



Engagement: The Grey Literature

What's known about engagement in the NHS, and what do we still need to find out?

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1 Introduction

This review of 'grey' literature on engagement is an interim report produced by Aston Business School as part of an ongoing series of reports into the current knowledge concerning engagement in the context of the NHS. Recently, several major large scale reviews have pulled together both academic literature, case studies and grey literature on the drivers, outcomes and measures of engagement. This review utilizes these reviews and adds NHS specific case studies and policy considerations to inform ongoing research funded by the Department of Health.

The findings are organised into sections covering the evolution of the concept of engagement in the NHS; definitions of engagement; methodological issues in measuring engagement using voluntary participation; drivers of engagement; and general observations on engagement and its implementation. Where appropriate each section is split into general findings, NHS specific findings, and identifies both policy implications and any research questions remaining.

2 Methodology

The literature search began with searching websites such as the Department of Health, NHS Employers and those of professional bodies such as the Institute of Employment Studies with the key words 'engagement' combined with 'healthcare'. The reports uncovered were used to 'snowball' to other research such as that conducted by Ipsos MORI and Gallup, and from other sources. The final sources include:

- Recent and wide scoping reviews of engagement conducted by government (Scottish Executive 2007; MacLeod and Clarke 2009; Darzi 2008)
- Ongoing research published by research consultancies (IES 2009; CIPD 2007)
- NHS specific research conducted by or funded by the Department of Health (NHS NWP 2007; Ham and Dickinson 2008; Ellins and Ham 2009), and
- International healthcare-specific research (Gallup 2002a and 2002b, Towers Perrin 2008).

This report compliments a review of more formal academic literature which summarised the status quo concerning the definition and measurement of engagement. The third and final literature review to compliment both that and this review will assess the international evidence for engagement of Healthcare professionals.

3 Engagement in the NHS: context and current activity.

One of the first documents produced by the Department of Health which explicitly linked improved staff conditions with better services was the 1998 publication *Working Together: Securing a high quality workforce for the NHS* (Ellins and Ham, 2009). Local NHS organisations were tasked with increasing staff involvement in planning and delivering care; reviewing induction arrangements and improving these at the local level, and undertaking an annual staff survey to benchmark working life

conditions. Consequently, the 'Taskforce on Staff Involvement' spent ten months visiting NHS organisations and concluded that a key factor affecting workplace satisfaction was staff involvement in both large scale and day to day decisions. Furthermore, it was argued that front line staff are best placed to suggest and implement improvements in the delivery of care and services. A few years later a government policy document *Shifting the Balance of Power* repeated the message that empowered front line staff were key to delivering service improvements. In 2003 the Department of Health launched a resource pack to help NHS organisations 'turn the rhetoric of staff involvement into a reality' (Ellins and Ham, 2009). In this pack, a staff charter and partnership framework were suggested, along with evidence of several NHS organisations which had already increased staff participation through involvement policies, staff forums, staff representation on committees, surveys and other feedback and communication tools. In 2007 a review of NHS workforce planning conducted by the Health Select Committee concluded that workforce planning was carried out in a non-integrated and piecemeal fashion, accentuated by the large staff reductions and pay restrictions implemented from 2006 onwards. A more integrated approach was recommended (Ellins and Ham, 2009).

The final report of Lord Darzi's Next Stage Review of the NHS recommended that the NHS should strive to develop locally led, patient centred and clinically driven services. Front line staff should have greater freedoms and empowerment. The large scale changes in the NHS in the past decade had caused a decrease in outcome measures such as waiting times and cancer mortality rates, but at the loss of staff engagement and the stifling of innovation. Ellins and Ham (2009) proposed that increasing the proportion of engaged staff would reverse to some extent these trends, and help make the NHS a 'self-improving system'. Levels of staff engagement could be measured using the annual NHS staff survey.

Staff engagement has in 2009 been given priority by the current NHS Director General of Workforce Clare Chapman, and the NHS Staff Survey is to be used to assess levels of staff engagement. Engagement-specific questions introduced into the survey in the 2009 sweep will mean 2009 is the benchmark against which progress can be measured. Furthermore, specific personnel have been appointed to embed engagement across the NHS. In a recent (unpublished) summary of the status of engagement work in the NHS, several case studies are cited where engagement is being achieved and where it is not yet being realised (Jupp, 2009).

Outside the NHS, a large scale review of employee engagement, its effects on businesses, and ways to increase engagement was very recently completed by the Department for Business, Enterprise, and Regulatory Reform - previously the Department for Trade and Industry. This is the Macleod Review, referenced as Macleod and Clarke 2009. Previously, the Scottish Executive had commissioned a review of literature to establish whether there is a difference between engagement in the public and private sectors (Scottish Executive, 2007). Most recently the Institute of Employment Studies has conducted a review of engagement and discussed its various definitions, variation across sectors and across employee groups, measurement of engagement and its drivers and outcomes (IES 2009). Therefore there now exists a body of information concerning engagement in the NHS and in other sectors. A key aim of this review is to highlight what is already known and what still needs to be established in order to fully understand engagement in the NHS and how to achieve greater levels of staff engagement.

4 Definitions of engagement

There is no one clear and agreed definition of engagement and there is variety in the way it is described by various researchers and practitioners (IES, 2009). The term engagement is relatively new to Human Resources literature, first appearing from 2000 onwards. The concept originated from consultancies and survey houses rather than from academia (Rafferty et al., 2005). It builds upon but adds to previous concepts such as 'commitment' and 'motivation' (CIPD, 2007).

The Scottish Executive (2007) commissioned research to assess the difference between engagement in the public and private sector. The work was essentially a large scale grey literature review, with some acknowledgement of and reference to more academic sources. Engagement was described as being more than the sum of the parts of its theoretical antecedents, including concepts such as Organisational Citizenship Behaviour, in that:

'engagement is a two-way interaction between the employee and employer, whereas earlier focus tended to view the issues from only the employee's point of view.' (Scottish Executive, 2007).

The definitions of engagement employed by academics, by companies and by research or consultancy institutions differ subtly, although there are commonalities. In a recent review of various definitions of engagement by UK companies, the Institute of Employment Studies (2009) concludes that:

"company definitions tend to view engagement as an outcome, something given by the employee. They often refer to the employee's attachment, commitment and loyalty to the organisation. They refer to the effort and time they are willing to expend, whilst constantly finding ways to add value and use talents to the fullest. Several of the definitions refer to the employee as an enthusiastic advocate showing pride and support for the organisation's values and goals. Many see engagement as a step higher than satisfaction or motivation at work. However, with the exception of the pharmaceutical company Johnson and Johnson, who indicate that engaged employees experience collaboration and feel valued, there is little mention of a reciprocal relationship and what the employer offers to enable engagement." (IES, 2009).

