The Point of Care Foundation

The case for employee engagement in the NHS

Three case studies

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Contents

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Executive summary

This report presents findings from case studies of three NHS hospital trusts. The trusts, in Leeds, Kettering and Tees, Esk and Wear, are diverse in their focus (acute trust, general hospital and mental health trust), but were selected for their success in improving staff engagement. The case studies reveal common traits across the trusts and point to ways in which other trusts – and policy makers – can better consider staff engagement; in terms of strategy and organisation and, more immediately, in terms of activities that could improve practice in the short term.

The case studies combine desk research and in-depth interviews with frontline, administrative and managerial staff, and senior leadership. They show differences in the understanding and experience of staff engagement between staff groups. For instance, frontline staff are more likely to consider engagement in terms of their immediate colleagues and teams, rather than at an institutional level. However, all staff at the three organisations recognise the value of staff engagement in terms of outcomes for patients.

The trusts pursued differing staff engagement policies and practices. The report lists a range of activities undertaken, but the impact of any individual practice is difficult to capture – largely because data collection processes are variable and there is little evaluation evidence available, but also because it is very difficult to demonstrate causality in such a complex system.

However, what is common to each of the trusts is that they have values that place patients at the heart of care and they view staff as their most important asset. This culture of support for staff engagement and institutional recognition of its value appears to be a strong driver of improved performance. Middle managers have a crucial role to play in helping this to filter through organisations to frontline staff, who need to feel valued and respected. This report therefore recommends that staff engagement should be placed at the heart of NHS trusts, with staff engagement a board-level priority. The delivery of staff engagement processes should be the subject of detailed planning. It should be monitored through effective quantitative and qualitative data collection, using tailored reporting tools. Strategies for staff engagement must be rooted in practice that makes a difference to the lived experience of frontline staff, with clear and visible commitment from managers.

Across the system as a whole, staff engagement can be enhanced through the relief of pressure on the workforce. There is widespread concern that staff engagement is unsustainable against a backdrop of ever-increasing patient demand and stretched resources. While transformation processes are ongoing – with the onset of Sustainability and Transformation Plans and Accountable Care Organisations – it is essential that lessons on the potential value of staff engagement to patient outcomes are translated into new organisational structures.

1. Introduction and context

These case studies were compiled as part of a larger piece of work in partnership with the Work Foundation[1] and RAND Europe[2], funded by the Health Foundation. The wider project sought to learn more about employee engagement in the NHS. The purpose of the case studies was to provide an in-depth review of employee engagement in practice. We selected three trusts[3] with the aim of exploring how employee engagement is defined; what employee engagement initiatives are currently in place; resources allocated to these initiatives; the rationale behind their implementation; how engagement is measured and the effectiveness of work done to promote it in relation to staff, patient and organisational outcomes.

This report follows earlier work from the Point of Care Foundation on staff engagement. 'Staff Care' (2014)[4] argued that caring about the people who work in healthcare is the key to developing a caring and compassionate health service, making the case that support for staff should be a central driver in efforts to improve patient care, productivity and financial performance. 'Behind Closed Doors' (2017)[5] highlighted the latest evidence on NHS staff experience at work, the pressures they face and the consequences for patients, arguing that when staff feel positive and engaged with work it has a positive impact on patient experience.

Case study methodology

The three case study sites were selected through purposeful sampling, based on the assessment of evidence emerging from a literature review and secondary analysis, as well as a range of other factors such as geography, the extent of improvement in outcomes, and awareness of sites where significant research into engagement had already been undertaken. The shortlist was drawn up with input from an Expert Advisory Group and the Health Foundation.

Considerations when selecting sites included:

- Good practice in relation to NHS employee engagement
- Staff engagement scores (as measured by the NHS Staff Survey) showing significant improvements over the last two years of data collection (2015 and 2016)

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1 Solving the Employee Engagement Puzzle in the NHS: making a better case for action. Overall report. Work Foundation (2018). Available at: http://www.theworkfoundation.com

2 Employee engagement in the NHS: A secondary data analysis of the combined NHS Healthy Workforce and BHW survey. RAND Europe (2018). Available at: https://www.rand.org/randeurope/research/projects/employee-engagement-in-nhs.html

3 Leeds Teaching Hospital NHS Trust (Acute), Tees, Esk & Wear Valley NHS Foundation Trust (Mental Health and Learning Disability), Kettering General Hospital NHS Foundation Trust (District General Hospital)

4 Cornwell J, Staff Care: How to engage staff in the NHS and why it matters. The Point of Care Foundation (2014) https://www.pointofcarefoundation.org.uk/evidence/staff-care-report/

5 Cornwell J and Fitzsimons B, Behind Closed Doors. The Point of Care Foundation (2017) https://www.pointofcarefoundation.org.uk/evidence/behind-closed-doors/

Data were collected through two main methods:

- Document review of relevant policies, procedures and processes; board minutes and minutes of other committees; CQC/NHS Improvement inspection reports; performance data; and documentation relating to the specific intervention/activity
- Depth qualitative interviews/focus groups with members of staff

Within each organisation, qualitative data collection was undertaken with between seven and ten respondents in semi-structured, one-to-one interviews and three focus groups with six to twelve frontline and admin/clerical staff. The participants included:

- Chief executive
- Chief operating officer
- Director of human resources and organisation development
- Staff with responsibility for employee engagement/support
- Medical director/director of nursing
- Departmental managers/middle managers/frontline team leaders
- Different levels of frontline clinical staff: ward managers, sisters, staff nurses, consultants, registrars, junior doctors, therapists, HCAs
- Administrative and clerical staff
- Domestic staff
- Chaplaincy and occupational health
- Trade union representatives

The research explored a range of views and experiences relating to staff engagement (see Appendices for discussion guides). The interviews and focus groups were recorded, and results were synthesised by the research team to draw out themes, recommendations and policy inferences.

2. The case studies

Acute: Leeds Teaching Hospitals NHS Trust

Leeds Teaching Hospitals NHS Trust is one of the largest in the United Kingdom, serving a population of approximately 780,000 in Leeds, and up to 5.4 million in the surrounding areas. The Trust is one of the busiest NHS acute health providers in Europe. It is a regional and national centre for specialist treatment, has a world-renowned biomedical research facility, a leading clinical trials research unit and is also the local hospital for the Leeds community. The trust employs 17,000 staff, has a £1bn budget and provides local and specialist services, as well as regional specialist care. Annual accounts for 2015/16 reported a £30m deficit. Fieldwork for this case study was conducted at Leeds General Infirmary, one of the hospitals within the Trust.

Care Quality Commission report

Following the most recent inspection in May 2016[6] the Trust moved from 'Requires Improvement' to 'Good', indicating a significant improvement in the quality, culture and safety across the Trust.

Among other findings, the CQC report highlighted that the Trust had invested time, effort and finance into developing a culture that was open, transparent and supported the involvement of staff, while reflecting the needs of the people using the services. The report noted the Trust's stable leadership team, and that staff across the organisation were positive about the access and visibility of executives and non-executives, particularly the chief executive. Additionally, the leadership team were aware of and addressed challenges when faced with providing service demands.

There was a positive culture around learning and safety, as well as learning from incidents with appropriate incident reporting and shared learning processes in place. Additionally, there were governance systems in place to ensure that performance, quality and risk was monitored, with each Clinical Service Unit meeting weekly and using the ward health check to audit a range of quality indicators.

