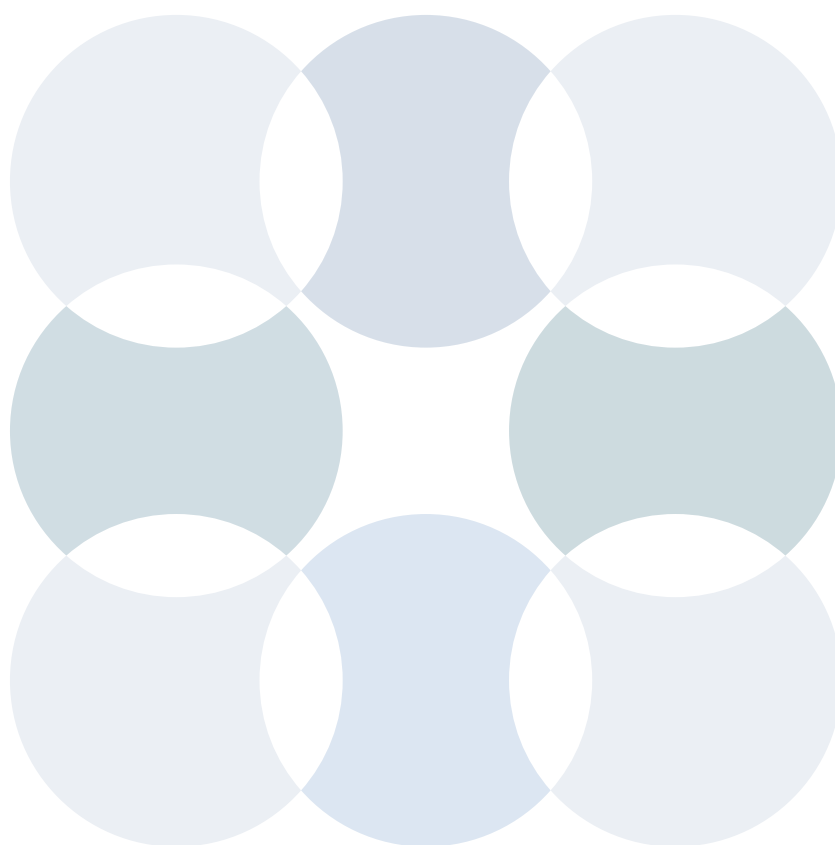

Improving NHS Care by Engaging Staff and Devolving Decision-Making

Report of the Review of Staff Engagement and Empowerment in the NHS



'We aim to create the largest social enterprise sector in the world by increasing the freedoms of foundation trusts and giving NHS staff the opportunity to have a greater say in the future of their organisations, including as employee-led social enterprises.'

Equity and Excellence: Liberating the NHS, 2010

'We have to find other ways of improving productivity and quality of service We have to be prepared to innovate and look at different models of ownership across the public sector.... For example, the role of mutuals in public service delivery – we have only just started to explore how far that can go.'

Rt Hon Norman Lamb MP, speech at the Tomorrow's Business Forms Report launch, November 2013

'People can see how things can be done better and do it. They can give effect and take responsibility and pride for making things happen. People typically say they are working harder than they were but they are enjoying it more, it's more rewarding, more fulfilling. That's why I think the public service mutual is the way of the future.'

Rt Hon Francis Maude MP, Robert Oakeshott Memorial Lecture, 2014

'In the future, mutuals will play an increasingly important role in delivering public services. Mutual organisations are controlled by their members; they are exceptionally well-suited to strengthening relationships between staff, users and the wider community – and these stronger relationships will lead to better outcomes for all.'

Rt Hon Tessa Jowell MP

Mutual Benefit: Giving people power over public services, 2010

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Foreword

Health care is first and foremost a people business. Around 1.4 million staff in the NHS in England provide care to 1 million patients every 36 hours. The quality of that care depends on the skills, commitment and compassion of staff. Technologies may be transforming how care is delivered but ‘high touch’ matters as much as ‘high tech’ in shaping the experience and outcomes of patients. It is for this reason that engaging staff in improving NHS care at a time of unprecedented financial and service pressures is an issue of the highest priority.