The IES review of *academic* definitions of engagement summarises the key points succinctly and is worth quoting at length:

"In their recent review, 'The Meaning of Employee Engagement', Macey and Schneider (2008) propose that engagement is sometimes defined on the basis of what it 'is' (psychological state), whilst on other occasions on the basis of the behaviours it produces (behavioural) and sometimes as a disposition or attitude towards one's work (trait). In defining engagement, Macey and Schneider (2008, p6) split engagement into these three areas and propose that '*trait engagement*' is an inclination to see the world from a particular vantage point and this is reflected in the individual's '*state engagement*' which leads to

'behavioural engagement', defined in terms of exerting discretionary effort. This proposition has, however received criticism by Newman and Harrison (2008) who argue that when engagement is broken up into the separate aspects of state, trait and behaviour, state engagement becomes a redundant construct and tells us nothing more than an individual's attitude towards their job which, as they point out, has been suitably measured by other constructs in the past. Instead, they argue that the defining features of employee engagement are the simultaneous presence of three behaviours in employees, namely their performance in the job, citizenship behaviour and involvement. However, this proposition shies away from defining the psychological state of engagement and merely describes its outcomes." (IES, 2009).

Research and consultancy institutions also define engagement in terms of a psychological state, which has various positive outcomes for their organisation. In addition, definitions consider the role of the organisation in enabling staff engagement. There is recognition of the need for both employee and organisational objectives to be aligned, in order that employees know they are contributing to something meaningful to them. Cultures are recommended where employees are listened to, valued and respected, and feel safe to be themselves. The result is a state of mind where employees involve themselves fully and have passion and energy for their 'cause', stemming from an emotional and intellectual connection to their role and their organisation¹ (IES, 2009).

In summary, the definitions proposed by companies, by academics and by consultancy and research institutes do not necessarily directly conflict: instead different definitions result in complimentary and overlapping views. There is commonality between the definitions, where engagement is seen as a good thing for both employee and organisation, and *'connotes involvement, commitment, passion, enthusiasm, focused effort and energy, so it has both attitudinal and behavioural components'* (Macey and Schneider, 2008; p. 4).

IES (2009) argue that the most comprehensive view of engagement is that proposed by IES in 2004, which stated that engagement is:

'A positive attitude held by the employee towards the organisation and its values. An engaged employee is aware of business context and works with colleagues to improve performance within the job for the benefit of the organisation. The organisation must work to develop and nurture engagement which requires a two-way relationship between employer and employee'. (Robinson et al., 2004, p. 4).

The characteristics of an engaged workforce are summarised as motivation, satisfaction, commitment, finding meaning at work, pride and advocacy of the organisation. A recurring theme

¹ This view is termed 'unitarist', where the goals of employee and employer are assumed to align and do not result in inherent conflict. This leads to 'involvement' initiatives stemming from management, which aim to increase employees' understanding about the business. In contrast, pluralist views recognise that there may be conflicts between an organisation's goals and those of the individual employee. Pluralism results in 'participation' initiatives from collective employee groups such as Trade Unions where employees are heard by and negotiate with management through defined processes.

noted from the literature was that engaged workers are prepared to 'go the extra mile' and would exert discretionary effort over and above their normal role expectations (Scottish Executive, 2007).

Various authors have argued that definitions of engagement can justifiably be organisation-specific, since there is unlikely to be a single 'one size fits all' definition (MacLeod and Clarke, 2008; IES, 2009; Scottish Executive 2007). The next section considers some current definitions of engagement in use within the NHS, and highlights the recurring issue of the need for clear and consistent use of language when referring to engagement. Currently, the term engagement is used in its more academic sense to mean a state of engagement, as well as in the more every day meaning of being involved in processes such as decision making or in change management.

5 NHS specific definitions of engagement.

5.1 The NHS National Workforce Project

The NHS National Workforce Project defines engagement from the employees' perspective. There is no mention of how the NHS could maximise the probability of staff being engaged, nor are health care outcomes mentioned:

'a measure of how people connect in their work and feel committed to their organisation and its goals. People who are highly engaged in an activity feel excited and enthusiastic about their role, say time passes quickly at work, devote extra effort to the activity, identify with the task and describe themselves to others in the context of their task (doctor, nurse, NHS manager), think about the questions or challenges posed by the activity during their spare moments (for example when travelling to and from work), resist distractions, find it easy to stay focused and invite others into the activity or organisation (their enthusiasm is contagious)'. (NHS NWP, 2007)

5.2 NHS Employers.

NHS Employers adopted the Institute for Employment Studies' (2004) definition of staff engagement, namely that it occurs when staff are committed, motivated and experience organisational citizenship behaviour (NHS Employers, 2008). This definition acknowledges the role of the NHS in enabling staff engagement:

'a positive attitude is held by the employee towards the organisation and its values' (NHS Employers, 2008).

5.3 Engagement in Pledge 4 of the NHS Constitution.

Pledge 4 of the NHS Constitution reads: "to engage staff in decisions that affect them and the services they provide, individually, through representative organisations and through local partnership working arrangements. All staff will be empowered to put forward ways to deliver better and safer services for patients and their families."

The verb to engage as it used here appears to mean *involvement* of staff in decision making and the empowerment of staff to make positive changes. This is not quite the same as a Pledge to maximise the proportion of staff who would be defined as 'engaged'. Decision making, involvement, and being empowered to enable change are all aspects which seem necessary for an individual to reach the state of 'being engaged', but these aspects are not necessarily sufficient for this to happen².

The three options below each offer a way to clarify the use of the term engagement in Pledge 4. Even if any decision is not publicised widely, it seems wise for those involved in engagement in the NHS to be aware of, and to agree on, the subtleties of and the importance of the clear use language in this context.

- a) Defining NHS engagement as the state of being engaged, where staff are prepared to go the extra mile, but where Pledge 4 is not directly related to this concept. In this scenario Pledge 4 could be altered to read "to *involve* staff in decisions that affect them...". In this scenario Pledge 4 commits to delivering several of the key factors which maximize the chances of staff becoming engaged, but does not promise to deliver an engaged work force.
- b) Defining NHS engagement as the state of being engaged, where staff are prepared to go the extra mile, and rewording Pledge 4 to reflect this. An example would be "to maximize the proportion of staff who are positively engaged in their work to the extent that they are motivated, committed NHS advocates, prepared to go the extra mile"
- c) Defining NHS engagement as involvement (engagement) in decisions and empowerment to enable this, and therefore leaving Pledge 4 as it stands, but recognizing that this Pledge is then separate from the concept of maximizing the number of staff who are engaged in the sense that they are prepared to go the extra mile.

5.4 The NHS Institute for Innovation and Improvement.

Significant pieces of work have been carried out by the NHS Institute into the engagement of Doctors in particular (see Dickinson and Ham, 2008; Ham and Dickinson, 2008). Engagement in this research means *involvement in managerial decisions, and in implementing changes*. Although these factors might be prerequisites for reaching the state of being engaged (prepared to go the extra mile), they do not guarantee the state of engagement. However the research is important because it demonstrates the importance of Doctors in implementing any organisational change, and it sheds some light on what motivates Doctors. The research is summarised in the section on Doctors below. Nevertheless, the 'engagement scale' which the NHS Institute devised measures the extent to which Doctors are willing and able to take part in managerial leadership (see Barwell, Mazalan and Spurgeon, 2008). Therefore it is important to note that this engagement scale is not the same as a measure of engagement as assessed by the NHS Staff Survey.