NHS Staff Survey

The Trust invites its entire staff to participate in the NHS Staff Survey. In the latest survey statistics 7,144 members of staff (46%) completed the survey, significantly more than any other Trust nationally, following a steady increase in staff engagement over the last five years (engagement was measured at 3.44 in 2012). This improvement in the engagement measure has meant that Leeds Teaching Hospital Trust has improved its ranking to be the second in the country.

Other areas where staff experience has improved most include: recognition and value of staff by managers and the organisation (3.49); fairness and effectiveness of procedures for reporting errors, near-misses and incidents (3.81); quality of appraisals (3.15) and staff confidence and security in reporting errors, near misses and incidents (3.74).

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6 CQC (2016) Leeds Teaching Hospitals NHS Trust; Quality Report. Available at: http://www.cqc.org.uk/provider/RR8. The report gives Leeds General Infirmary an assessment of 'requires improvement'.

The 'Leeds Way'
Staff at Leeds Teaching Hospital Trust worked with the executive team to develop a set of values, known in the Trust as 'The Leeds Way'. These values aim to define what the Trust is, what it believes in and how it works to deliver the best outcomes for patients. The Trust values are for all staff to be patient-centred, fair, collaborative, accountable and empowered.

The Leeds Improvement Method
Leeds Teaching Hospitals Trust was chosen as one of five trusts in the UK to work with the Virginia Mason Institute on a programme to provide a framework for improving quality and efficiency across the organisation. The programme also provides the opportunity for the Trust to bring about sustainable and lasting culture change. The aim of the programme is for the Trust to become one of the top Trusts for patient safety and efficiency in the country.

Mental Health and Community Trust: Tees, Esk & Wear Valley
Tees, Esk & Wear Valley (TEWV) is a mental health and learning disability NHS Foundation Trust providing services for over two million people in a geographically wide area encompassing the Tees Valley, County Durham, Scarborough, Whitby, Ryedale, Harrogate, Hambleton, Richmondshire and the Vale of York. It covers industrial, urban, remote rural and coastal areas. The population profile is diverse, with high levels of deprivation in former mining and steel industry areas, as well as large pockets of agricultural land. The Trust employs 6,400 staff with an operating income of around £345m per annum. The deficit for 2016/17 was £19m.

Care Quality Commission report
The most recent inspection by the CQC in 2017[7] gave TEWV an overall rating of 'Good.' Assessors reported that staff engaged with patients 'in a caring, compassionate and respectful manner'. The views of patients and carers were actively sought and feedback on care and treatment was invariably positive. Staff in areas visited, were aware of TEWV values. Overall, the CQC assessed staff morale to be high. They reported that the Trust actively promoted staff wellbeing and quoted a staff engagement pilot aimed to increase engagement. TEWV is currently accredited as an Investors in People Gold Standard organisation.

NHS Staff Survey
The Trust promotes the NHS Staff Survey as soon as it goes live and staff are advised that their opinions and feedback can support service improvement. Teams are asked to display, share and discuss findings. When data are available, a report is produced by the Trust and disseminated publicly. Teams that report well are highlighted in e-bulletins.

The TEWV response rate for the NHS Staff Survey was 49% in 2016; above average for that of comparable trusts. It was lower than the TEWV rate of 55% in 2015 and 57% in 2014. The Trust score for engagement in 2016 was above average as compared to other mental health trusts. (Average 3.77). The overall engagement

7 CQC (2017) Tees, Esk & Wear Valley NHS Foundation Trust: Quality Report. Available at: http://www.cqc.org.uk/sites/default/files/new_reports/AAAG2395.pdf

score for TEWV increased from 2014 (3.88) to 2015 (3.98) and decreased to 3.88 in 2016.

There were three scores where TEWV scored better than comparable trusts:

- For 'The percentage of staff feeling unwell due to work related stress', the TEWV score was 33% compared to the average in comparable trusts of 41%.
- The Trust score for 'staff satisfaction with level of responsibility and involvement' was 3.98 in 2016 compared to the average score of 3.87
- 'Staff satisfaction with resourcing and support' was 3.51, higher than the average for mental health trusts of 3.36.

The largest improvement in staff experience was the 'percentage of staff/colleagues reporting most recent experience of harassment, bullying or abuse'.
This had decreased from 57% in 2015 to 35% in 2016.

TEWV mission and values
TEWV's mission is 'to minimise the impact that mental illness or learning disability has on peoples' lives'. It lists its values as: commitment to quality, respect, involvement, wellbeing and teamwork.

TEWV is consulting with staff, service users, carers and stakeholder organisations to review its set of values and behaviours statements, initially called the 'TEWV Way', now known as 'Making a Difference Together'.

District General Hospital: Kettering
Kettering General Hospital (KGH) is an acute trust providing healthcare services to a population of around 320,000 in North Northamptonshire. It has outpatient services in Corby, Wellingborough and Rushton. There are currently 3,700 full-time equivalent staff and it is an affiliated teaching hospital to the University of Leicester. The operating income for the Trust was £236.5m for 2016/7. The deficit for 2016/17 was £25.6m. KGH provides an emergency department, speciality acute services, obstetrics and maternity services. The Trust has reported a considerable increase in demand for services throughout the last few years and that has impacted on performance, quality outcomes and the financial position. Year on year, A&E attendance has increased by around 10%. From 2015/16 to 2016/17 there was an increase in inpatients of 11%. During 2016/7, KGH financed 60–80 more beds, but bed occupancy still ran at over 100%.

The past few years have seen a significant turnover in senior staff (with the exception of human resources). The chief executive in post during the research phase was appointed on an interim basis following the sudden departure of the previous chief executive due to ill health. The new chief executive, Simon Welton, was recruited during the course of the research but did not take up the post until April 2018.

Care Quality Commission report.
The most recent review and rating by the CQC was published in April 2017[8].

8 CQC (2017) Kettering General Hospital NHS Foundation Trust Quality Report September 2017 (Inspection June 2017). Available at: http://www.cqc.org.uk/sites/default/files/new-reports /AAAG6609 pdf

The Trust was rated as 'good' for being caring and found that staff were professional and passionate about providing high-quality patient care. Staff were reported to be hard working and caring, and they treated patients with dignity. Feedback from patients was very positive.

However, the overall rating for the Trust was assessed as 'inadequate' and the Trust was placed into special measures. Concern was expressed about the inadequate numbers of staff, resulting in long delays for some patients, as well as issues about safety and management. The Board was aware of the staffing and recruitment issues, and the pressures staff were under.

A focused inspection took place in June 2017, as an unannounced CQC visit. It included the emergency department (ED), children and young people's service and outpatients department. The inspection found areas where significant improvement had been made. In the ED, staff were reported as showing care and compassion towards patients and families. They showed commitment to improvement and staff felt communication from board level had improved. There were positive changes in waiting times and governance.

NHS Staff Survey
Between 2014 and 2015, the Trust was recognised as the most improved acute trust in the country for staff engagement (scores rose from 3.55 to 3.71).

The staff response rate has fluctuated over the past few years: 39% in 2014, falling to 28% in 2015 and then rising to 32% in 2016. There was a significant increase in the overall staff engagement measure from 3.71 in 2015 to 3.78 in 2016 (3.55 in 2014)

Of the staff who completed the survey, positive shifts in scores that relate to staff engagement included:

- a significant increase in the percentage of staff agreeing that their role makes a difference to patient service, from 87% in 2015 to 90% in 2016;
- a significant increase in staff confidence and security in reporting unsafe clinical practice from 3.57 in 2015 to 3.68 in 2016;
- a significant increase in effective use of patient/service user feedback from 3.58 in 2015 to 3.72 in 2016;
- a significant increase in recognition and value of staff by managers and the organisation from 3.33 to 3.44;
- a significant increase in the percentage of staff reporting good communication between senior management and staff, increasing from 26% on 2015 to 30% 2016.

