by ambulance to the public and visitors to British Columbia.

5.5 BCEHS in 2022 is led by a Chief Ambulance Officer and Executive Vice-President, reporting to the BCEHS Board Chair. The executive leadership team reporting to the Chief Ambulance Officer consists of a Chief Operating Officer, a Chief Medical Officer, and a Chief, Strategies and Systems Officer. Supporting daily front line operations are many critical departments, including Clinical and Medical Programs, Learning, Logistics and Transportation Operations, which includes both ground and air ambulance operations.

5.6 Additional corporate services include Communications; Administration; Finance; Learning; Human Resources; Information Management/Technology; Quality, Safety, Risk Management and Accreditation; Facilities Management; and Labour Relations.

5.7 Serving an area of almost one million square kilometres, BCEHS is the largest provider of emergency health care in Canada, and it is one of the largest providers across North America.

5.8 Close to 5,000 BCEHS employees support patient care, including paramedics, medical emergency call-takers and dispatchers, nurses, front-line staff, administrators, and managers working from 184 stations and several admin hubs.

5.9 Through three dispatch centres and paramedic services, expert patient care is delivered from the moment a 9-1-1 call for medical help is received, to treatment at the scene and transport to hospital.

6.0 Vision and Values of BCEHS and PHSA

6.1 BCEHS is responsible for the delivery, coordination and governance of out-of-hospital emergency health services and inter-facility patient transfer planning and coordination services.

6.2 Mission

- We are responsible for the delivery, coordination and governance of appropriate and effective out-of-hospital and inter-facility health services throughout B.C. We are a responsible and integrated partner in the healthcare system.

6.3 Vision

- To be international leaders in healthcare innovation and delivery.
- To be integrated members of the health sector and communities we serve.
- To be recognized as an exceptional employer.

6.4 Provincial Health Service Association & BC Emergency Health Service values

- Respect people
- Be compassionate
- Dare to innovate
- Cultivate partnerships
- Serve with purpose

6.5 Strategic goals

- To continually improve the patient and provider experience

6.6 Objectives

- Provide appropriate care
- Ensure the right care is provided to the right patient with the right resource at the right time.

6.7 Develop innovative care models:

- ***Explore new models for providing appropriate patient care***
    - Integrate with the health care system

- ***Shift culture and systems to create a seamless patient journey across the health system***

7.0 Staffing Breakdown (2022)

7.1 Total Number of Staff (Gender)

- Female 1725
- Male 2561
- Undefined 1
- Ethnicity is not tracked
- Sexuality is not tracked
- Disability is not tracked
- Total staffing 4287

7.2 During this review it was identified that data on protected grounds includes, Ancestry, Colour, Criminal Conviction, Family Status, Gender Expression, Gender Identify, Indigenous Identity, Marital Status, Mental Disability, Physical Disability, Place of Origin, Race, Religion, Sex, Sexual Orientation, Source of Income, are not collected at the time of employment.

7.3 It could be useful to track apart from gender and age, which is collected, gender expression and gender identity, indigenous identity, physical disability, sexual orientation as a starting point for BCEHS.

7.4 Currently at BCEHS it's not easy to identify how many staff with the protected grounds, are employed, and whether these characteristics are impacting on recruitment, retention, promotion, or disciplinary activities.

7.5 An implication is that intersectionality data is therefore not reviewed by the organisation, where staff may have more than one protected grounds i.e., a woman may identify as disabled, or a man may be indigenous and gay.

7.6 If this data were collected, it would allow for a clearer picture of how equitable the organisation is functioning in terms of employing staff who may need reasonable adjustments in the workplace, demonstrate how inclusive it is (or not) towards marginalised groups and how responsive it is in terms of employing staff who reflect the ethnicity of the local community.

7.7 Without this information, it was not possible to track a range of activities to measure equity and fairness in the existing culture, for example whether promotion opportunities are available to the whole staff group at BCEHS or if Bullying and Harassment complaints are raised more or less by staff with protected grounds.

8.0 Women in Paramedicine

8.1 Paramedicine has typically been a male dominated role. Women joined as paramedics in Canada circa the 1970's and in 2022, women represent only 25 % of paramedics across Canada and women in leadership positions are represented at less than 5%.

8.2 The Women in Paramedicine Special Interest Group (WIPSIG) supplied the following data: (appendices 3.2)

8.3 In BCEHS 40% of the workforce are women and Human Resource data reports this as representing 1725 staff.

- 47 % are emergency responders
- 38 % are primary care paramedics
- 19 % are advanced care paramedics
- 12 % are critical care paramedics

8.4 Women make up approximately 30% of Patient Care Delivery leadership with recent restructuring and hiring resulting in an increase in female representation.

8.5 However, global concerns about sexism in ambulance services and the impact of casual sexism and sexual harassment concerning women in paramedicine are growing, with major inquiries being held within Australia and the United Kingdom in the past few years outlining the seriousness with which Ambulance organisations must treat this issue.

8.6 This is a quote from Alisha McFarlane, a senior paramedic and lecturer who contributed to the Victorian Equal Opportunity and Rights Commission Investigation into Sexual Harassment and Bullying directed towards female paramedics in 2021 and 2022 (appendices 3 .7) which encapsulates the concerns researchers are identifying within the ambulance workforce.

…Whilst it is understood that paramedicine is a risky occupation with its exposure to traumatic events, dealing with difficult and sometime violent patients, long hours and shift work, the exacerbation of these problems by the culture of discrimination, bullying and harassment is the larger problem. It is concerning to find that a raft of research has been conducted on paramedics and the effects of exposure to the traumatic nature of their work, but that virtually no research has been conducted on women's experiences of everyday sexism within the ambulance services despite the recognition of the existence of these issues over a lengthy period of time...