5.5 Ipsos MORI (2009) Healthcare 100.

The aim of the Healthcare 100 research was to create an Index of the top 100 employers within the NHS, by rating both employer's views of their organisation (15% of the final score) and employees' views of their organisation (85% of the final score). Each trust was asked to hand out a minimum number of surveys randomly to staff. The highest response rate reported was 51%, with no other

² A parallel example comes from Schmidt (2004) who notes that employees can be both motivated and committed to their jobs but not necessarily engaged with the overall strategy of their organisation.

response rates being stated in the Ipsos MORI report. Therefore it seems safe to assume that survey non-response will be an issue (see below), though the exact scale and nature of the differences between non-respondents and respondents cannot be determined.

13 factors were used to assess employee engagement. Responses were weighted to account for the relative effect each factor had on engagement. Finally, responses were adjusted to account for factors such as employee occupational group, level of patient contact, level of responsibility and the sector they were employed in.

6 A note on non-response in voluntary surveys.

A key issue with the methodology of research that relies on voluntarily completed surveys is that of survey non-response. Previous research has shown that in general terms, those dissatisfied and not prone to act conscientiously towards their organisation will tend to not respond to organizational surveys. Spitzmuller et al (2006) showed that respondents who agreed to engage in organizational surveys and then did so (active respondents) and those who stated they would participate but then did not (passive non respondents) differed in their perceptions of the organization when compared to those who openly stated they would not complete an organizational survey (active non respondents). Active non respondents were more likely to perceive their organisation as socially unjust, as unsupportive, and as not being 'fair' in their social exchanges than were respondents and passive non respondents. Rogelberg (2000) showed that active non respondents were more likely to be less 'satisfied' with the organization sponsoring the survey, and they scored lower on the personality trait of agreeableness. Some were also more likely to express intentions to leave the organization.

To summarise, those least likely to respond to organizational surveys are most likely to have negative perceptions about their organization. Therefore when low response rates are obtained it seems reasonable to assume that the responses mainly come from those who are satisfied and so most likely to be engaged. Even if non-respondents are not that different in engagement levels to those who did respond, they are likely to view work from a different ideological perspective: those individuals who are in alignment with their organisations' objectives are most likely to participate, and a unitarist framework of policies would work with these individuals. Those least likely to respond could be termed as those who would fit the pluralist stance, where conflict with organisational objectives or management practices means initiatives based on unitarist assumptions might not work.

6.1 Evidence of sample bias in NHS case studies.

Several pieces of research have measured, albeit imperfectly, levels of staff engagement across sectors and across countries. General trends are apparent. Research conducted within the NHS appears to be at odds with these trends and so it is necessary to consider whether the research itself is flawed, or whether levels of engagement in the NHS are genuinely different to other organisations.

Three different polls of engagement in random samples of the US workforce aged over 18 revealed that in 2004, the majority of staff were not engaged. International research conducted by Towers Perrin, by Gallup and by Concoors Group revealed that around 20 to 30 percent of all workforce employees were engaged, while fewer than 20 percent were actively bitter towards their employer. The remaining majority (between 55 and 64 percent) were neutral (NHS NWP, 2007).

In contrast, 69% of respondents in the NHS Trust case study cited by Gatenby et al (2008) were classified as 'highly engaged'. This was the third point on a four point scale extending to very highly engaged. Even taking into account likely differences in the methodologies of assessing engagement, this result suggests the case study sample was biased towards engaged staff. This could well be due to the issue of non-response, as discussed above. The response rate for the Gatenby survey was only 20% (Gatenby et al, 2008).

Research conducted by Ipsos MORI (2008) has so far informed much of NHS policy on staff engagement (IES, 2007). A proxy measure of engagement was advocacy of staff's teams, advocacy of trust and advocacy of organisation. Nearly half (49%) of the staff who took part in the What Matters to Staff survey would speak highly of their employer, trust or practice. However only 27% would speak highly of the NHS. If advocacy is a good enough proxy of engagement, this suggests that engagement varies depending on which relationship is being considered, and suggests that either NHS staff were more engaged with their employer (Trust or practice) than the general population, or that again the sample was biased towards the more engaged.

Policies based on research which tends to exhibit this bias towards more engaged staff risk ignoring the factors which might better engage the least engaged staff. To devise policies which will best reach all staff, those who are least engaged need to be compared to those who are more engaged. Aston plan to explore this issue further by carrying out case studies with the least engaged sectors of staff at 2 NHS Trusts.

Ipsos MORI (2008) suggested that 43% of staff would speak critically of the NHS as an organisation. Gallup (2006) argued that the least engaged staff, described as actively disengaged, were most likely to share their discontent with their co-workers and the wider world. Therefore ignoring the least engaged NHS staff seems to pose a significant risk to the internal and external reputation of the NHS.

7 The benefits of engagement

Systematic research which describes the antecedents, outcomes and dimensions of engagement in organisations is scarce (Gatenby et al, 2008). However, some recurring and generic themes can be summarised.

7.1 Generic outcomes: organisational performance

Organisations with higher levels of engaged staff tend to have lower staff turnover, absenteeism, and higher productivity and financial returns (MacLeod and Clarke, 2008; IES 2009). Being engaged is a positive experience in itself (Schaufeli et al. 2002) and can increase staff health and well being (IES, 2009). Staff themselves who are engaged have more positive attitudes towards work and towards

colleagues, increased productivity, and tend to increase customer satisfaction and loyalty (MacLeod and Clarke 2008; IES 2009). Towers Perrin (2007) found that organisations with the highest percentage of engaged employees increased their operating income by 19 per cent and their earnings per share by 28 per cent year-to-year. Highly engaging organisational cultures may also have an attractive employer brand, being an employer of choice which attracts and retains the best talent (eg. Martin and Hetrick, 2006 in IES 2009).

However there is some debate as to whether higher levels of engagement *cause* increased productivity: it could be that a more productive environment increases engagement levels. One example where causality is difficult to ascertain is when a successful and effective manager and engaged employee interact, feeding in to each other's success and positive relationships with each other, with role and with organisation (Luthans and Peterson, 2002 in IES 2009). The relationship between engagement and productivity is certainly not linear even if it is causal (Balain and Sparrow, 2009 in IES 2009).

7.2 Generic outcomes: staff behaviours

Various pieces of research show that more engaged staff are happier in their work and this affects their behaviour as logic would predict. Helping behaviour, sportsmanship and civic virtue are themes of Organisational Citizenship Behaviour according to Podsakoff (2000, in Scottish Executive 2007). Each of these three employee behaviours are associated with increased organisational effectiveness, although helping behaviour was not associated with increased effectiveness in all case studies (Scottish Executive, 2007). Increased staff involvement is associated with staff reporting increased levels of satisfaction and finding meaning in their work (West et al, 2005).