The percentage of staff experiencing discrimination at work in the last 12 months increased significantly from 7% in 2015 to 12% in 2016. 29% of staff said that they had experienced violence, harassment and bullying from other staff in the last 12 months, which was the same as 2015. This is higher than the average for acute trusts.

Quality improvement

Rather than adopt a systems methodology, KGH has adopted a series of initiatives as part of its improvement strategy. This combines measurement, culture and leadership initiatives with quality improvement (QI) methods. The QI process was further developed with plans including training across the Trust in 2016/17 by the East Midlands Patient Safety Collaborative.[9]

Additional ways of measuring feedback relating to improvement are collected through the staff Friends and Family Test, local surveys and 'safety and quality walkabout'. To improve the number of patients providing feedback to KGH to respond to voiced need, engagement with the Friends and Family Test was set as one of the priorities for 2017/8. Plans were to use a 'listening booth', assess other ways of collecting FFT data and harness the support of volunteers to collate responses. Progress is being measured through the monthly production of a Quality Dashboard.

Vision and values

KGH's vision is 'to provide safe, high quality CARE to our communities.'
Its values are summarised in the acronym CARE – compassionate, accountable, respectful, engaging. These were developed with staff as part of 'Link Listeners', the Leadership Forum and engagement events across the Trust.

9 KGH (2016) Operational Plan. Available at: http://www.kgh.nhs.uk/EasysiteWeb/getresource.axd?AssetID=14024&type=full&servicetype=Attachment

3. Analysis

What does employee engagement mean in the NHS?

Staff engagement was reported both by managers, directors and frontline staff to be key to the effective working of the organisation. The frontline staff, who have most contact with patients, link engagement directly to a patient-focused vision. Stories where staff had a tangible impact on patients' experiences were often given to illustrate how staff felt fulfilled and valued.

Relationships appeared to be fundamental to the way individual employees felt about coming into work. These included staff to patient, staff to team leader, colleagues and the immediate team. Factors that were integral to maintaining good relationships that were frequently mentioned included communication, trust, support, respect and being valued.

Directors tended to put forward a definition of engagement that was more strategic than frontline staff, but it was nonetheless consistent with a strong, patient-focused vision.

How is engagement measured?

The reputed links between patient experience, staff engagement, sickness rates, recruitment issues and staff turnover rates seemed widely acknowledged. Managers want good and actionable data on staff that they can use to improve both the quality of care for patients and staff wellbeing. Data, it was reported, need to be robust (in terms of survey response rates) and timely. Better insight into why staff behave as they do was perceived to inform how staff can be supported. This was both to maintain staff wellbeing and secure ongoing commitment to the organisation and its values.

However, some managers in the acute sector stated that it was often problematic to report a negative shift in measures, such as infection rates or falls.

> ***'It can become a vicious cycle. Staff can get dissatisfied because of the low metrics and not getting good results, and then staff can get more stressed.'***
> *(Director/Manager)*

Staff survey

Data from the staff survey were valued by some senior managers across the trusts and were seen to be a reliable measure of engagement, with results being disseminated down to frontline teams. A number of methods including visual maps were used to help ensure that use of and response to data were maximised. Results were used to compare levels of engagement within teams and between professional groups and often data from the survey were triangulated with information from other sources (staff sickness rates; staff retention; CQC ratings; exit interviews; anecdotal data collected through social media, open forums, wider communication systems and manager observation such as the KGH 'safety and quality walkabout') to inform appropriate responses. Managers also felt that the results were an opportunity to monitor the impact of engagement of policies and initiatives around ongoing challenges, including bullying and harassment.

There were however concerns voiced by HR, both in relation to the low response rates (30–50%) and the time lag between survey completion and results.

> ***'Of the 50% who do not respond, what do they really think? It could be because they are quite content and have better things to do or it might be that they are pretty disengaged and think "what's the point, no one will listen to us'."***
> *(Director/Manager)*

One Trust suggested that if the survey was conducted biennially it would allow more run-in time to respond to and act on results.

From the perspective of frontline staff, the Staff Survey was felt to lack clarity at times. For example, did certain questions relate to their team leader or more senior managers, the national picture or their local team? It was considered by some to be onerous to complete and there were concerns expressed about preserving anonymity. Despite attempts from managers to boost completion rates, it was something that could easily slip down the list of unread emails into obscurity.

Patient and staff Friends and Family Test

Friends and Family Tests completed by both patients (FFT) and staff (S-FFT) are made up of one mandatory question relating to the likelihood of recommending the trust either as a place to work or a place to visit as a patient, along with some demographic data and an opportunity for free-text responses. Frequently, a small number of questions are added locally. The S-FFT was reported to be quick to complete and in some cases can be done on a smartphone app, by postcard or online. Senior staff saw the benefits of carrying the survey out on a quarterly basis rather than annually; real-time data can be sent to the appropriate teams to act upon.

Data collected and reported back to staff from the FFT was seen to be pivotal to supporting staff (particularly nurses) to feel valued and, consequently, more engaged. Staff in the teams interviewed, valued what went well from the patient perspective and what could be improved. This was captured and displayed on 'You Said: We did' notice boards placed visibly in public areas and helped staff recognise the immediate impact of their actions.

Additional data sources

Solutions to get around shortcomings in national data collection were considered and regional, trust-wide, or team-based tools were all referred to – though awareness that staff were under threat of feeling over-surveyed tended to prevent overzealous data collection. In the Adult Therapies team in Leeds the Consultation and Relational Empathy Test was made up of ten questions that patients were encouraged to complete. It was used to monitor team performance and TEWV mentioned similar tools used to try to provide more insightful feedback from young people in the Child and Adolescent Mental Health Service. While the importance of gathering patient feedback was recognised, staff reported being mindful of the challenges of undertaking surveys with patients who were either physically frail, cognitively impaired or recovering from labour and nursing new-born babies.

A couple of managers mentioned the use of 'HSE Stress Surveys' which were used if staff were felt to be under high levels of stress and were seen to be a useful tool to assess needs and respond with specific interventions (such as building special equipment or managing relationships).

Tools for measuring engagement	**Pros**	**Cons**
NHS Staff Survey. Annual. Composite engagement measure made up of questions around: tendency to recommend trust as a place to work or be a patient; staff motivation at work and staff ability to contribute towards improvement at work.	Statutory measure, therefore available for longitudinal analysis and comparison (internal and external) annually.	Results slow to emerge. Low response rates. May not accurately measure engagement as defined, particularly by frontline staff. Staff reported length of survey was a disincentive to completion. Non-responder bias.
Patient Friends and Family Test. Ongoing.	Provides data at ward/team/service level to inform improvement. Gives patient-related data that staff value and can improve morale. Local questions can be added. Comment and response can be posted online or displayed.	Completion rates variable and generally low. Does not cover all services. Cannot be reliably compared to other services within and beyond the trust.
Staff Friends and Family Test. Flexible, usually quarterly.	Quick to complete. Provides data that can be drilled down to ward/team level to inform improvement. Feedback more timely and immediate than Staff Survey. Local questions can be added.	Completion rate varies.
Other organisational intelligence, including staff sickness rates, retention figures, CQC ratings, exit interviews and anecdotal data.	Helps triangulate data from other sources.	A number of indicators are seen to be linked to staff engagement but wariness over complexity of picture.
Locally collected qualitative data.	Provides richer picture of local issues.	Resource intensive to collect

Why is employee engagement important in the NHS?