It is understood that workplaces that struggle to effectively address sexism are commonly workplaces that have developed from a strong masculine culture. These workplaces commonly offer poor flexibility in terms of work-life balance, lack family friendly policies and demand long hours. What is known about the often invisible impact of everyday sexism on women working in these environments is that they have higher levels of job dissatisfaction, lower self-esteem and associated issues of wellbeing, fewer opportunities for career development and advancement, and that it can contribute to post traumatic stress disorder (PTSD) a condition already more strongly associated with the type of work that paramedics do...

8.7 It would be beneficial to include the findings of these recently published investigations, into future training and policy decisions, as the lived experiences from these findings whilst emanating from a different country, have many similarities with BCEHS service and the challenges faced by staff.

9.0 Engagement Survey Results 2022

9.1 As part of this review, the recent staff survey findings of 2022 were analysed as part of the triangulation process alongside other metrics, to provide an insight of staff views on culture. These were the most recent staff survey results and were completed post Covid.

9.2 In particular findings concerning culture, Bullying and Harassment, Sexual Harassment and Diversity Equality & Inclusion were interpreted and used as context within this review. A total of 1862 staff responded to this survey, and this represents 43% of the BCEHS workforce.

9.3 Key findings and wording from the survey are included verbatim below :

a) The gap to organizational scores increases for lowest scoring factors at BCEHS (training & development and senior management, both having less than 25% favourable)

b) Employee morale is extremely low given a lack of acknowledgement from leadership and burnout. There appears to be consistent sentiment that leadership does not value BCEHS, due to a lack of recognition or business decisions that do not support BCEHS and a lack of visibility or listening to employees

c) Employees are burnt out with mental health stressors, being overworked due to understaffing, scheduling and payroll errors that have affected their belief and passion for their roles

d) Improving visibility and interactions between management and front-line employees. Employees have expressed extreme frustration with the lack of acknowledgement and being listened to by leadership; employees believe solutions and processes that leaders are putting in place do not address employee needs and do not take employee/manager feedback into account

e) Action results and value employee feedback: Mixed sentiment around the purpose of the survey, as some employees are thankful for the opportunity to provide feedback, while others are pessimistic that results will be actioned in a meaningful way to improve the employee experience

9.4 In terms of scores – the high scoring results are where staff rated these statements as *unfavourable*

- 39% My workforce takes effective action to prevent disrespectful behaviour
- 50 %My workforce is psychologically safe
- 62% Work is not having a significant impact on my psychological wellbeing
- 69% Senior managers act on feedback
- 45% Overall training and development
- 64% I receive recognition for good work.
- 67% I am consulted about changes affecting my job.
- 72% I am satisfied with my total rewards package (base salary, vacation, dental and extended health, perks, etc.).

9.5 This survey did not ask about bullying and harassment directly, but this may be listed under disrespectful behaviours and psychological safety.

9.6 The survey asked limited questions about treatment of Indigenous staff and colleagues of different cultural backgrounds and the results were as follows

- Q1, have you experienced unfair treatment due to your race or cultural background?
  - 9% responded yes

- Q2 How often do you experience unfair treatment due to your race of cultural background?
  - 11 % responded this occurred daily

5% of the staff surveyed self-identified as Indigenous

9.7 This staff survey did not ask questions about gender bias or sexual harassment, given this is a global issue for ambulance services, it should be included in future surveys.

9.8 The questions with scores signaling the most positive responses, were around co-workers, working with supervisors and aspects of the role.

9.9 Several of the findings in this survey mirrored findings in the individual staff interviews, in particular concerns about management visibility, training and development, and disrespectful behaviours.

10.0 Training and Policy Review

10.1 In this section of the organisational review, training documents, handbooks and policies relating to the review scope are reviewed.

These include the following five documents :

1) Fostering a Culture of Respect Handbook (PHSA)

2) Fostering a Culture of Respect Policy (PHSA)

3) Fostering a Culture of Respect Policy Complaint Procedure (Bargaining Unit & Excluded Staff) BCEHS

4) Respect in the workplace BCEHS online learning module

5) Safe Reporting system

10.2 It was noted that these first three documents including policies set out to identify wrong and harmful behaviours and promote respectful behaviours in the workplace and provide clarification between what is disrespectful behaviour and what broadly is management behaviours is explored. They also described process in detail and how investigations would progress.

10.3 There are alternative options included in the Fostering a Culture of Respect handbook (PHSA) with a nod to facilitative support and the use of coaching, and the intervention suggested is a clarifying conversation.

10.4 This is later demonstrated with a list of guidelines on delivering a clarifying conversation, but it was reported training in this skill, is not available. It could be considered a big ask, for staff to tackle conflict without a core set of skills that have been practiced and honed before implementation.

10.5 Another area to be considered, is the language within the first three documents and the possible weighting that the language may provide.

10.6 Sexually harassing behaviours are detailed in a list of bullying and harassment behaviours within the Fostering a Culture of Respect handbook (PHSA) and there are the following four examples of descriptors which are listed:

- Making unwelcome remarks, jokes, innuendos, or taunting remarks about a person's body, sex, or sexual orientation, including sexist comments or sexual invitations.
- Display of pornographic or other sexual materials.
- Unwanted physical contact such as touching, pinching, or hugging.
- Sexual advances with actual or implied work-related consequences

10.7 It could be an option to call it what it is, which is "Sexual Harassment"and group the behaviours under the relevant protected grounds, as the implication throughout the documents is that sexual harassment falls under general bullying, and this may have the unintended consequence of minimising the seriousness of it.

10.8 Within all three documents the phrase sexual harassment does not appear, and the behaviours are included within the catch all phrase below:

"Bullying and Harassment, Disrespectful Behaviour, Discrimination and Racism "

10.9 Again, this may have the unintended intention of minimising the experience of women in paramedicine who would not necessarily identify sexual harassment as disrespectful behaviour, but a form of harassment based on protected grounds.

10.10 The Canadian legal definition of sexual harassment is "unwelcome conduct of a sexual nature that detrimentally affects the work environment, or leads to adverse job-related consequences for the victims of his harassment "

10.11 As 40% of the workforce are women at BCHES, and globally it's being reported as an issue, it is not unreasonable that a policy is drafted that is specific to the impact that everyday sexism may have on staff, and the rights and expectations that all staff should model in the workplace.