7.3 NHS outcomes: patient and public outcomes

Ipsos MORI (2008) explored the relationships between the factors which affected staff advocacy, and patient satisfaction and with public satisfaction. The two factors 'I've got a worthwhile job that makes a difference to patients' and 'I am able to improve the way we work in my team' were the only 2 factors which seemed significantly correlated (at the 95% level) to levels of patient satisfaction with the care they received. The factor 'Senior managers are involved with our work' was the only factor which seemed significantly correlated with public satisfaction with the overall running of the NHS.

Results from a longitudinal study at Aston University showed that increased levels of staff involvement, especially when supported by their organisation, were associated with decreased patient complaints, decreased waiting times, and decreased patient mortality (West et al., 2005).

Similar results have been found elsewhere: Raleigh (2008, unpublished, in Ellins and Ham (2009)) reported that initial analysis of data from the 2006 inpatient survey and the corresponding NHS staff survey cohort revealed a positive correlation between patient experience and higher levels of managerial support; and negative correlations between patient experience and longer working hours and work-related stress.

7.4 NHS outcomes: more flexible and 'change tolerant' workforce

For the NHS, an engaged workforce who are committed to and enthusiastic about their work will mean it is easier to implement recent initiatives such as the European Working Time Directive 2009 which will alter working practices and demand more flexibility from staff. Furthermore, over the

coming decade an ageing UK population with fewer younger graduates replacing retiring specialists will mean suitably qualified and valuable staff will become more scarce, increasing the need to retain the best employees (NHS NWP 2007).

8 Downsides of engagement

Rarely discussed negative outcomes of increased engagement include the possibility of increasing employees' attractiveness to outside organisations and so encouraging turnover in certain groups of staff; the costs of increasing engagement, and the possibility that those who are most likely to become engaged find it difficult to 'ride out' tough times when they are faced with obstacles or a less productive or engaged period at work (IES 2009). As such it is difficult to assess the potential downsides to increasing engagement, and in which context the different negative effects might become apparent. In the NHS, the NWP (2007) has argued that even if staff are initially attracted away from their current organisation, they are more likely to return if they were more highly engaged before leaving. Overall, the cost-benefit ratio of increasing NHS engagement seems unknown at present and so it is not possible to assess whether the financial implications are a significant negative issue.

Future research should explore the cut off point where engagement is at an optimal level given the available resources: the laws of economics dictate that there will be an optimum level of staff engagement at which the most staff are as highly engaged as possible given the resources available. Attempts to increase engagement above this threshold would be extremely expensive per employee, or per outcome measure, compared to increases achieved below the threshold. Since it seems that this state of affairs is a way off, there seems little need for the NHS to consider such research in the short term. However, research which measures the cost of increasing engagement and which assesses the financial benefits will be necessary in the medium to longer term. It is difficult to place monetary value on 'soft' outcomes such as patient satisfaction, or staff morale, but it is better than nothing. Lessons might be gained from the field of criminology where, although not ideal, estimates of the costs of crime attempt to measure the financial costs of victim's trauma in order that informed policy decisions are made. A key measure used is the loss of quality life years, which itself is derived from medical estimates of injury severity.

9 Generic drivers of engagement

Several recent and large scale reviews of engagement across sectors have summarised the key drivers which tend to result in employee engagement. Those cited by the IES (2009) are below. Other reviews by MacLeod(2009), The Scottish Executive (2007), and the CIPD (2007) all repeat these same generic and logical sounding drivers.

- The nature of the employee's work has a clear influence on their level of engagement. It is important to have challenging, creative and varied work that utilises old and new skills.
- A perception that the work undertaken is important, and has a clear purpose and meaning.

- Having equal opportunities for, and access to, career growth, development and training opportunities is considered important in enabling employees to engage with the organisation.
- Receiving timely recognition and rewards is a key driver. Salary is important but more as a disengager than an engager.
- Building good relationships between co-workers is important, especially the relationship between employee and manager. This critical relationship needs to be a reciprocal one of making time for, and listening to, one another.
- Employees may engage in an organisation if they can understand the organisation's values and goals, and how their own role contributes to these.
- Leaders and managers who inspire confidence in individuals, giving them autonomy to make decisions with clear goals and accountability, are perceived as engaging.

10 NHS specific drivers of engagement

In 2002, Finlayson described three factors which drove NHS staff motivation and morale: feeling valued, working environment, and resources and pay. Feeling valued was itself made up of the factors: perceived worth, levels of support, being listened to, and recognition and good treatment.

More extensive research by Robinson et al (2004) has built upon that work by assessing the views of over 10 000 NHS employees in 14 NHS organisations. The results confirmed the importance of feeling valued and involved, which is made up of:

- Involvement in decision-making
- The extent to which employees feel able to voice ideas, and managers listen to these views, and value employees' contributions
- The opportunities employees have to do their jobs
- The extent to which the organization is concerned for employees' health and well-being. (Robinson et al., 2004)

Further research by Robinson et al (2007) has demonstrated the importance of locally lead organisational cultures, and the negative, disempowering effect of being micro managed and of top-down management strategies.

Work at Aston University (West et al., 2005) based on the analysis of the responses from more than 10 000 NHS employees and the performance data of their trusts showed that staff drivers of *involvement* could be affected by management activity, and this in turn could affect patient outcomes. Including staff in involvement initiatives increased staff's perception that their work was meaningful and important; regular meetings with line managers increased the clarity of roles and increased the extent to which staff felt supported; these lead to staff feeling they had increased levels of autonomy and greater influence over decision-making , as well as greater confidence in their abilities. When staff were genuinely involved with management initiatives and the organisation supported this involvement, the involvement lead to:

- decreased absenteeism,
- decreased patient waiting times,
- decreased patient complaints,

- and decreased mortality rates, as well as:
- increased job satisfaction for staff,
- higher levels of innovation,
- higher levels of cooperation with co-workers.

An influential piece of research by Ipsos MORI (2008) was also based on the responses of NHS staff. Entitled What Matters to Staff, the research aimed to establish the key drivers of both positive and negative staff attitudes. Staff were asked which factors affected their advocacy of the NHS, and advocacy was used as a proxy measure for engagement. Table 1 below displays the factors reported by Robinson et al (2004) to be highly correlated ($p < 0.01$) with NHS staff engagement, along with those factors reported by Ipsos MORI (2008) as being correlated with staff advocacy of the NHS. The factors are ranked in descending order of importance. It is not clear from the report by Robinson et al whether the sample of staff is thought to be fully representative or if, as with Ipsos MORI, the sample was biased towards those who willingly took part in the survey and so might well over represent those most likely to be engaged.