Staff were recognised by the senior leadership as being 'the trust's most important asset'. The rationale for fostering engagement by looking after staff appeared to be both moral ('it's the right thing to do') and a way of increasing efficiency through the process of change management.

There was agreement that investing in staff was beneficial on a number of other levels. Happy staff make happy patients, with improved retention and reduced sickness absence. In a competitive market with staff shortages across many areas, retaining staff to achieve high-quality care was expressed as a necessity. Benefits relating to employee engagement were considered differently, depending on the professional group. Senior managers occasionally linked engagement to productivity:

> ***'It is difficult to measure, but if people feel happier at work then this is linked to productivity. They will pay more attention to their tasks in their jobs, which trickles down into patient outcomes, patients are happier, they go home earlier and they are happier with the care they are given.'***
> *(Director/Manager)*

Frontline staff were more likely to link good staff engagement to patient experience and the connection appeared intuitive to many:

> ***'If patients see nice happy staff, it makes them feel better... if you have just one member of staff smile at you and reassure you, it makes so much difference.'***
> *(Focus Group)*

While there was recognition that investing in staff wellbeing and broader engagement initiatives was worthwhile, there was no explicit attempt to quantify the amount of funding that was allocated to such programmes, nor the relative outcome. The underlying reason for this appeared to be an acknowledgement of the complexity of any trust-wide initiatives and the fact that there could be multiple distinct outcomes (both intended and unintended) arising from individual initiatives.

Although financial outcomes were rarely mentioned in relation to staff engagement, senior managers, if probed, did draw some links between higher levels of staff engagement and longer-term financial benefits:

> ***'If staff are happier then this leads to less sickness absence, and staff are less inclined to take time off. This leads to a more stable workforce which results in higher-quality care, less locums, less agency spend, so more money to spend on other needed resources.'***
> *(Director/Manager)*

What are the enablers and barriers to good staff engagement in the NHS?

ENABLERS

A number of initiatives at individual, team and organisational level were said to be instrumental in facilitating engagement. The list of enablers that emerged from the three sites is not exhaustive and there is a degree of overlap between the various headings.

Patient-focused vision

Staff across the nine focus groups reported a sense of connectedness to the common purpose of making a tangible difference to patients, and staff appeared to be committed when work was meaningful. Professionalism, compassion and care come out strongly throughout the narratives. This vision, often expressed as a key organisational aim, was perceived by senior managers as an essential prerequisite to engagement:

> ***'...if people are enthusiastic about their role, they will carry it out better, especially when there is direct patient contact, this discretionary effort will spill over to patient care'.***
> *(Director/Manager)*

Team support, relationships, proximity and permanence

The importance of peer support was apparent particularly for frontline teams and, for some, it was the key motivator to come into work. Staff on the front line were reassured by being part of a team. The cohesion, stability and permanence of a team enhanced the feeling that staff could rely on each other, particularly when under pressure. Teams that work in close proximity appear to be more connected and are able to communicate informally.

> ***'I feel valued by other members of the team; we have to help each other out and other team members are really grateful for that.'***
> *(Focus Group)*

A strong sense of connection between team members was reported by some, removing perceived hierarchies between professional views; everyone had their role and could be respected for the job they did.

> ***'In previous roles I have found it very hard to speak to consultants, but here I can just go to them. There is less of a hierarchy within this team. I don't feel set back because of my role, we work tightly together.'***
> *(Focus Group)*

Team leaders also saw the value in spending quality time with each other to discuss issues without necessarily having higher-level managers present.

> ***'Staff need the opportunity to discuss issues with their peers without management, to enable a safe space. For example, how they are managing to do things, how they cope with the pressures they are under in their teams and a chance to share good practice – or simply to offload.'***
> *(Director/Manager)*

People management and leadership style

The participants in the focus groups – drawn from teams exhibiting higher and improving levels of measured engagement – identified the style of leadership by local managers as being of considerable importance. Empathetic and inclusive leaders were reported to foster a sense of staff wellbeing and job satisfaction. Team leaders interviewed were consistent in their adherence to open, transparent leadership styles, involving staff in decision making and avoiding micro-managing. This was corroborated by staff who suggested that managers acted as a buffer between the organisational demands and the team, in the context of pressured work environments.

> ***'(Our team manager) is fantastic, she is very approachable. She is containing as a manager, will always offer support and is willing to listen. It makes a big difference.'***
> *(Focus Group)*

Staff considered their line managers to be receptive and responsive, giving them a high degree of control in how their work is organised.

> ***'We are encouraged by the organisation to suggest improvements; if we can make it any better we will do that. We work in a fairly autonomous way. If I do have an issue, I would pass it on my line manager.'***
> *(Focus Group)*

Team recruitment for a 'good job fit' was seen by some teams/managers to be crucial in achieving quality care for patients and a positive effect on team dynamics and morale.

> ***'Our recruitment approach has completely changed – we have recruitment fairs and days where we invite a range of people for interview, so that we can really select those who are right for the team and offer [clients and their families] the interventions that they need.'***
> *(Director/Manager)*

Access to training and development was perceived by staff to be an indication that they were worth investing in and gave them a sense of progression in their own careers. Many staff and team leaders spoke about the shift to more regular appraisals to be a positive move which, along with supervision sessions, allowed time for discussion, review and support.

> ***'We were supposed to have them [appraisals] back in the day, but we just had a quick chat and that was it, you didn't even know that you have had your appraisals. It has been formatted, and we are happy that they are now being delivered.'***
> *(Focus Group)*

Reflective space

The benefit of informal contact across teams was strongly voiced by staff who valued time to talk to each other, suggesting that opportunities for communication helped to maximise the value of effective, multi-disciplinary working and offered the chance to reflect on the patients in their care.

> ***'I enjoy working with a multi-disciplinary team and having the time to hear from other professionals of ways of understanding complex problems; it feels good when you have the resources in order to do that in an effective way.'***
> *(Focus Group)*

Valuing staff/appreciation

Staff reported that feeling valued by patients, other staff, managers and the wider organisation was a factor that fostered wellbeing. Across the case study sites, ways of communicating this included:

- Patient feedback either directly or through managers from data collected by the FFT;
- Positive feedback by managers, for instance by acknowledging staff contribution to improvement and being paid for overtime without requesting it;
- Award and reward schemes such as smile awards, team of the week, wall of thanks and annual reward events to recognise achievement. Awards at all levels were invariably shared on social media to act as motivators to other teams and to share good practice;
- Staff valuing each other with support and acts of kindness.

> ***'The NHS survives on good will. Almost everyone goes above and beyond. If we all worked to rule the whole thing would come to a halt. We dig deep and do things off our own backs. For example, I make cakes for staff – it makes them feel appreciated and they are more likely to give of themselves.'***
> *(Focus Group)*

Modelling organisational values

The leadership teams in the case study sites espoused a commitment to involving staff in co-creating the vision and values for their organisation. Senior management expressed the significance of modelling organisational values and behaviours that then permeate through the trust. Developing a culture where the employee voice is not only accepted and appreciated but is also actually elicited was seen as a key driver for building trust and respect in relationships.