10.12 It could be considered that a stand-alone policy on "Sexual Harassment in the Workplace" is developed for the organisation, which clearly identify harassing behaviours, and directs staff towards the support and resolution systems available.

Respect in the workplace BCEHS online learning module – June 2022 (point 4 above)

10.13 This module, which is a 30-minute online learning module, is comprised of slides with information. It is aspirational in content in that it describes the culture at BCEHS as working to eliminate sexism and racism and bullying, it focussed on process and how the system works in raising a concern. It was written to provide an overview of a range of disrespectful behaviours in the workplace.

10.14 The presentation can't be downloaded to be read later, and it has no sound and limited interactive graphics.

10.15 There are 8 learning styles available which trainers rely on to ensure the best uptake of training material.

a) Visual or spatial learning
b) Linguistic or verbal learning
c) Logical or mathematical learning
d) Naturalistic learning
e) Kinaesthetic or Physical leaning
f) Interpersonal or solitary learning
g) Aural learning
h) Physical learning

10.16 It is not apparent if staff with neurodiversity issues or those who learn by relating to others, or hearing the spoken word, will be able to fully utilise this workshop, which would work best for a visual and solitary learner.

10.17 It prompted further analysis of the feedback in the 2022 Staff Survey, where 45 % of staff polled, rated Training and Development as unfavourable, this finding should be interrogated.

Safe Reporting system (point 5 above)

10.18 PHSA makes a commitment within this policy to provide a neutral place for reporting wrongdoing.

10.19 Anything reported through Safe Reporting that falls under the Fostering a Culture of Respect policy (or any other policy violation) would be forwarded to the HR team at BCEHS for investigation.

10.20 This is the following process for reporting concerns or wrongdoing as described from the list below :

Wrongdoing – Behaviour that:

- Undermines the quality of care.
- Is of substantial and specific danger to the patient, public health, safety, or the environment.
- Is unlawful or unethical.
- Is against organizational policy, contract, or other obligatory standards.
- Amounts to fraud or corrupt activity.
- Reflects a real or perceived conflict of interest.
- Represents the unauthorized use, misuse, or waste of public funds or resources, which may be of a tangible or intangible nature.
- Does not adhere to appropriate PHSA accounting policies or procedures, internal accounting controls, or auditing procedures; and / or
- Constitutes any other unethical or improper conduct or abuse.

10.21 The language describing wrongdoing, does not make it transparent if this a whistleblowing service, for reporting behaviours such as Bullying and Harassment, Racial or Sexual Discrimination, or more focussed on fraud and ethical issues, but it is a neutral option for staff to use, alongside this following list of routes for raising a concern.

10.22 Other methods to raise concerns include :

- Complainant discusses concerns with their leader
- Complainant submits complaint via respect@phsa.ca or respect@bcehs.ca;
- Complainant submits claim through the Workplace Health Call Center or WorkSafe BC; Prevention Line; Safety Rep notifies HR Business Partner (HRBP); or Leader contacts HRBP regarding complaint; and/or Union brings forward complaint to Leader or HRBP.

10.23 It would be a recommendation to have one flow-chart which identifies the range of routes to raise concerns, so the process of escalating a concern is made as easy and accessible as possible.

11.0 Themes from Staff Interviews

11.1 Lived experiences were collated through multiple staff interviews on the following five areas and anonymised examples were provided throughout.

What is the existing culture at BCEHS and what factors underpin it?
What does Bullying and Harassment look and feel like in the workplace?
What does Sexual Harassment look and feel like in the workplace?
What is your understanding of Diversity, Equality, and Inclusion (DEI) in the workplace and towards patients, and colleagues and what does this look like?
What are the strengths and motivators in the current workplace at BCEHS?

11.2 Existing culture at BCEHS factors that influence (point 1 above)

a) The Heat Dome in 2021 was reported as having majorly impacted on staff morale, leaving some staff experiencing shame and anger about how the situation unfolded and a sense of moral injury in terms of the number of deaths in the community. Staff expressed it further amplified existing perceptions, that staff at the top of the organisation did not recognise or respond to frustrations in the operational ranks of the organisation.

b) Leadership training was consistently identified as a skills gap for both Unit Chiefs and Management. The online available training was described as lacking content in people management skills, many of which had been gained through an individual's life experience. This led to inconsistency in how staff were managed and in the main, it was reported that soft skills or interpersonal skills, such as coaching, having difficult conversations, managing absence were self-taught and at times, management communication was clunky.

c) It was reported the current management of sick leave allowed for a small group of staff to take high levels of sick leave with limited reprisals and this in turn caused conflict in the wider team. Staff expressed they were required to undertake additional work because of colleagues "taking advantage" of the current system

d) The increase in call outs due to the Opioid crisis and the lack of an organisational response to this crisis, was believed to be contributing to increased risk of burn out in some colleagues. Staff reported having to attend patients who had overdosed, on occasions multiple times a day and this led to a sense of helplessness and frustration in attending teams

e) The relationship between the Union and management was cited as strained by a number of staff, it was also described as an adversarial relationship and the cause of conflict for staff, some who expressed respect towards the union's intentions if not their methods.

f) Some staff expressed concerns about the Union and its relationship to the existing culture, it was perceived that the Union historically had not taken a proactive stand around addressing bullying and harassment and sexual harassment in the workforce and this in turn caused both organisational and personal conflicts for staff.

g) Some staff expressed a different opinion, that the Union was working towards a more effective relationship with management, which would be aided by more regular dialogue and better management engagement at early stages of decision making.

h) A perception was expressed that a two-tier system exists between part time staff and full-time staff and between urban based teams and those working in remote areas. It was alleged that full time urban based teams of paramedics, at times saw themselves as superior to colleagues working in less populated areas.

i) It was noted that many staff had served via the route of part time working in a remote area, before attaining a full-time role in an urban area and this for some meant there was a sense of entitlement enjoyed through time served and not skills acquired.

j) The lack of visibility of managers, was described as creating a top down, hierarchical and "do as I say" culture. Staff shared the perception that an autocratic stance exhibited by some managers, contributed to a general sense of not being heard and in some areas had formed a divide between operations and management teams

k) A low level of awareness about Diversity, Equality and Inclusion was cited by a few staff, some who felt limited progress had been made on making transparent changes to increase inclusion for both women and indigenous staff in the workplace. Examples of a limited knowledge of DEI issues impacting on patient care were cited, with some staff reporting a lack of sensitivity and awareness in colleagues working with indigenous patients and communities who made disparaging comments such as "just another drunk Indian" when attending a scene.

l) Longstanding issues with scheduling and payroll were cited as severely affecting staff morale. Staff wanted this urgently resolved as it impacted on trust within the organisation on many levels and contributed to a sense of not being heard by the senior management team.