Table 1: Factors that correlated significantly to engagement in the NHS

Factor: engagement in 2003 (Robinson et al., 2004).	Rank	Factor: advocacy in 2007 (Ipsos MORI, 2008)
Feeling valued and involved	1	Understand role and where it fits in
Co-operation	2	Provide high quality patient care
Communication	3	Senior managers are involved
Training, development and career	4	Treated fairly with pay, benefits and facilities
Equal opportunities and fair treatment	5	Opportunity to develop own potential
How the Trust compares as a place to work with two years ago (excluding staff <2yrs in post)	6	Manager/ supervisor is supportive
Job satisfaction	7	Have knowledge, skills, equipment to do a good job
Immediate management	8	Feel trusted, listened to, valued
Pay and benefits	9	Able to improve work processes in my team
Performance and appraisal	10	Worthwhile job that makes a difference*
Colleagues	11	
Current career intentions	12	
Stress and work pressure	13	
Days spent training in the past 12 months	14	
Length of service (negative correlation)	15	

(Source: Robinson et al., 2004 and Ipsos MORI, 2008).

*This factor is not in the Ipsos MORI quantitative model of what affects staff advocacy of the NHS.

The final model suggested by Ipsos MORI of what motivates staff in the NHS suggested that nine factors together accounted for 27% of the variance in staff motivation. Given the low response rate

to the research this model is clearly only indicative. The ten factors do not capture entirely what motivates NHS staff to advocacy, since 73% of the variance in advocacy is not explained.

Furthermore, the assumption that advocacy was a sufficient proxy measure of engagement has been questioned. Although robust enough to form a good pilot study, the Ipsos MORI model should be understood within the limitations of the methodology. (Initial re-analysis of the data carried out at Aston University suggest that a 7 factor model might optimally fit the data.) The methodology of both the Ipsos MORI analysis and the Aston based analyses are open to debate, but the slightly differing results do highlight the fact that although the Ipsos MORI research was seminal in its time it is best viewed as a sound pilot study upon which to base more nuanced research.

Most recently, Steve Jupp has been appointed to embed engagement within the NHS. AN unpublished summary of case studies within the NHS summarises some of the factors which seem to be increasing engagement, and the practices in place in Trusts with lower levels of engagement. It is not entirely clear how engagement in these case studies is measured, and if the term engagement here means the involvement of staff in decisions, and empowerment of staff, rather than reaching the state of being engaged. Nevertheless, it is clear that benefits are being realised from the following:

- Little and big conversations, meaning discussions between high level managers and front line staff, as well as more localized discussions with immediate line managers and within teams;
- Diverse approaches, what might be termed a problem solving approach, where each issue is dealt with at the local level according to needs and resources instead of trying to shoehorn the response into a rigid policy or procedure;
- Consistent leadership, but recognising the importance of line manager relationship with each employee.

NHS case studies where engagement was not being realised tended to report:

- A lack of understanding that the benefits of staff engagement included quality care and positive patient outcomes. Staff engagement was seen as an 'extra' to be achieved after other measurable targets were achieved.
- Staff engagement being seen as a fluffy concept, or an HR ideal, with little return on investment.
- Staff engagement was assumed to be 'happening' either due to the staff survey, or because staff seem satisfied.

(Source: Jupp, 2009).

10.1 What engages which groups of staff?

In order to reach the state of 'being engaged' different people will require different needs to be met (Silverman, 2004). There may not be a 'one size fits all' definition of engagement in general, or within the NHS. Different and even unusual organisation specific drivers have been found. While feeling valued and involved was a prime driver of engagement when an NHS staff sample was

considered, assessment of staff from different sectors and organisations relegated feeling valued and involved to joint second place with the driver 'job satisfaction' (Robinson et al, 2007).

Clearly it is not economically feasible to devise a tailored engagement policy for each individual. Instead, people need to be grouped together and specific policies applied to each group. Such grouping will be a balancing act, countering on the one hand the need to minimise the number of different policies and bespoke implementations by aggregating people into as large groups as possible, while at the same time being careful not to aggregate dissimilar groups together in the name of economy. This would result in overly compromised policies which do not quite meet the needs of any group. The key question then is *how* to differentiate NHS staff into these groups where there is sufficient similarity between the engagement factors to warrant grouping the people together, but there is sufficient difference between engagement factors to warrant a separate policy or practical implementation when compared to another group.

10.1.1 Socio-demographics

Research within the NHS conducted in 2003 showed the following results (adapted from Robinson et al. 2004). They are presented below as contrasted with results also produced by IES (2007) where staff from a variety of organisations were asked the same questions as the NHS staff. Overall the results suggest some general patterns of variance in engagement according to some socio-demographic characteristics, but also re emphasise the need for organisational-specific analysis.

- Male and female NHS employees did not report significantly different levels of engagement.
- In contrast, some organisations revealed gender specific differences in engagement levels, while others revealed identical scores.
- Minority ethnic NHS employees had higher engagement levels: in particular Black, Chinese and Asian employees had higher engagement levels than Mixed and White employees.
- This variance by ethnicity was to a large extent replicated when non-NHS organisations were considered, but again variety was seen when organizations were considered in isolation from the aggregate.
- Different age groups reported significantly different NHS engagement levels: engagement levels decreased as employees got older, with a final spike of high engagement in the oldest age group (60 and over).
- In contrast, some of the non-NHS organizations showed engagement varying by age in very different patterns to those seen in the NHS.
- NHS employees aged 40 to 50 reported the highest levels of workplace stress and difficulties balancing work and home life. It is not clear whether this was due to having children, or whether people in this age category were more likely to be young managers adapting to more demanding roles as they were promoted.
- NHS employees with family caring responsibilities for their children reported lower levels of engagement than colleagues with no caring responsibilities.
- NHS employees with a disability or medical condition reported lower engagement levels than those without.

10.1.2 NHS role

Ipsos MORI (2008) recommended that engagement in the NHS is best understood by examining separately the drivers which affect staff's relationships with their patients, with the public, with their

profession and with the NHS as an organisation or employer. It is likely that different roles will be variously affected by each of these four relationships. Evidence that doctors for example, rank their patient relationship as far more important and relevant than their relationship with the NHS, is presented later.

In summary, and again with the caveat that the sample might not have been representative of each staff group, Ipsos MORI (2008) found that staff with low patient contact and with non clinical roles were significantly less likely to advocate their team, as were staff within the occupational groups of ambulance trusts³; social care; nursing/healthcare assistants; admin and clerical, and NHS Infrastructure.

In research conducted in the NHS in 2003, engagement levels varied greatly across job role (adapted from Robinson et al. 2004). The results are presented below and again contrasted with similar research carried out on non-NHS organisations (IES 2007).

- NHS managers and professionals (e.g. nurses) have higher levels of engagement than their colleagues in supporting roles (e.g. clerical, secretarial).
- This pattern was not repeated in all non-NHS organizations: some case studies revealed that professional roles (such as teachers, business consultants) had higher engagement levels than managers, while in some case studies this pattern was reversed.
- However, NHS doctors and midwives reported relatively low engagement scores, while healthcare assistants reported higher levels, suggesting that variation across job roles is specific to micro level roles and not to macro level categories such as 'management' or 'clinicians'.
- Full time NHS workers were more engaged than part time workers; those who worked days were more engaged than those who worked nights or shifts.
- Engagement levels generally decreased with length of NHS service, though the relationship to this and age is not clear.

Although feeling valued and involved was the key driver for most NHS employee groups, Pharmacists differed in that job satisfaction was the key driver of engagement (Robinson et al., 2004).