> ***'I haven't worked anywhere in my career that takes staff engagement and involvement as seriously as TEWV does. It is built into the DNA of the organisation. It has become instinctive in the way we think about things – let's get people together and ask them.'***
> *(Director/Manager)*

The need to develop a positive and open culture was emphasised at executive team level in all three trusts. The belief expressed was that if staff were travelling in the

direction in which the trusts were moving, they would have a greater understanding of and involvement in its development. Some staff reported being personally inspired by the vision of their executive team and they were seen as a driver in setting the organisational tone.

Communication

Systems that are two-way, transparent and responsive seem to play a pivotal role in encouraging engagement in case study trusts. Management expressed the need for a structured system to communicate effectively with staff to involve them in the change process and to respond to issues raised by staff. In turn, staff considered it helpful that there were mechanisms in place for them to share their ideas. Processes for communicating from bottom-up and top-down included a variety of methods – both formal and informal – throughout the trusts. An essential part of the engagement equation was to 'join up the top and bottom of the organisation'.

Structured meetings

The three trusts reported on a system of regular, interconnected meetings for different levels of staff. For example, TEWV described a system where staff are split into multi-disciplinary groups (cells) of around seven people who meet in daily 'huddles' for around 15–30 minutes. 'Supercell' huddles take place every two weeks between team managers and heads of services.

> ***'The daily rigour of having a huddle means that communication is stronger and people are supportive of each other. We can focus on today's work today and fix on today's problems by tomorrow... People feel part of something. They feel that they have a role, they feel that they have a voice, they feel that they can be heard and they feel that they can influence and that their expertise is valued. This is a really strong part of what we try and do in terms of engagement which influences the care that is given.'***
> *(Manager/Director)*

Leeds reported on a cascade system whereby 'Team Briefs' were conducted with 100–150 senior managers, who then briefed their ward managers in teams. A similar practice takes place in KGH, led by the chief executive. Some of the clinical teams also have daily huddles.

Newsletters, magazines, bulletin boards, social media, intranet videos and open forums were other ways mentioned and valued by staff as a way of feeding into and finding out what was going on.

Responsive systems for suggesting improvements and voicing concerns

Voicing suggestions and escalating concerns under conditions of trust were important to staff as a way of achieving 'psychological safety'. Staff in the teams who participated in the focus groups felt able to speak their mind, seemingly without risk of repercussion.

> ***'A clinician in the team recently fed back to me that they felt that they could offload about something that they were not happy with and I would not be judgemental. It is about managers providing that safe space for clinicians to have a rant and tell me, for example, that they are really not happy about a decision that affects them and discussing a way to resolve it.'***
> *(Director/Manager)*

A 'no-blame' culture was one in which learning could occur and potentially improve patient care. Problems could be highlighted and addressed, and actions put in place as a preventative measure.

> ***'It is important to be open and honest about our successes and challenges, sharing information as part of a moral obligation, rather than being driven by scores.'***
> *(Director/Manager)*

Staff in all trusts identified a number of vehicles by which they could suggest improvements and ideas, or express and escalate concerns. These included routine communication governance structures, Freedom to Speak Up Guardians (FTSUGs), Link Listeners and opportunities for anonymous reporting through electronic and paper-based modes. In each case, concerns were reported and reviewed by senior team members who then responded accordingly; an important building block for good engagement.

> ***'I took two issues to Link Listeners which I hadn't been able to take anywhere else...The chief executive is impressive – she doesn't 'flannel' you – if she doesn't know the answer she will tell you – and then she'll go away and find out. At each meeting they feedback the outcomes of the last meeting to tell you what's happened as a result of people's input. If you don't want to attend in person you can email your suggestions. There's normally a good mix of staff – anyone can go... It helps people feel that they are listened to by people high up – and I think that's important. You're never made to feel that you've wasted their time.'***
> *(Focus Group)*

Receiving a response, either feedback to demonstrate that the changes had been enacted or why it was not feasible, was seen as crucial to show staff that their views had been taken into account and valued. Building support in the organisation was also seen as a way of mitigating the negative effects of change.

Effective systems for monitoring data (including data on patient and staff experience, and engagement) are integral to the development of responsive systems.

<u>Influence of top team</u>
At one trust, the consistency and stability of the executive team was seen as an important driver and their ways of working could be sustained with longevity. However, paradoxically, change can inject new life into systems; one trust reported that a shift in the organisational team had a positive impact on organisational culture; 'the way we do things round here'.

Looking after staff: enabling flexible working, responding to personal needs and individual wellbeing

Enabling staff to juggle the demands of personal life around their job, alongside provision for emotional support, reflection and wellbeing is key to staff feeling valued and engaged. Work rosters were mentioned frequently during interviews. Technology, such as e-rostering, that allows staff to plan shifts well in advance will potentially be of value. However, there were a number of glitches relating to mastering the use of the software. Staff reported that flexibility and the ability to forward plan enhanced their work/life balance. HR linked e-rostering to improvements in managing patient demand, and reduced churn.

> ***'Reduced attrition helps reduce temporary staffing spend and a more stable workforce means better engagement.'***
> *(Manager/Director)*

Managers took the health and wellbeing of staff seriously and recognised the value of investing in staff to enable them to maintain good health. Examples given included carrying out adequate return-to-work interviews following periods of illness, building special equipment to ensure disabled staff could be both comfortable and effective, and carrying out 'stress tests' to resolve problems when concerns had been raised. Managers also mentioned that relationship to unions, partnerships and reviews of policies that ensure the consideration of inclusion and diversity help staff to feel safe.

BARRIERS

Although staff reported on a number of factors that were seen to develop and drive the staff engagement agenda through the organisation, it was clear from the narratives that barriers were present that hampered development and, if they persisted, these barriers could potentially undermine the good work that the trusts had achieved.

Unprecedented and increasing demand and pressure

Concerns about workload were expressed at all trust levels, with financial pressures and growing demand inevitably compromising the quality of care to patients.

> ***'If there are too many pressures, of course this impacts on our patients. We are often seeing them at a hugely traumatic time of their lives – they're often in the middle of chemo or other treatments – and as a member of staff you want to feel that you have time to talk to them and empathise with them – but if the pressures are too great you just can't do this.'***
> *(Focus group)*

> ***'As managers we feel that pressure – we are having to ask our team members to perform more effectively, be leaner, see more people, meet that demand.'***
> *(Director/Manager)*

Increasing demand and pressure were variously attributed by research participants to:

- Demographics – increasing population density and ageing;
- Specialist status of some trusts;
- Funding;
- Structural problems – buildings and surroundings, lack of beds, black alerts;
- Competing demands, varying priorities;
- Rising patient expectations.

Some staff felt that their mental health needs were not being adequately addressed, given the increasing demand for services, which created additional pressure and stress. There was a sense that staff services were not sufficiently robust 'to offer the right type of support at the right time.' Staff in the TEWV Trust suggested that support should be an integral aspect of the multi-disciplinary team.

> ***'We need non-pathologising and mechanisms to help us deal with day-to-day stress, which is just a given in this line of work. It carries a stigma to self-refer to Occupational Health. There is a feeling that it is something you really ought to deal with – support needs to be an embedded part of the service.'***
> *(Focus Group)*

Although attitudes to engagement were largely positive, some respondents voiced disquiet about the risk to self of being engaged and 'productive'. In the minds of some staff, work stress is directly connected with sickness. Moreover, one trust has recently revised its sickness procedures, which are now perceived as being more punitive, contributing to an erosion of 'trust'.