11.3 Bullying and Harassment in the workplace (point 2 above)

a) Many staff expressed that conflict between colleagues was often not well managed, with limited resources except to escalate a concern to a 3103 or an 1104 and undertake a formal process which necessitated the involvement of both Human Resources and the Union. A number of staff believed formalising staff differences, as a first resort, was not helpful.

b) Skills in empathy and self-awareness were described as limited in some operational colleagues, it was expressed that training traditionally focussed on clinical practice and tasks and not on communication in the workplace and that a skills gap now existed, and this led to bullying communication and language

c) Some staff believed colleagues utilised sick leave to avoid dealing with situations of bullying or conflict in the workplace between crew members .

d) Historically training on Bullying and Harassment (respect in the workplace) has been delivered online, it was described as a training exercise without meaningful engagement, in that staff reported, you could click through slides and still be able to pass the course.

e) Some Bullying, and Harassment was described as generational conflict, between older white males who may take an autocratic approach to colleagues and appear directive and intimidating. A number of staff cited poor communication as a key factor in many bullying allegations

f) Many staff stated that advanced communication skills were needed by leaders, including giving praise, and recognition for a job well done and positive feedback, opportunities for

recognition needed to be increased as well as team building to maintain optimism during challenging times.

11.4 Sexual Harassment (point 3 above)

a) Historical patterns of how sexual harassment claims were addressed, is still impacting on complaint reporting in 2022 and it's a reasonable conclusion that sexual harassment is under reported at BCEHS. A number of staff expressed that in raising a complaint, it will not be acted upon or taken seriously. Anecdotally it was reported that females had been treated poorly when raising complaints as this had resulted in both direct and indirect reprisals. For some it remained a terrifying prospect to consider raising a complaint about sexual harassment. Some staff reported the unions advice historically had been to drop it as it was described as a "he said, she said, issue".

b) Some staff believed managers may be complicit in protecting friends and that a "boys club" was still in existence that protected predators. In some cases, allegations had been minimised by s.22(1) [redacted]

c) Sexualised comments and gender based derogatory banter were tolerated in certain teams, which staff claimed made it harder to raise incidents as complaints, as the wider team colluded with the perpetrators humour and every day sexism became normalised. An example being s.22(1) [redacted]

d) Some staff believed that female paramedics, needed to stand up to perpetrators and it was part of the job to have a gutsy, tough demeanour, and not to take comments too seriously.

e) Many staff described having heard about or been aware of sexual harassment in the workplace, examples were given including sexualised language and innuendo and offensive remarks, which were labelled as humour by the perpetrators, examples included:

s.22(1) [redacted]

f) Examples of inappropriate touching were also shared, which included stroking, smacking, and rubbing against by males to females.

g) Examples of gender bias were reported, examples provided cited that women who were pregnant or on maternity leave, missed out on promotion opportunities and faced difficulties in returning to the workplace as a parent. For part time staff there were no graduated return to work systems in place, post maternity leave.

h) Staff expressed concerns that the union had reportedly supported alleged perpetrators, both historically and currently, and this created conflict. Some staff alleged it appeared perpetrators were protected through minimal sanctions for those found to have sexually harassed others, and these minimal sanctions might reinforce a sense of impunity in colleagues

s.22(1) [redacted]

11.5 DEI in the workplace (point 4 above)

a) Most staff described Diversity, Equality, and Inclusion, as a good thing in terms of widening the recruitment net but could not articulate what it meant in terms of BCEHS being an inclusive organisation.

b) Some staff felt that BCEHS was the starting point in terms of inclusion, and a place to start would be by introducing preferred pronouns in patient conversations and having and introduction to DEI within induction/new employee orientation.

c) Staff provided examples of casual racism made by colleagues about patients, who did not recognise their colleagues' cultural origins and expected them to join in, this was sometimes directed towards and about indigenous patients.

d) Several staff expressed that historically promotions were not always based on merit, but on time served and this had excluded staff who were outside of the old boys' network or not white.

e) Several male staff admitted they were informally mentored and supported to apply for leadership positions because of who they knew in a management role, and that this informal mentorship did not apply to everyone in the service.

f) Staff described banter that would be termed as racist being directed at them and that for some staff there was limited self-awareness of the repeated impact of this action on colleagues.

g) This is an excerpt shared with permission from an email from s.22(1) [redacted]

[redacted]

s.22(1) [redacted]

11.6 Strengths in the workplace (point 5 above)

a) Staff described feeling passionate and committed within their roles despite increasing pressures and workload and the phrase “I love my job,” was used a number of times

b) Staff described a culture of strong camaraderie and teamwork within stations and teams

c) Staff described a commitment to the service of patients and their personal commitment to providing a professional quality service for local people

d) Staff expressed the importance of role modelling and doing the right thing in the workplace

e) Staff talked about the pride they felt within their teams and towards their local communities for the care, treatment, and skills they used and the help they were able to provide.

12.0 Assessment of Available Data

12.1 A lack of accessible data on HR metrics was identified during this review, as potential contributor to organisational risk.