Therefore the evidence is mixed as to whether role is a suitable variable by which to group staff when measuring engagement and when planning implementation of engagement initiatives. Furthermore, different pieces of research have found conflicting evidence of engagement levels in healthcare workers, despite being based on samples of NHS staff. Robinson et al (2004) found that healthcare workers had relatively high levels compared to other clinicians; in Ipsos MORI (2008) they were reported as having low levels of advocacy. Both pieces of research found that support roles reported lower levels of engagement and advocacy.

It is not clear to what extent the differences in results are due to the following factors:

- Different sample types (the number and representativeness of the samples; the possibility that the research methodology introduced sample bias)

³ Note that only 1 ambulance trust took part in the research and so it is questionable whether this result allows generalisations to be made about all ambulance trusts.

- Different timing of samples (extensive changes to working practices between 2003 and 2006 might have been experienced differently by different groups of staff)
- Different measures of engagement (Ipsos MORI assume that advocacy is a proxy; Robinson et al. devised a more robustly researched measure based on numerous question items and previous research).

It is impossible to assess the scale of impact that these factors did or might have had on the results from both pieces of research. Therefore comparison of these two pieces of work does little to advance knowledge, especially detailed knowledge, about the drivers of NHS engagement.

The fact that sample make up and workforce experiences will change over time suggest that ongoing measurement of engagement in the NHS is necessary. Results from the 2009 NHS Staff Survey should provide the first baseline measure of engagement across the NHS using a fully representative staff sample, against which to assess future trends and to use for quantitative analysis of the associations between current NHS engagement levels and various drivers.

10.1.3 Experiences at work

Negative experiences such as accidents at work, exposure to harassment, and positive experiences such as having a personal development plan were associated with variance in NHS employee's engagement levels (adapted from Robinson et al. 2004):

- Having a single accident or sustaining a single injury at work decreased NHS engagement levels, while having more decreased scores even further.
- Exposure to verbal, racial or sexual harassment at work and exposure to violence at work decreased NHS engagement levels. The impact of harassment from managers or colleagues is much greater than the impact of harassment from patients or the public.
- Having a personal development plan, and receiving a formal appraisal were both associated with increased engagement levels for NHS staff.
- In non-NHS organizations, having an appraisal increased engagement, but receiving a Personal Development Plan (PDP) was associated with an even greater increase in engagement.
- Similarly, receiving training during the 12 months prior to survey increased the engagement scores reported by non-NHS organizations. High levels of training however resulted in decreased engagement, perhaps because high levels of training (over 10 days in one year) suggest that low performance is being tackled (IES 2007), or that significant change is occurring which will disrupt engagement levels.

10.1.4 Engaged with whom?

Ipsos MORI (2008) suggested that engagement varied depending on which aspect of engagement was under consideration: for example those working in general practice were very positive about their immediate working environment, but were the most critical of the NHS as it was run (in 2006) and what the NHS currently stood for. Frequency of patient contact was also associated with variety in staff opinions. Senior managers were more positive advocates than other staff and than lower managers, while newly recruited staff were the most likely to be advocates of the NHS and what it stands for (Ipsos MORI 2008).

Ipsos MORI (2008) suggested that NHS staff had four different key relationships and that engagement within each might vary. These four relationships were with patients and the public, with profession, with the NHS and with colleagues. Robinson et al (2004) found that Doctors and midwives often reported that their relationship with their patients was more important than their relationship with the NHS as an organisation. This is discussed in more detail in the sub section 'Doctors'.

10.1.5 The segmented workforce model

A pilot survey of three NHS trusts carried out by the NHS NWP (2007) found there were differences in engagement levels across NHS staff. As discussed previously, there is a need to disaggregate NHS staff into meaningful groups for which different engagement policies and initiatives can be developed. Research carried out for the NHS NWP suggests that staff can be broken down by their attitudes towards work. The six personality types identified by the NHS NWP research are summarised below:

The segmented workforce model.

- Accomplished contributors focus on adding to the success of the enterprise. Work is an opportunity to be a valuable part of a winning team
- Demanding disconnects find work to be an often unpleasant obligation. Work's value is largely the short-term economic gain
- Fair and square traditionalists want to follow a stable path to a secure future. Work is what we do – a steady, predictable path
- Maverick morphers want to experience new things and find adventure in work. Work is one of multiple opportunities to live lives filled with change and excitement
- Self empowered innovators want to create things and have long-term impact. Work is about building something with lasting value beyond themselves
- Stalled survivors want to make a living and get their careers in gear. Work is a source of livelihood but not yet (or not currently) a satisfying priority in their lives.

What is not clear is how the variance in the importance that staff give to their relationships with patients, public, with colleagues and with profession map on to this model of 'personality types'. Nor is it clear how the drivers of engagement differ across the types. For example, would increasing the engagement in one of these relationships automatically promote staff up through the segmented workforce model until they reach the status of 'accomplished contributors'?

The Institute of Employment Studies (2004) described engaged employees as those who are motivated and committed to their organisation, as well as displaying organisational citizenship behaviour. When asked what motivates them, NHS staff have consistently reported that their relationships extend beyond that with the organisations (the NHS), to include their relationships with their patients and their families, as well as with team members (Ipsos MORI, 2008). The patient

relationship is the prime emotional motivator for the majority of staff. Therefore it seems sensible that any definition of engagement in the NHS should acknowledge this relationship with patients, as a key motivational factor and aspect of the overall work experience. However, since the Ipsos MORI research relied on a voluntarily completed questionnaire which achieved only a 28% response rate, it is also necessary to assess whether non-respondents are also motivated as highly by the patient relationship.

10.1.6 Nurses.

US nurses feel their job is important but lack equipment and resources, feel their colleagues are not necessarily committed to quality care, and do not have close friendships with colleagues.

Research into the US Healthcare workforce in 2002 indicated that nurses score differently compared to other healthcare professionals on four key engagement indicators used by Gallup (2002a). On the item 'The mission or purpose of my organisation makes me feel my job is important', nurses scored more highly than other healthcare workers and than the population as a whole. This implies that they need to have an aligned sense of mission, even more so than other health professionals. However, nurses scored below other healthcare workers and below the general population on three items which Gallup ascertain are associated with engagement levels. Firstly, nurses scored lower on the item 'I have the materials and equipment I need to do my work right'. The lack of equipment and resources in general includes opinions about physical equipment and staffing levels (Gallup 2002a). Gallup state that a workforce which is committed to quality is another important indicator of an engaged healthcare workforce. They assess this factor via the statement: 'My associates are committed to doing quality work'. Healthcare workers as a whole scored higher than the general population on this factor. However, the sub group of nurses scored lower than both the general population and much lower than healthcare professionals overall (Gallup 2002b). Gallup assert that this might be due to the increasing feeling among nurses that their colleagues are being driven by business outcomes rather than by healthcare quality.