> ***'Sickness procedures have changed and staff feel more of a pressure to come in. Before, if there were 3 episodes of illness you would have a welfare review... and you would be supported to help you improve sickness rates. This has now gone... and been replaced – after 10 days sickness or four episodes, you will trigger a formal stage 1. An outcome of this could be a first written warning. You are penalised for being sick. We can understand that some people abuse sickness absences but then, for others, there is lack of trust.'***
> *(Focus Group)*

Scepticism around the pace of change

The suggestion in some focus groups was that while aspects of the quality improvement were well received, there was nonetheless a degree of scepticism about the continuing pace of change; especially surrounding the notion that the senior leaders were at times imposing a cumbersome process with a predetermined agenda on frontline staff. There was also a sense that promoting engagement was another way of management practices trying to boost performance and squeeze more blood from the NHS stone.

The drive for creating 'greater value with few resources' could have potentially negative consequences. Management, were, however, very much aware of the pressures staff were under and acknowledged the impact of the continual drive for efficiency.

> ***'I am going to be cynical but every time I hear about an improvement event, my heart sinks... Everyone knows what they are after in reality is cutting time, which is completely unrealistic. There is always the pretence that we can change things for the better.'***
> *(Focus Group)*

> ***"There are barriers to this kind of working such as staff cuts, efficiency savings and when resource is limited.'***
> *(Director/Manager)*

Limited human resource

Periods of increased staff turnover and sickness absence were also linked to pressures, potentially leading to staff feeling '*displaced, unsettled and stressed*'. It was noted that additional pressures could result in the conflict arising between colleagues, particularly when clinicians '*prioritise in different ways*'.

Permanent staff raised concerns about the use of bank/agency staff to cover periods of absences and unfilled posts, even though the recruitment of extra staff is meant to improve staff-to-patient ratios. Where agency staff made up a high percentage of the team, staff said that it erodes solidarity and ownership of work, and other members of the team feel resentful that they are taking on a disproportional burden of the work but receiving (or so it seems to them) less pay.

> ***'When you employ agency staff, which is rare, they did get paid so much more than the individuals they are filling in for that it just doesn't really seem fair... with bank staff we are finding that some for a particular service just haven't got the skills we need, or their skills are really limited. And they are just here for a short time, and you spend so much time getting them up to speed and then they go. The morale just goes down. You have spent all that time helping them with what to do, and then they just leave!'***
> *(Focus Group)*

Variations in the level of engagement

Drawing on observations from senior managers and findings from the NHS Staff Survey, it appears that levels of engagement are not consistent across teams and professional groups. This was illustrated in the case of admin/clerical staff, junior doctors and middle managers. Secretaries and admin staff were a key group who could easily be left out from organisational processes – often to the detriment of quality. Bands 1–3 were said by one acute trust, to be the '*forgotten soldiers of the organisation*'.

Some teams did not feel sufficiently integrated and suggested that it reduced job satisfaction. Sometimes structural barriers such as the way wards and staff were separated made team working difficult, which resulted in feelings of frustration.

For the highly engaged teams participating in the focus groups, consultants and junior doctors were very much integrated both into their teams and the organisation. This may be linked to specialisms in mental health and maternity care. It was suggested that 'in mental health trusts, doctors tended to be more team-focused, with multi-disciplinary teams working closely together which breaks down

professional barriers'. A small number of senior staff voiced concerns about the challenges of engaging clinical staff in some departments – while recognising that real engagement demands the luxury of time and space that is not always available to clinicians. A senior manager in one trust, reflected on the old system of the 'firm', and the changes in the way that junior doctors are now supported. The fact that juniors are often on rotation makes it harder for them to engage – yet it's in the organisation's interests to help them feel valued.

> ***'In the days of the 'firm' the consultant would have had juniors to dinner. Now, that doesn't happen. We rely on pastoral care provided by the medical co-ordinator – but that's not guaranteed. There's also no common room to get together, so young medics are really missing out... I think the organisation needs to begin to fill this gap.'***
> *(Director/Manager)*

Although it was recognised that consultants are likely to show high engagement with the job, it was suggested that in one trust their engagement with the organisation was less apparent. Managers suggested that this may be influenced by their more rigid timetables and job plans, and fewer opportunities to attend staff meetings and other 'engagement events'. Additionally, progression and movement across specialisms becomes limited, and thus their role may feel 'static'.

> ***'They do work in their silos sometimes, in their own specialties, so they can get caught in their own world...They are also not always as easily accessible as other staff. Their work patterns make that difficult. They also can approach these things with a high degree of cynicism.'***
> *(Director/Manager)*

<u>Punitive impact of targets, regulation and inspection reports</u>
While there was an understanding of the rationale and aspirational value of setting targets, there was some concern expressed by both team managers and practitioners that target setting can be obstructive to providing a quality service. Pressure to comply with targets inevitably filters down from government directives, to directors, through to managers and ultimately to the front line and patients. The recent set of mental health access and waiting time standards is an example of the unintended consequences of regulation and the potential adverse effect on patient care.

> ***'Referral to assessment has reduced but then the second appointment is delayed because there is not the capacity.'***
> *(Focus Group)*

> ***'The reality may mean, in the end, people will have appointments but they will be more spread out. They will not be seen so often, it will be less effective and so treatment time is longer. There is also the management of risk. If appointments are less frequent, this may lead to an increase in DNAs and then drop out of the service as they [patients] will feel less engaged.'***
> *(Focus Group)*

The impact of CQC ratings on engagement was variable. In one case study trust, being under 'special measures' was generally seen by frontline staff as being punitive and unsupportive:

> ***'I don't think that it's helping us to improve. It's beating you with yet another stick.'***
> *(Focus Group)*

However, more senior managers recognised that ratings help to galvanise and focus improvements and there was a rallying cry of 'bring it on'.

In a second case study trust, the shift in the CQC rating from 'needs improvement' to 'good' was seen as recognition of the effort that the trust had made and a member of the executive team suggested that this was a measure of improved staff engagement.

Finally, in a third trust, it was suggested that although a CQC report may be useful in emphasising some promising practice, it was not always a sound indicator of care quality. One particular service was given an exemplary CQC report and positive rating. However, a senior manager reported that at the time of the assessment by CQC, the site was in receipt of enhanced support by Organisational Development for issues relating to the quality of its services to patients.

What interventions are effective in improving employee engagement in the NHS?

It was often hard to identify initiatives uniquely as engagement initiatives, since projects and processes tended to have multiple aims – both at local and organisational levels. Additionally, there seemed to be a crossover between engagement as an 'outcome' and other constructs such as wellbeing, commitment and job satisfaction. What was clear throughout the data collection was how few evaluated workplace initiatives have been undertaken. However, a wide range of workplace practices through which employee engagement could be improved were described.

All three case study sites mentioned a package of staff engagement provision, which was often formed as part of a broader engagement strategy. Typically, items discussed in the engagement agenda included:

- Staff sickness and retention policy, and practice;
- Systems for induction, appraisals, supervision and support;
- Staff progression, training, talent leadership;
- Review and dissemination of engagement data;
- Staff rewards and recognition;
- Communication systems and governance structures;
- Mechanisms for reporting staff concerns;
- Developing and maintaining values and vision;
- Staff engagement using Commissioning for Quality and Innovation (CQUIN) as a potential lever;
- Staff health and wellbeing practices, including those offered as a way to mediate the effects of austerity measures.