12.2 The metrics sought during this review included:

a) Training effectiveness – there is not a consistent model used to evaluate the impact of training across the organisation

b) Training efficiency – a range of training is delivered online and often with an individual reading and processing slides; it has not been evaluated as to whether this is the best method of imparting information relating to interpersonal skills

c) Employee Happiness – apart from the 2022 survey, there was a gap of several years between when the temperature was last taken within the organisation

d) Absence – Information based on gender was not easily accessible – it was cut via roles but not gender or ethnicity %

e) Sickness - Information on sick leave and who takes it based on gender or ethnicity % was not easily accessible

f) Turnover - Information on the gender or ethnicity of staff who have left the service was not easily accessible

g) Exit interviews - Exit interviews are not routinely conducted and therefore the intelligence on why staff are leaving, was not accessible.

h) Diversity and Inclusion monitoring – this appears minimal from induction onwards, apart from findings within the 2022 staff survey, as limited information on protected grounds is collected at the time of appointment.

12.3 The systems for staff complaints and how they are escalated, was reviewed.

12.4 Staff who raise complaints can do so from a variety of routes, but there is no data held by HR on which route collects the most data: i.e., it is not possible to identify if discrimination complaints were largely identified through the respect email inbox.

12.5 Therefore, the efficacy of each reporting route cannot be measured.

12.6 Drilling down into investigations logged on the Investigation Spreadsheet:

- January 2020 to July 2022, a total of 799 cases were logged with the Human Resources Team.
- This means circa 26 investigations are raised on average per month from BCEHS staff looking at 30 months of statistics.
- Investigations relating to this review include the following numbers between 2020 and 2022:
    - 236 disrespectful conduct investigations
    - 44 bullying and harassment investigations
    - 18 Sexual harassment investigations
    - 16 Discrimination investigations

12.7 This means over 30 months there were 18 sexual harassment and 16 discrimination investigations undertaken, so circa 5- 6 complaints are raised annually this does not appear to align with staff's lived experiences, it is still concerning re numbers.

12.8 It appears the current reporting systems may be contributing to this and unintentionally minimising the number of investigations recorded involving protected grounds, which has the potential of minimising risks to the organisation.

12.9 Within the disrespectful conduct caseload which is by far the largest grouping – complaints are allocated to this within a drop-down menu of disrespectful behaviours.

12.10 Definitions of disrespectful behaviours:

- A lack of consideration or regard for co-workers, including their privacy, physical space, belongings, viewpoints, and philosophies
- Interpersonal conflict
- It can become bullying when people pick on a specific individual

12.11 Potentially bullying and harassment and sexual harassment and discrimination complaints may be included within the 236 total of disrespectful behaviours, dependent on who and how they were graded, it may be masking the actual number of cases.

12.12 Next, it was not possible to test how escalation systems were working as its not currently identifiable which routes complaints are raised through, but anecdotally staff reported that escalation of a complaint was complex as there were a range of systems available, but staff reported they didn't know whether to use a patient reporting form or staff reporting systems and this led to some staff alleging colleagues may not pursue a complaint formally.

12.13 Alternatively, staff who are referred to the regulator post investigation, their details are not held centrally, so therefore the numbers of staff referred, the reasons they were referred, are held in distinct files by the Human Resource team, and do not appear to be interrogated to identify themes or clusters between respective years. It is an organisational risk if numbers are increasing.

12.14 In summary, the findings of the Victorian Equal Opportunity and Rights Commission into Sexual Harassment 2021, which are particularly relevant for BCEHS on the relevance of workforce data (appendix 3.12 & 3.13) are as follows

…The Commission was concerned to learn that Ambulance Victoria did not explicitly treat discrimination, sexual harassment, bullying and victimisation as significant organisational risks. Furthermore, the Commission found an overreliance on, and lack of analysis of, available information and data, including using data to monitor, identify and assess related risks. Low rates of complaints and participation in staff surveys, driven by fear and a lack of trust, masked the extent and nature of harm. There is a need to establish the systems and culture which enable victims and bystanders to speak up, call out behaviours, raise concerns and make complaints safely. …

13.0 Good Practices Identified

13.1 PHSA Leadership Certificate – the new leadership training prepared by Theresa Newlove and the Psychological Health and Safety team was cited by a number of staff as very much needed, as it focussed on soft skills and interpersonal awareness and was designed to support leaders to strengthen their existing leadership skills.

13.2 New Employee Orientation, this training was described as useful in that it provided a common foundation for new starters and allows for staff to meet in real time, albeit it is only available to staff who work on the ambulance.

13.3 San'yas Indigenous Cultural Safety Training was described as meaningful and interactive and a useful workshop to attain a better understanding of the culture of Indigenous staff.

13.4 Women in Paramedicine Special Interest group – were described by staff as inspirational in that they were raising concerns about gender and producing evidenced based materials and sharing them across the service including with senior managers and the Unions.

13.5 Historically recognition awards, such as Awards of Excellence, Q Pin and Development days had been appreciated by staff and provided opportunities to network.

14.0 Conclusion

14.1 This independent review was conducted remotely and used a mix of qualitative and quantitative information to identify staff concerns and risks and strengths in the existing culture at BCHES.

14.2 Staff voluntarily took part in helping provide information to complete the diagnostics and were candid and honest about how they described the existing culture and what they hoped to see this as the first step in creating a refreshed culture going forward.

14.3 Some of the stories shared within the review are lived experience, and it may be tempting to try and evaluate every case using investigation methodology. However, lived experience needs to be accepted at face value as reflecting the perceptions of the staff who shared it.

14.4 Despite the challenges which staff describe they face, working in diverse geographical areas with unique challenges of their role, there was a sense of optimism and hope evident in many of the conversations.

14.5 One issue that arose throughout the review was the inability to find data that evidenced trends that would aid management and leaders in planning and responding to organisational risks around people. It did not appear that staffing information is routinely analysed for trends and action taken to address unfavourable trends, such as refreshed policies or training.