This has been recognised for a number of years and the good news is that levels of staff engagement as measured by the annual NHS staff survey are increasing. The not-so-good news is that there are wide variations across the NHS with examples of excellent practice and rapid improvement in some organisations co-existing with stubbornly low levels of engagement in others. The consequences of disengaged staff were evident in Mid Staffordshire NHS Foundation Trust where poor leadership and a disengaged and demoralised workforce resulted in shortcomings in quality, safety and compassion in parts of the organisation.

This report argues that the NHS will not be able to deliver high-quality care for all within constrained budgets unless renewed efforts are made to engage staff and harness their commitment to improve care continuously. This is first and foremost a responsibility of the leaders of NHS organisations, starting at board level and extending to the frontline clinical teams delivering care to patients. It is also a responsibility of the regulators who can support efforts to strengthen staff engagement if they adopt a proportionate approach to inspecting and regulating NHS organisations and support them to improve care. Politicians have a vital part to play too in showing that they value staff and recognise their vital contribution.

High-performing health care organisations throughout the world have understood and acted on these simple truths for some time, with impressive results. These organisations have made a sustained commitment to investing in their staff and providing them with the skills and tools to improve care and outcomes. The results can be seen in the experience of organisations like Intermountain Healthcare in the United States, Jonkoping County Council in Sweden, and Canterbury District Health Board in New Zealand. Closer to home Salford Royal NHS Foundation Trust has achieved a deserved reputation for its work on patient safety and quality brought about in part through engaging and supporting staff in improving care. A new report from The King’s Fund distils the implications for the NHS from the experience of these organisations.¹

¹ Ham (2014)

A major challenge is how to learn from these exemplars and ensure that best practice becomes common practice. Nye Bevan's aspiration to 'universalise the best' by establishing the NHS remains unfulfilled with wide variations in standards and performance still in evidence. As this report argues, staff engagement cannot be strengthened by setting targets and managing their implementation. Rather, the initiative has to come from within the NHS, following the example set by high-performing NHS Trusts and Foundation Trusts that have long recognised the essential contribution of staff engagement to performance improvement. This requires leaders to show that they are personally and visibly committed to engaging and working with staff, investment in leadership and staff development, devolution of decision-making, and a flattening of hierarchies.

It also requires a willingness to study and learn from the experience of mutuals delivering a range of public services and those working in other sectors. The Panel that has worked with me on this review heard testimony from staff and leaders of mutuals delivering NHS services of the benefits of owning and running their organisations and the sense of liberation associated with this. This testimony lies behind the report's recommendation that there should be greater freedom for NHS organisations and emerging integrated care providers to become staff-owned and led where leaders and staff have an interest in doing so.² This is particularly important in relation to acute hospital services where there is currently much less diversity of ownership models than in other sectors of care.

In putting forward this recommendation, the Panel is clear that the mutual model is not a panacea. The successes of organisations like the John Lewis Partnership need to be viewed alongside the well-publicised problems of the Co-op Group, recognising that the staff-owned mutuals discussed in this report are fundamentally different from consumer-led co-operatives. It is also clear that successful mutuals will need to ensure that the voice of customers and users, as well as that of staff, is taken into account. A period of 'accelerated evolution' and evaluation of alternative models is needed to gather evidence about the impact of different organisational forms on staff engagement and performance. This would enable the journey of mutuality that started with the creation of Foundation Trusts in 2004 to be continued and extended in a wider range of organisations and settings.

A consistent and proportionate approach to regulation of all providers of NHS services whether Trusts, Foundation Trusts or mutuals is a prerequisite of the transformational changes in care that are urgently needed. Improvement on the scale required in the NHS will not happen unless providers of NHS services operate with presumed autonomy, with regulators creating space and opportunity for leaders to innovate in the delivery of care. This means calibrating the degree of regulation in relation to organisational

² Throughout the report, the terms 'staff-owned' and 'staff-governed' are used interchangeably with –'employee-owned' and 'employee-governed'

performance and supporting providers to make the changes in leadership and culture on which improvements in staff engagement and ultimately patient experience and outcomes depend. In the next phase of evolution, it is essential that there is much greater devolution, recognising the impossibility of managing an organisation as large and complex as the NHS from Whitehall and Westminster.