> ***'Clinical pressures are really stark at the moment, with more referrals loading the system and difficultly in some areas with retention and recruitment. We are investing in staff wellbeing and review this regularly to see what more we can do to keep people well and engaged. We have an extensive offer around Occupational Health services, staff retreats, self-referral for the psychology programme as a preventative measure for sick leave. There are also social events such as staff walking groups and exercise clubs on offer.'***
> *(Director/Manager)*

Initiatives for health and wellbeing included:

- Stress reduction courses, mindfulness training, gym membership, yoga;
- The delivery of support services for work-related conditions, including physiotherapy, counselling and psychotherapy;
- Social events and staff retreats;
- Programmes to reduce infections such as flu vaccinations and infection reduction;
- Workplace areas for food and relaxation, fruit and veg stalls.

Culture of Quality Improvement

Quality Improvement (QI) was ostensibly introduced to improve patient outcomes and reduce wastage. However, it was seen by the executive teams and by many staff as a means of positively influencing staff engagement. Staff had an opportunity to contribute to and influence practice, and it was believed that by participating, staff were encouraged to feel both accountable and empowered. Both at Leeds and TEWV, the approach to QI is systems-based, inspired by Lean methodology. At KGH, QI incorporates a range of interconnected strategies and initiatives to include the workforce strategy, improvement and retention group, targeted training and reward schemes.

4. Discussion

The case study trusts that participated in this study are driven by a set of values developed through consultation. They put patients at the heart of care and view their staff as their most important asset.

For many frontline staff, engagement relates to what the literature describes as engagement with the role rather than the organisation. This would appear to be both an attitudinal and behavioural construct. Staff relationships with immediate colleagues and patient outcomes seem to be the most important aspects of their personal engagement. Staff reported that they engaged more closely with their immediate peers and identified with their local department, rather than with the trust as a whole.

Engagement with local teams and close colleagues appears more apparent than organisational engagement. It would seem that for frontline staff, 'home' is their team and for the managers it is the organisation. This could have a significant impact on any future measures that are used to increase staff engagement, and it is conceivable that these measures should be focused specifically at the local and departmental level. Having said this, there is a real commitment to staff feeling involved and committed to the organisation, contributing to organisational change and having a say in how they do their jobs.

Although organisational management and trust in top-level directors were not equally articulated across the trusts, staff did value the idea that they have a connection with the senior team. It may well be that these factors are more of a cultural prerequisite that needs to be in place for the organisation to be working well, but they are not necessarily a priority for all frontline staff.

There were some differences in narratives between the top and the bottom of the organisation; in some cases more clarity might reduce this incongruence. In others, it might simply be a reflection of the fact that staff at more junior levels relate better to their teams.

Ultimately, it seems that engagement emerges from a combination of influences both at the strategic and micro-level. The cultural climate at the top matters. It permeates to the teams and individual staff via leaders who have the drive and capacity to model and create conditions for mutual respect. Having explicit projects and interventions that operate across organisations and within local teams matters. Based on case study data, we can deduce that there is a link between the range of practices that are in place at strategic level (such as trust values, transparent leadership and co-creation of services), and the enhancement of positive relationships, staff motivation, skills development and support.

The variations in levels of engagement across an organisation might be explained by peer support and positive relationships within teams that are managed by empathetic and inclusive leaders. Middle managers have a crucial role in building engagement and resilience in their teams. In turn, they need to be supported and

coached in their roles. The way staff are treated by their manager and the wider organisation is key to nurturing feelings of being valued, respected and looked after. Additionally, communication systems that work inclusively (up, down and horizontally) were valued, as was a feeling that staff had a voice and were listened to. Engagement levels are not static in an organisation or a team. They are influenced by a wide variety of factors.

The flexibility of teams was identified as key to surviving periods of intense pressure (including staff shortages and periods of high demand). The ability of staff to take on different roles relied on goodwill, in-depth knowledge of the local environment and training. Having good personal relationships and familiarity with each other's roles is key.

Management suggested that staff wellbeing initiatives were linked to staff engagement, contributing to a climate where staff feel safe and looked after. This was true even if staff were not able to or chose not to access programmes that are offered. An inclusive wellbeing programme builds a sense of a nurturing environment, creating the bridge that is needed to develop and maintain reciprocity. Staff health and wellbeing was seen as both an antecedent to and outcome of engagement. However, staff wellbeing is more than a programme of opportunities; it is the provision of the right environment for nurturing staff and fostering engagement.

The value of effective measurement systems – both to draw attention to areas needing improvement and to engage staff in the purpose of their work – was strongly highlighted in our findings. More national guidance may be useful in outlining best practice in human capital reporting, incorporating relevant metrics around diversity and inclusion, absence and sickness, grievances and disciplinary processes, career development, education and training in a single report.

At trust level, assessing staff engagement with one instrument was seen to be limited and the case study sites reported that the triangulation of the information with data from other local surveys, team leaders and observations gives a fuller picture of engagement.

The key barriers to engagement appear to be strongly linked to wider socio-economic and political factors, including NHS finances and services, and the current state of austerity. Pressures of funding, lack of resources and staffing levels pervade every aspect of organisational life. As currently available resources are unable to keep up with demand, this will inevitably impact further both on frontline engagement and on recruitment and retention. It is important to find a way of mitigating the potentially damaging effect on engagement. This needs to be considered in tandem with the enablers described in this report.

At the moment, it would appear that the resourcefulness and resilience of frontline staff working in a cash-strapped economy, where doing a good job is often reliant on the goodwill of individuals, has become second nature. Staff who are encouraged and supported to be engaged and motivated are likely to show more discretionary effort and willingness to go beyond their role. Yet if over-reliance on staff goodwill becomes standard working practice, it is likely that staff resilience to withstand constant and unremitting pressures will begin to crumble. Financial arguments, demonstrating the

long-term savings to be gained by staff support and investing in staff wellbeing, could be strengthened and used more boldly at board level to ensure that staff are given the space and support to continue to build valued relationships both within their teams and with the patients they serve.

5. Recommendations

Recommendations for improving NHS staff engagement are derived from listening to staff in the case study trusts and discussions with the Expert Advisory Group.

For policy makers (in the Department of Health, NHS England and the big national agencies, CQC, NHS Improvement and Health Education England)

Strategic recommendations

At national level, policy makers must translate the evidence on effective staff engagement into the world of Sustainability and Transformation Plans and Accountable Care Organisations. In the future, the focus for national policy and for accountability may shift from individual NHS trusts to networked organisations and collaborative structures, but staff engagement will still be the property of teams and organisations. In a system of networked providers, the core principles that underlie effective staff engagement – involving staff in the production of future plans, treating them with empathy and respect, and taking time to understand what effects them – will remain. The real challenge for senior leaders is how to keep in touch with frontline staff. This may require new technical solutions when organisations become larger, but the importance of connecting will not disappear.

The main contribution national policy makers could make in the short term to boost staff engagement would be to relieve the pressure on resources and offer a compelling vision of the future of the NHS for NHS staff. In the three case study trusts, which were selected for their effective staff engagement, people at all levels expressed concern about how long they could sustain staff engagement and wellbeing alongside rising levels of activity and patient demand, falling resources and the requirement to transform services on the ground.

Specific actions national policy makers should take to boost engagement:

- Develop and refine the evidence for the return on investment (ROI) in staff and produce a standard methodology for trust boards (that can be adapted to Sustainability and Transformation Plans (STPs) and Accountable Care Organisations (ACOs)) to calculate levels of staff engagement and report to commissioners;
- Recognise the intense pressures on the workforce and include staff experience and wellbeing in the narrative about the transformation that is required. Be more explicitly appreciative about how hard NHS staff are working to maintain standards for patients;
- Broaden the metrics that regulators and commissioners use to assess trust performance. Expect NHS boards to provide reports on human capital that incorporate standard workforce metrics, plus narrative accounts of what they are doing about diversity and inclusion, absence, sickness, reducing violence and bullying, career development, education and training;
- Recognise the unintended and harmful consequences of short rotations on junior doctors' morale and reform the approach to training;
- Act as role-models for the NHS by co-producing new policies with local organisations and their staff, by demonstrating values and behaviours of respect and empathy in relationships with local NHS leaders. Recognise that the way the regulators behave towards local NHS organisations sets the tone

for relationships throughout the system, which affects the staff who interact with patients.