14.6 An example being sexual harassment investigations which are referred the regulator (EMALB) the numbers are not held on a central database, so it's not immediately apparent if more, less or the same number of cases are being reported annually.

14.7 Staff surveys conducted in 2018 and 2022 showed very different in results, four years apart, a more consistent polling of staff views would provide up to date information on staff morale and changes in the workforce and mitigate against risks such as the recruitment challenge that has worsened within four years.

14.8 Data on staff ethnicity is not routinely collected, this means managers may not know the diversity of their staff and does not allow for monitoring to see if fairness and equity is applied in recruitment or any HR process.

14.9 These are a few of the examples found, that could indicate moving the culture towards having a stronger internal audit system and building in quarterly reviews of intelligence through staff metrics, that could help with planning and addressing risks more proactively.

14.10 Strategy being tied into culture changes, is something staff identified, as helping provide a sense of organisational direction. Staff stressed the need for more communication and engagement around changes to the workforce. One staff member summarised this as s.22(1) [redacted]

14.11 Staff wanted to see better communication and visibility of management arising out of this review and there was general acceptance that skills for leaders around communication and conflict were urgently needed.

14.12 Staff requested more recognition for their work, whilst some of these opportunities had ceased during covid staff wanted renewed management recognition for the work that had been completed.

14.14 Issues around bullying and harassment, sexual harassment and a low level of diversity awareness were explored and these need to be prioritised with interventions within a strategy to unify resources and monitor changes to culture, to stop further deterioration and the impact on both the organisations morale and reputation.

14.15 Some long-standing issues that impacted morale needed unpicking and active progress on resolution.

14.16 The long-standing payroll and scheduling issues require a deep dive and commitment to address this issue which was causing both frustration and a real worry for staff as well as impacting on morale.

14.17 Rebuilding relationships with the Union was a priority for a number of staff who felt it would benefit many to move away from what appears to be a current adversarial relationship in some regions.

14.18 The heat dome was recognised as a tragedy, that staff expressed a deep sorrow that some felt had not been acknowledged by BCEHS leadership team. However, work was ongoing to address with listening sessions planned and work by the Psychological Health and Safety team.

14.19 The new leadership training designed by the Psychological Health and Safety team, Union and leadership team was viewed positively and viewed as impacting on the skills required for staff management.

14.20 New roles with BCEHS of an Executive Director, Employee Experience and a Director of Diversity Equity and Inclusion, will help improve the understanding of DEI in BCEHS and bring a focus to the work needed as well.

14.21 Despite multiple challenges, overall staff expressed a willingness to be part of any culture change needed, and there was a consensus that wide ranging and bold change across a range of areas is now required.

15.0 Recommendations

The recommendations are the start of creating a comprehensive road map to build sustainable change and a more fair, equitable and inclusive workforce.

1. People Strategy

1a. A BCEHS People Strategy be drafted which sets out the behaviours and culture the organisation agrees on and defines as relevant to the agreed culture vision and values going forward. This would list the required actions and responsibilities over several years and include measuring any interventions effectiveness by tracking changes in data for all staff employed by BSEHS.

2. Data Collection

2a. Human Resource Metrics needs to be interrogated regularly particularly around areas such as recruitment and retention, sick-leave, and referrals to the regulator, to provide assurance that governance is in place to manage risks, particularly relating to staff with protected grounds and these are shared with the management team.

2b. Collecting more detailed ethnicity data at the time of employment is essential to measure diversity across the organisation, and to ensure during any disciplinary procedures the protected grounds of the staff involved are known and where possible mitigated. (i.e providing culturally sensitive panels).

2c. Ensure exit interviews are routinely held and information tracked that relates to poor work experiences. It is essential to capture and interrogate why staff leave the organisation and what can be learnt from their leaving.

2d. Track all referrals centrally to regulators and review quarterly for trends. Review both the number of referrals and themes of referrals, and share with relevant departments such as Clinical Governance, Training and Development and Professional Practice for actioning.

3. Clinical Leadership

3a. Operational Managers need to ensure visibility by attending stations and ensuring they meet the whole team and not only the unit chief when on site. Visits should include a written record of attendance, able to be audited. Ideally all managers clinical and non-clinical staff including the Senior Leadership team will work towards having a minimum of five days a year spent engaging and working with staff to ensure that silo working is reduced, and an understanding of staff's lived experience is gained.

3b. Managers and Leaders will have access to training to enable them to improve their soft skills, including conflict management and active listening and have a chance to practice these skills and refine them in a face-to-face setting.

3c. Managers and leaders will seek additional opportunities to recognise staff achievements and will be encouraged to include this in staff appraisals and share good practices across and between services.

4. Developing Talent

4a. Reverse mentoring will be introduced to match senior leaders and senior managers to females who are aspiring leaders. Reverse mentoring is an initiative that encourages junior staff to take the lead in sharing their lived experiences and enabling senior staff to recognise how their decisions impact working life.

4b. Create a number of shadowing opportunities for female paramedics to access senior managers and understand decision making, networking, business planning and how a senior manager/director makes decisions.

4.c Ensure interview panels are diverse in membership to reduce both unconscious and affinity bias. Staff recruiting to any level with a management role & responsibility should have attended an inclusive recruitment skills training to ensure they are aware of the benefits of diverse teams and can mitigate their own biases.

4.d Ensure all recruitment panels viewing internal candidates are robust and use evidence of ongoing professional development as part of the criterion for promotion.

4.e Ensure that DEI is included in induction, for both clinical and non-clinical staff, alongside the expected behaviours of all staff, as well as information on escalating concerns and explaining the process if you witness discrimination at work.

4.f Ensure that teams who lead on recruitment for services, are diverse in makeup and include staff from different backgrounds/ ages/genders to promote better representation.

4.g Nurture the Human Resources team by implementing a suite of training for them around conflict resolution, clarifying conversations, active listening, investigation skills, and inclusive recruitment panels, so they all are responding consistently to human resource and people issues.