The fourth key measure of engagement according to Gallup is the item 'I have a best friend at work'. The best friend item is a predictor of effective teamwork, which is itself linked to patient satisfaction. In 2002, US nurses scored lower than both the general population and other healthcare professionals on this item. High staff turnover rates, staff shortages and changes in shift patterns are suggested as causes of the low score for nurses (Gallup, 2002b).

If Gallup are correct and the issue of friendship at work is closely correlated with engagement levels, this might be one of the factors 'missing' from the Ipsos MORI model of engagement where a large proportion of variance in engagement was not explained by the factors within the model.

10.1.7 Doctors

Engaging Doctors: part of the Enhancing Engagement in Medical Leadership project, NHS Institute for Innovation and Improvement.

The NHS Institute for Innovation and Improvement (NHS Ili) has undertaken research to assess the impacts of involving doctors in clinical leadership, particularly when considering the effectiveness of

change management. The research focused on 'engaging doctors *in leadership*' i.e. encouraging them to take on managerial responsibilities along with clinical ones. This meaning of the term engagement needs to be clearly understood as distinct from research into what engages Doctors per se. However the research has many parallels with the research in to engagement per se and the effects of engagement.

Gruen et al (2004) suggest that engagement in medical leadership is 'advocacy for and participation in improving the aspects of communities that affect the health of individuals'.

The NHS Alliance (2003) defines engagement as 'involvement which is two-way between health professionals and the PCT, with that involvement at a level that influences decision-making. It is involvement at the beginning and as an integral part of the decision making process, rather than as an add-on or afterthought once the decisions are more or less in place'.

Both definitions differ from the definition of an engaged employee as someone who is prepared to go the extra mile. However, the Gruen definition mentions advocacy, while the NHS Alliance definition mentions the two-way nature of the engagement relationship, and involvement in decision making and change management. Advocacy of their organisation, a two-way interaction, and the need for involvement in decision making reappear time and again within reviews and discussions about engaged employees. Therefore the research into the engagement of Doctors in decision making and in change management does have relevance to the discussion of engagement per se.

Ham and Dickinson (2008) show that if NHS doctors are involved in (engage with) leadership within their organisation, then positive medical and organisational outcomes result. This is because the doctors have power resulting from their extensive specialised knowledge which non-medical managers and leaders are not privy to. Doctors have the most influence when it comes to implementing operational changes that can lead to improved performance. If doctors are not engaged (involved) in leadership, and instead either act autonomously or even block top-down changes and policies, the opposite occurs and outcomes are more negative. Since 'clinical autonomy' was a key feature of the NHS from its formation, the importance and significant effect of doctors in implementing any changes must be taken into account in any realistic policy. The Griffiths report (1983) initiated changes resulting in the establishment of the NHS' Clinical Directorate, where doctors accept management responsibility as well as assuming clinical freedom. As such, there exist in today's NHS a number of Clinical Directors who have both managerial and clinical responsibilities. While some directors operate in a non-hierarchical and 'power-sharing' fashion, others appear to have maintained a more traditionalist structure with little scope for innovation and change.

Research by Davies et al (2003) showed that clinical directors were the most dissatisfied group of managers, being 'the least impressed with management and the most dissatisfied with the role and influence of clinicians'. Earlier research to evaluate quality improvement schemes (Total Quality Management) revealed that doctors were unlikely to attend training events, with some acute trusts reporting attendance rates of between 1 and 5% of consultants (Joss, 1994). Although not a direct measure of engagement, if the participation in training events mirrors the same decision-making process of voluntary surveys, where the least engaged staff are the least likely to become involved in the research, then this suggests that a high proportion of clinicians were not 'engaged'.

Logically, it seems likely that a model of engagement for doctors might place much greater emphasis on the patient-clinical relationship than would non-clinical roles. This is backed up by evidence from several case studies of effective change management reported by Dickinson and Ham (2008) where the most effective implementation of changes to working practice only occurred when there was 'buy in' from clinicians. The repeated non-involvement of clinicians in various change management strategies suggests that the importance of their relationship with the NHS and with their managers is weaker than the influence of their relationship with their patients and with their clinical peers.

In reality, it is likely that within the NHS there will be a spectrum of roles where staff's relationships with patients, with colleagues, with profession and with the NHS (as suggested by Ipsos MORI, 2008) occupy different ranks of priority. As discussed above, research into the involvement of doctors with change management, coupled with their high degree of autonomy, suggest that the patient relationship is the major influence on role behaviour and probably therefore on engagement. Similarly, clinical staff reported to Ipsos MORI (2008) that the patient relationship was very important to them; for non-clinical staff this was less so. In order to better understand how different roles rank the importance of each of the 4 relationships several research questions need answering:

- 1) How can the importance of the various relationships – with patients (and public), with profession, with colleagues and with the NHS- be measured?
- 2) How can NHS staff then be grouped together into similarly influenced groups?
- 3) Do the prerequisites for engagement, and the outcomes of engagement, differ across these groups of staff?
- 4) What does this mean for engagement definitions, for policy and further research?

11 Other observations on engagement

11.1 Implementing engagement

The NHS has a sound basis upon which to increase staff engagement levels: implementation of initiatives such as agenda for change (AfC) and improving working lives (IWL) should have improved work-life balance and the flexibility of NHS employment (NHS NWP, 2007).

11.1.1 Generalisations

In a pilot study of 3 NHS trusts, NHS NWP recommended that engagement could be achieved by using the following ten basic principles:

- 1 Do the simple things well – develop an enjoyable workplace that enables growth
- 2 Give feedback on abilities and involve clinical opinions in decision making
- 3 Treat all staff as individuals – no one size fits all
- 4 Share the big picture with all staff
- 5 Use the tools already in place in the NHS – IWL, AfC , IPR staff survey etc

- 6 Use performance review and PDP to make work more stimulating
- 7 Utilise the workforce segmentation model to target particular groups of staff but avoid labelling groups or actions
- 8 Review your own baseline information – staff survey, recruitment and retention rates, complaints, feedback on AfC etc
- 9 Communication is key to informing staff of options and benefits, a steady stream of information is better than any one off communication
- 10 Organisations need to be consistent in their approach. Engagement is hard to build, easy to lose.

11.1.1.1 More specific recommendations

The importance of engaging doctors in any programme of change has been repeatedly demonstrated and should be considered when the NHS intends to maximise staff engagement. Both in the UK and the USA, the types of physicians who sat on hospital governance boards had an impact on the effective adoption of Total Quality Management programmes (Weiner, 1996). Part of their influence is hypothesised to be because other clinical staff will be reassured that since clinicians are involved, the interests of clinical staff and their ideals are likely to be represented in policy decisions (Shortell, 1991). Therefore it might be that doctors could be a key group of staff to engage in order to increase the acceptance and take up of engagement initiatives in underperforming trusts.

Although outside the scope of this review, the review by Dickinson and Ham (2008) on the influence of different leadership and team working styles on the take up of operational changes within healthcare appears to have much to offer those interested in how best to maximise the take up of engagement initiatives. An area where the lessons learnt might be effectively applied would be the trusts highlighted by Steve Jupp (2009) as currently underperforming in this area.