For leaders and managers in NHS trusts

Staff engagement is a product of the way the NHS conducts the business of caring for patients in all its complexity. While staff value initiatives that target their health and wellbeing, how engaged they feel has more to do with the satisfaction they derive from their work, the quality of their relationships with their immediate colleagues and the way managers treat them. The case studies presented here illustrate how to do engagement well, with all the subtlety, richness and detail of what is involved.

For trusts that have not made yet staff engagement a board level strategic priority, the recommendation is to make it one. All trusts should have board level strategies for staff engagement that supported by an operational plan, a two-way communications plan co-created with staff, a governance plan and a plan for investment in organisational development and training.

All organisations need a dashboard of metrics to monitor the effectiveness of their engagement strategies. In large and small organisations, levels of engagement vary between occupational groups and service units, and change over time. Leaders and managers need information, derived from formal and informal methods of data collection, which allows them to rapidly identify areas where engagement is low, along with organisational development approaches and resources that can be deployed to strengthen it. The metrics required will be a mix of feedback from surveys and near-real-time data collection methods including exit interviews, measures of sickness and unplanned absence, vacancies, incidents of violence, harassment and bullying, and complaints and grievances.

Strategies for staff engagement are meaningless unless they are grounded in real practices on the ground that let employees know that senior leaders are committed to their wellbeing. Employees are always acutely sensitive to dissonance between what managers say and what they do. If relationships with patients and between staff count, the organisation has to ensure that employees have space and time to build and sustain relationships with patients and with each other, both within their own teams and with colleagues from other parts of the organisation.

Managers – at all levels – should be expected to know their own staff personally and need to be held to account for the health, wellbeing and engagement of employees on their team. Staff should have opportunities for training and development in the key skills needed to create effective teamwork: empathetic management, communication, co-design, coaching and appraisals.

Appendices

Appendix 1: Topic guides – director level

Thank you very much for taking the time to speak to us today.

Quick project outline.

Check consent form status and whether they are ok to be recorded.

If they have any questions, they are free to ask these throughout the interview and they have the right to withdraw.

Introductory questions
How long have you worked for this Trust and in what role?

What do you understand by the term staff engagement?

Why do you think staff engagement is important for a) the NHS, b) the Trust c) the staff and d) patients?

What are your responsibilities (either directly or indirectly) for staff engagement and patient experience? What committees/working groups explicitly include staff engagement and patient outcomes in their remit and what is your role within them?

Engagement at the Trust
We have chosen your Trust as a case study, due to substantial improvement in the consistently high levels of employee engagement in the NHS Staff Survey. Why do you think this is and how well do you think the Trust is currently performing?

How has the level of engagement varied over the past few years? (If there have been changes – what would you put these changes down to?)

Is engagement uniform across organisation? Are there areas of concern? What do you think causes any variations? What are you doing to tackle variations?

Is engagement prioritised in the Trust and why (or why not)?

How easy or difficult was it to persuade the board/other senior staff to get involved with the engagement agenda?

How do you review/respond to your staff engagement scores in the staff survey? Is there specific consideration of these scores at board level? Do you use other national or local data to determine levels of engagement?

How is engagement measured beyond the staff survey? Is the staff survey a sufficient measure of engagement?

Patient experience

Do you think there is a link between staff engagement and patient experience? In what way?

For example, why might staff behaviour have an impact on patient experience? Does patient experience have an impact on staff engagement?

How is patient experience measured within the Trust? Do you have any evidence to show this is related to employee engagement? Is this of interest to the Trust?

Policies/strategies/interventions

What do you consider to be the most important policies/strategies that the Trust has for enhancing employee engagement?

What is/was your role in implementing them?

What has been most important in enabling the policies/strategies to be successfully implemented?

How well do you think these policies/strategies are being/have been implemented across the Trust?

What specific activities or interventions have been used in the Trust to improve employee engagement? Probe: relevant policies, strategies, resources allocated?

Measures of success? Barriers and enablers? Communication of values, vision?

Leadership training? Clear systems around appraisals. Supporting teams.

Why did you opt for these actions? (Probe for evidence-based or cost?)

How do you measure the impact of these actions? Is there a value-for-money consideration?

How do you ensure that staff at all levels in the Trust know about and 'buy in' to these interventions?

How well do you think staff engagement initiatives are communicated to all levels of Trust staff?

How do you communicate to the Trust what is occurring?

Is the term engagement specifically mentioned? What language works best?

How are staff involved in employee engagement decision making?

What mechanisms are in place for staff to communicate issues/concerns and how are these addressed?

Are there any further interventions or actions that you would like to implement to improve employee engagement?

What, if any resources from Think Tanks etc do you use (eg Kings Fund/Engage for Success) when you are developing employee engagement strategies and initiatives?

Future of engagement in the Trust
What learning would you want to pass on to organisations trying to improve staff engagement?

How do you hope to sustain the level of staff engagement seen in the Trust? What are your plans for the future?

Final questions
Are there any further comments regarding employee engagement and patient outcomes that you feel have not been covered in this interview that you think are important to mention?

Appendix 2: Topic guide for clinical and non-clinical focus groups

Thinking about your work, what makes a good day for you?

What does it look like when you do your job well? What gets you to work in the morning?

What is it like working in this team/department?

Can you tell me about a time that you felt really valued at work?

What helps you do your job well? What helps you feel valued?

Autonomy, feeling you can contribute to improvement, resources, good communication (daily huddle etc) support from colleagues/team, positive feedback from line manager and patients, good training, mentoring/career opportunities, wellbeing initiatives, work/life balance, shared values, respect.

Why is the way staff feel about their job important for patient care?

What hinders you doing your job as well as you would like?

Tell us about an initiative at your Trust that you have been involved with that encourages you to engage more (do your job better)

Can you tell us about a time when you felt undervalued?

Lack of support, poor communication, lack of understanding of how our roles contribute, poor teamwork and leadership, lack of appreciation/recognition, unrealistic targets, blame culture.

Are there ways that you are able to feedback to the organisation about the way you work?

Does being in 'special measures' affect how you feel about your job? (KGH only)
Round: Which three things would you like to change to improve your experiences at work?

Ranking activity (carried out at TEWV and KGH)
Wider research shows a range of factors that affect the way staff feel about their jobs and helps them do their job well. We have put these enablers on strips of paper as well as giving you blanks to complete your own. Can you discuss these 'enablers' in your group of 3/4? Rank them (or select the 3 most important to your group) and report back.

- Being treated with respect and looked after by the organisation (having a voice, given time for talking/reflection, good rosters, health and wellbeing initiatives, local support);
- Belief that I can make a difference to patients and am able to offer a good standard of care within resource constraints;
- Having the necessary resources to do my job properly;
- Opportunities for development (coaching, training, career progression);
- Being led well by your team leader (being valued, regular meetings with two-way communication, being listened to);
- Having a cohesive team with good relationships with immediate co-workers;
- Having a say in how I do my job (opportunities to show initiative and contribute to improvements).

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