5. Addressing Gender Equality

5a. Implement a Gender Equality Strategy that sets out the organisation's commitment to fairness and equity for female paramedics, across areas such as salary, access to promotion, access to training, as well as providing assurance on how to manage and report and reduce sexual harassment over a 2–5-year period.

5b. Set clear and progressive targets within its forthcoming Gender Equality Strategy to increase the representation of women in operational leadership roles at the middle, senior and executive management levels.

5c. Create a Sexual Harassment in the Workplace policy, which identifies the behaviours that constitute sexual harassment and provides advice on direction on reporting, escalation, and resolution of issues. This policy should clearly identify support for complainants using a trauma informed model.

5d. Train staff in Human Resources who specifically deal with sexual harassment complaints who will have a consistent working knowledge of trauma informed practices, absenteeism, and the impacts on staff morale of sexual harassment, gender bias and sexualised workplaces.

5e. Train union members and senior leaders on recognising the impact of sexual harassment and how it may appear in teams, in terms of morale and the impacts on the recipients.

5f. Create a Women in Paramedicine staff network with a Senior Leadership team sponsor (chair and sub chairs) who receive protected time to prepare and hold meetings to monitor and share concerns about gender issues in the workplace including maternity rights and status, as well as access to training and progression.

5g. For the executive team and BCEHS board to have training on sexual harassment and the risks to the organisation. For regular quarterly reports on progress and assurance on the Gender Equality strategy and work on eliminating sexual harassment and gender bias is progressing.

5h. Targeted bespoke training delivery for teams who have reports of sexual harassment within a cluster (3 or more cases in a year) and monitor the effectiveness of training and leadership interventions to change the culture.

5i. Create and publicise a flow chart the easily explain how to report complaints around Sexual Harassment and what will happen, including time frames, resolution methods and how to access trauma informed support.

5j. Support allyship awareness, through training which uses evidence-based examples of what an ally does and how to engage meaningfully when being a witness to incivility or harassment of colleagues. This could include encouraging staff to speak up if they see something they are uncomfortable such as sexualised banter and to check in with the staff involved around how they may be coping and direct them to appropriate support services at BCEHS.

5k. Ensure that in any future staff surveys that gender and diversity is more fully addressed, to ensure the organisation uses every opportunity to push the message about gender equity and DEI, to treat all colleagues with respect.

5l. Ensure all staff undertaking investigations involving sexual harassment have received training and are fully impartial. Investigating incidents where potential bias could be raised needs to be mitigated by using a staff member from outside the area, or potentially an external investigator

6. Addressing Diversity, Equality, and Inclusion

6a. Include an awareness and commitment to DEI in all job descriptions, as a necessary requirement of role, including senior manager and executive team members.

6b. Include at least one question in every management interview on DEI, asking staff about actions they have taken to support DEI in their service, this could be support around DEI towards staff or patients and their families.

6c. Encourage staff to ask patients for their preferred pronouns

6d. Implement a DEI staff network group with a Senior Leadership team sponsor (chair and sub chairs) who receive protected time to prepare and hold meetings to monitor and share

concerns about diversity issues in the workplace including cases of discrimination, as well as access to training and progression.

6e. Develop diversity champions, which are staff who undertake additional training to support and improve knowledge of local communities to improve patient care, and also the culture of DEI amongst staff.

7. Training and Development

7a. Undertake a review of the effectiveness of current training modules on respectful workplace, bullying and harassment and sexual harassment and related communication skills. To review how effective the training delivered is in terms of impacting on trainees' knowledge, skills, performance and return on investment back in the work setting.

7b. Develop a system to consistently evaluate training provision and its effectiveness using online surveys and collect training feedback after every session and ensure this is fed back into curriculum planning.

7c. Move to including a range of soft skills and interpersonal skills within induction and internal training programmes and monitor knowledge before and after attendance.

7d. Move towards multi modal learning which engages senses, visual, auditory, kinaesthetic styles so that staff with different learning styles understand what is being taught, as it allows staff to remember more effectively.

8 Hotspots

8a. Undertake an external review of both payroll and scheduling and commit to resolving the issues and investigating an alternative service within 12 months.

Appendices

I. Staff Interviews

To ensure the confidentiality of staff who agreed to take part in this review, a summary of the process is provided.

Staff reached out from across the organization and were individually interviewed via Teams, including front-line paramedics and dispatch staff and employees from areas such as human resources, clinical operations and learning. Discussions were also held with the BCEHS Senior Leadership team.

There was no set list of interviewees, employees were encouraged to participate in the review and contact the reviewer directly. In addition to the interviews some employees also contributed additional information to support the work of this review. A number of staff expressed they were also representing colleagues' views who may not be able to speak up, and a number contacted colleagues personally and invited them to contact the reviewer.

Further external information was supplied in an interview with:

Alisha McFarlane – Lecturer paramedicine and healthcare sciences, Australia – contributed to the Victorian Equal Opportunity & Human Rights Commission Review 2021, was interviewed for her experiences in the Australian Ambulance services and provided both written and oral information included within this review.

ii Documents Reviewed: BCHES or PHSA Documents

1. 2022 Engagement Survey Results
2. 2017 Survey Results PHSA Work life Pulse
3. BCEHS – Turnover Data
4. Employee Demographics
5. BCHES Investigation Tracker 2020 -2022
6. Districts matrix
7. How to be an effective workplace investigator PHSA V.20 slide deck
8. Fostering a culture of respect handbook
9. Fostering a culture of respect policy
10. Safe Reporting policy
11. BCEHS and CUPE Joint memo respectful workplace
12. Respectful workplace procedure
13. Preventing violence in the workplace policy
14. [redacted]ectful workplace online training course
15. [redacted]personal email
16. Safe and Respectful workplace Initiatives Memorandum – Feb 7th, 2022
17. Human Rights Code https://www.bclaws.gov.bc.ca/civix/document/id/complete/statreg/00_96210_01
18. BCEHS Respect and Dignity in the workplace training slides (June 2022)
19. Psychological Health and Safety leadership Curriculum outline 2022
20. New Employee Organisation programme BLS V.2 2022
21. Code of Ethics
22. Standards of Conduct
23. Draft WIPSIG PDF of data required
24. BC WIPSIG presentation 2021
25. Fostering a Culture of Respect Policy Complaint Procedure (Bargaining Unit & Excluded Staff) BCEHS

iii Literature Review

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iv Culture Change Checklist CIPD

The CIPD have put together a checklist highlighting some points for HR and others involved in implementing culture change to consider. The points are drawn from the experiences of the organisations involved in the research.
The list is not intended to be a comprehensive list, but instead draws attention to the key success factors and challenging aspects of culture change as highlighted by the case studies.