11.2 Looking to the future: recruiting for engagement ready personalities?

Some evidence exists which suggests that various characteristics of employees predict engagement levels: in general, females tend to be more engaged than males; ethnic minorities more engaged than their white colleagues; very young or new employees more engaged than their longer serving colleagues; so called generation Y employees (born after 1980) were determined to find both fulfilling and financially rewarding jobs and did not engage until they had found their personal 'calling' (IES, 2009). However, these findings were not always replicated within individual organisations. Vosburgh (2008, in IES 2009) has suggested that there is a need to devise tools to assess personality traits which predispose individuals to a greater or lesser propensity to become engaged. For this to be possible, those traits need to be defined, although the research in this area is sketchy. Some of the initial research which explores the effects of personality traits is reviewed by IES (2009) but the conclusion is that much more work is needed in order to fully understand and identify the relationship between such traits and the contexts in which they affect the likelihood of engagement. The segmented workforce model proposed by NHS NWP (2007) might map well on to

the personality traits of individuals and prove to be the most appropriate means of disaggregating NHS staff into manageable groups with tailored engagement policies.

This area needs to be more fully investigated before the implications for the NHS can be assessed. For example, if more neurotic individuals are more likely to suffer from burnout (as suggested by Langelaan et al. 2006, in IES 2009), then what other traits does this 'neurotic streak' also bring to the role? What are the implications for distinguishing neurotic individuals from non-neurotic individuals at the recruitment stage: do the benefits of this trait and associated behaviours outweigh the potential risk of burnout or not? The policy implications for the NHS appear to be that decisions need to be made as to whether recruitment policies would ever be tailored to select individuals with a higher propensity to be engaged. The decisions might vary across roles: while highly qualified clinical personnel remain scarce and are therefore needed regardless of personality traits, there might be scope to be more discernment in the recruitment for roles which demand less skills and education. At the present time however, knowledge about the distribution of different personality types throughout the NHS and their propensity to become engaged is lacking and a first step would be to include questions to assess personality traits in one of the annual staff surveys in order to take a snapshot of this distribution. Coupled with the recently included questions about engagement, some assessment could then be made as to whether this was a research agenda worth pursuing or parking until further research outside of the NHS could contribute to knowledge.

11.3 Recession proofing engagement

Blattner (2009) suggests that healthcare leaders can take simple and low cost measures to reduce the risk of the current economic climate decreasing employee engagement and motivation. One idea proposed is to keep in place low cost, highly visible every day incentives and rewards for employees, such as subsidised canteen food and parking, and modest rewards for excellent performance. Another recommendation is to keep on communicating organisational operational and financial performance even if it 'bad news'. Stopping or reducing such communication distances employees from management and increases anxiety about organisational changes and job stability. 'Openly engaging employees in realistic discussions about performance is not only reassuring but might yield some constructive ideas' (Blattner, 2009).

12 Conclusions and recommendations

In general, knowledge about what engages NHS staff is sketchy but some information is available. Various pieces of research have identified some of the drivers, outcomes and measures of engagement. However, the research has mainly relied on voluntary participation which itself increases the probability that the research sample is biased towards more engaged employees. Despite this, some observations and recommendations for future research are clear from the review of the grey literature and these are summarized below.

12.1 Conclusions

Engagement is achieved via a reciprocal process: staff are able and willing to give their best only when empowered and enabled to do so. Although the definitions of engagement cited in the grey literature vary, they do not necessarily contradict each other and to a certain extent reveal the point of view of the organisation employed to conduct the research.

NHS staff have reported that it is important to them to feel valued, to be listened to, and that they are motivated by providing high quality patient care. Therefore the NHS is in a position where the majority of staff are primed ready to deliver an excellent service: the key goal is how to enable them to achieve this.

The key drivers of engagement in the NHS are varied but centre around being treated as adults, with respect, being listened to and being empowered. Communication between the 'shop floor' and management at all levels is key to making staff feel aligned with the values of their employers, and understanding of change and of limitations to resources and other frustrations. For many, doing a good job that makes a difference is more important than pay and conditions but this does not mean that pay and conditions are not important. It means that NHS staff have a public sector ethos which should be cherished and nurtured.

There is unlikely to be a 'one size fits all' definition of engagement for all NHS staff. Instead, different people will be motivated by slightly different needs and their specific requirements will vary according to a range of local factors. Research has shown that engagement varies according to age, ethnicity, length of service and other factors, but does not vary consistently across different pieces of research. This suggests that these factors are not suitable for aggregating staff into similarly motivated groups. It is clear that external factors such as having an appraisal, personal development plan and suitable training increase engagement levels, while factors such as being exposed to harassment or bullying at work decrease levels. What is less clear is how the internal personality traits of staff affect their *propensity to become engaged*: in common with the propensity to display certain illnesses, the full picture is most likely a complex mixture of nature plus nurture. It seems wise to more fully explore how important the nature (personality types) of staff affects their propensity to become involved in order to assess whether personality types is the more robust way to group similarly motivated staff.

The effects of engaged staff in the NHS have been shown to include better patient care, increased satisfaction, decreased mortality, decreased staff absenteeism and increased staff morale. The

financial effect of these outcomes and the cost of increasing engagement have not yet been assessed together in any one study.

It seems likely that NHS staff are affected simultaneously by their relationships with their patients, with their colleagues, with their profession and with the NHS as an organisation. Understanding how important each of these relationships is relative to the other is key to understanding how best to increase staff engagement. A receptionist who is happy enough with their role but feels ostracized at an isolated desk needs a very different intervention compared to a Doctor who feels overwhelmed with work and angry at 'the NHS'. Until staff are able to be grouped according to some characteristic which predicts engagement, NHS managers should continue to use a problem solving approach and tackle specific and local problems identified by their staff as important to them. The problem solving approach has been shown to be effective in increasing engagement in NHS Trusts. Indeed it is possible that if all managers were equipped to increase engagement in this way there would be no need for a generic policy, since locally lead interventions would continue to deliver the tailored solutions necessary to maximize staff engagement.

The NHS staff survey provides the key method for assessing year on year changes in staff engagement levels. Analysis of the survey results should provide insights into how staff might usefully be grouped together, whether this be by staff group, by socio-demographics, by length of service or indeed by a combination of these factors. If no reliable predictor of engagement levels is found it is possible that locally lead solutions are the way to increase staff engagement and that no generic central policy can be devised; or that the definitions and measurement of engagement need revisiting.

12.2 Further research

The key research questions remaining include:

- Do the engagement levels, drivers, and outcomes, of staff who never take part in research differ from those who do take part?
- How can the NHS workforce best be aggregated into meaningful groups, each of which will respond to different engagement initiatives and therefore require slightly different initiatives and implementation strategies?
- Is the segmented workforce model suggested by NHS NWP (2007) an appropriate way to aggregate staff when devising tailored engagement initiatives?
- How does the importance of engagement with patients, with the NHS as an organisation, with colleagues and with profession vary across NHS staff groups? Is this another way to aggregate staff into meaningful groups? Does this mean that the NHS needs several measures of engagement, each measure relating to each of these relationships?

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