1 Planning the culture change

- Have a clear, public plan of action for the culture change, in addition to a more detailed plan within the change team, which:
- – communicates the need for a new way of working
- – makes clear how the new culture fits with the overall vision of the organisation
- – articulates what the desired culture will look like.
- Identify aspects of the current culture, and existing good practice, which fit the new cultural vision and need to be preserved.
- Stick to the plan but remain alert to external events that may influence the culture change messages and should be integrated into activity.
- Regardless of who is leading the culture change, it is imperative that it is 'owned' by the business.

2 Who needs to be involved in the culture change and to what extent

- Be open and honest about the degree to which employees will be consulted and involved and make it clear that not all decisions will be up for discussion. Think about the points in the change process where involvement will be most valuable.
- Ensure decisions about staff involvement are congruent to the new cultural values. For example, if empowerment is a facet of the desired culture, a more inclusive approach to change should be considered.

• Determine HR's role in the culture change, playing to their strengths and using their expertise. • Assess whether and how key stakeholders will be involved in the change process, from being advocates of the new way of working to playing a more active role in shaping the new culture.

3 The role of leadership

• Encourage leaders to play an active, visible role in driving the new culture, demonstrating the new behaviours expected of people.
• Ensure leaders and managers at all levels are genuinely bought in to the new way of working, so that consistent messages are communicated. Do not neglect the middle management layers.
• Recognise the valuable role of line managers in translating for employees what the new culture means for how work gets done and the behaviours expected.
• Carefully consider the composition of the change team, particularly how the degree of representation of people from different levels and different parts of the organisation, or the use of external consultants, will impact perceptions of the change process and, hence, culture change outcomes.
• Promote effective teamworking among change agents, encouraging the development of effective, trusting relationships to facilitate decision-making and increase the pace of change.

4 Encouraging employee buy-in to the new culture

• Help employees to emotionally engage with the need for a new way of working that's clearly linked to the organisation's core purpose or real service improvements.

• Examine how you can best bring the new cultural values to life for employees, such as through encouraging storytelling.

- Promote fair and consistent implementation of the culture change programme across the organisation, being mindful that staff perceptions of how they are treated during major organisational change will impact on their engagement with the organisation.
- Maintain a constant focus on promoting employee buy-in to the new culture, which can vary during different stages of the change process.
-

5 Enabling culture change through the organisation's infrastructure

- Evaluate the degree to which the organisation's structure enables or impedes the desired culture, in particular, within and between subcultures.
- Be mindful that the success of the culture change may vary between subcultures, with some aspects of the new culture meeting resistance or taking longer to embed.
- Review the extent to which existing systems and processes support the new culture, addressing those which undermine the new way of working.
- Encourage visible signs of the new culture which reinforce the culture change messages and demonstrate that change is happening.
-

6 Developing the capabilities needed for the new way of working

- Identify and develop the skills and behaviours needed of people within the new culture, locating capability gaps.
- Incorporate the new capabilities into existing HR processes and ensure they are integrated into practice.
- Pay attention to the skill sets required of line managers, both in terms of managing through organisation change and the capabilities required by the new way of working and consider how HR can best support their development.
- Be creative about how to develop staff capability when resources are tight.
-

7 Measuring the impact of culture change

• Make assessment and evaluation of the culture change a continuous part of the programme.

• Place considerable emphasis on ensuring you have the right measures to evaluate the impact of the culture change, considering both qualitative and quantitative options.

• Determine how the data collected will be analysed and used to both evaluate progress to date and inform the future direction of the culture change process.

• Regularly communicate to staff about progress towards the new way of working to prompt discussions about what needs to be done to further develop the new culture.

v Glossary of terms

Ally - A person who acts against oppression out of a belief that eliminating oppression will benefit members of targeted groups and advantage groups. Allies acknowledge disadvantage and oppression of other groups than their own, take supportive action on their behalf, commit to reducing their own complicity or collusion in oppression of these groups, and invest in strengthening their own knowledge and awareness of oppression.

Diversity -Psychological, physical, and social differences that occur among all individuals; including but not limited to race, ethnicity, nationality, religion, socioeconomic status, education, marital status, language, age, gender, sexual orientation, mental or physical ability, and learning styles. A diverse group, community, or organization is one in which a variety of social and cultural characteristics exist.

Equality - Evenly distributed access to resources and opportunity necessary for a safe and healthy life; uniform distribution of access to ensure fairness

Harassment - Unwelcome, intimidating, exclusionary, threatening, or hostile behaviour against an individual that is based on a category protected by law.

Inclusion - The act of creating environments in which any individual or group can be and feel welcomed, respected, supported, and valued to fully participate. An inclusive and welcoming climate embraces differences and offers respect in words and actions for all people.

Intent vs **Impact** - This distinction is an integral part of inclusive environments; intent is what a person meant to do, and impact is the effect it had on someone else. Regardless of intent, it is imperative to recognize how behaviours, language, actions, etc. affect or influence other people. An examination of what was said or done and how it was received is the focus, not necessarily what was intended.

Intersectionality -The ways in which oppressive institutions (racism, sexism, homophobia, transphobia, ableism, xenophobia, classism, etc.) are interconnected and cannot be examined separately from one another.

Morale Injury the distressing psychological, behavioural, social, and sometimes spiritual aftermath of exposure to events, it can occur when witnessing behaviours that go against an individual's values and moral beliefs.