The Panel's recommendations on how to make this happen can be found at the end of this report. I would like to thank members of the Panel and the secretariat from the Department of Health for their contribution to this review. Notwithstanding lively debates and honestly held differences of view on some issues, we all agree that improving NHS care through engaging staff and devolving decision-making has never been more important.

Chris Ham

Chief Executive

The King's Fund

Executive summary

1. There is compelling evidence that NHS organisations in which staff report that they are engaged and valued deliver better quality care. Superior performance is evident in lower mortality rates and better patient experience. The corollary is that organisations with a disengaged workforce are more likely to deliver care that falls short of acceptable standards. Failures of care at Mid Staffordshire NHS Foundation Trust were one well-publicised example – but by no means the only example – of an NHS organisation where poor leadership and a disengaged and demoralised workforce resulted in shortcomings in quality, safety and compassion in parts of the Trust.
2. NHS providers exist, first and foremost, to serve their patients. An engaged and valued workforce is not a ‘nice to have’. It is a necessary condition for meeting the NHS’s unprecedented challenges against a backdrop of growing service pressures and tightening finances. The Panel leading this review sees an urgent need for renewed effort to engage staff across the NHS, with all NHS organisations viewing engagement as a key priority. We need to unleash the power of NHS staff to drive service improvements and innovations that transform care, including maximising the discretionary effort staff bring to caring for patients.

Levels of engagement in the NHS

3. Evidence on the relationship between staff engagement, patient experience and organisational performance shows why engagement matters (see appendix 4 to this report for a review and summary of this evidence). A small number of NHS providers such as Salford Royal NHS Foundation Trust and Oxleas NHS Foundation Trust consistently achieve high staff engagement scores in the NHS staff survey and this is reflected in better care for patients. Others, such as Wrightington, Wigan and Leigh NHS Foundation Trust, have demonstrated that it is possible to deliver significant improvements in a relatively short period.
4. Against this it is clear that some NHS providers, including a number in special measures, have had low levels of engagement for a number of years. The evidence shows that this can result in poorer quality of care for patients. The time has come for all providers to learn from the experience of organisations in which there are high levels of staff engagement in order to narrow the gap that exists across the NHS. They need to be supported in their efforts by regulators and by greater sharing of experience and learning within the NHS itself. If this does not happen, then the NHS will not be able to respond effectively to the challenges it faces with adverse consequences for patients.

5. Evidence from the NHS staff survey shows that Foundation Trusts outperform Trusts on staff engagement, but the differences between the two types of organisations are marginal and have not changed over time. Alongside this evidence there is emerging experience that many of the staff-owned and led public service mutuals in the NHS,³ created (for the most part) during the Transforming Community Services programme, are improving levels of engagement among their staff, and that this is bringing benefits, including reducing absenteeism and staff turnover. These early successes are encouraging and if sustained lend support to the case for mutuals playing a bigger part in the NHS in future alongside existing organisations. Evidence from other sectors summarised in appendix 4 to this report confirms the advantages that well-managed mutuals are able to offer.

The role of leaders

6. If there were a silver bullet for securing high staff engagement, it would probably already have been found. We cannot instruct NHS organisations to engage their workforces or orchestrate higher engagement simply by changing legislation or pulling regulatory levers. Leaders and managers at all levels within the NHS hold the keys and success lies, typically, in sustained effort to embed the right behaviours, ways of working, and values throughout provider organisations. The boards of NHS organisations must lead this process and show through their actions and words that staff engagement is a high priority.
7. We believe that successful leaders are those who work in partnership with staff, giving them a strong voice, involving them in decision-making and empowering them to improve care. Yet the NHS culture has traditionally been one of performance management in which providers have been expected to deliver improvements based on centrally determined targets and standards. We know that pacesetting (typified by leading from the front, setting demanding targets and, often, a reluctance to delegate) is the dominant leadership style and this needs to be complemented by coaching and participative approaches if staff are to be engaged effectively. We need sustained effort and investment in leadership and management development to support this.
8. Leaders and managers at different levels have a central role to play in creating the right cultures within NHS providers, where staff have confidence in the integrity of the organisation, recognise the fairness of its procedures, and feel valued, safe and supported. These cultures must focus on care for patients and how it can be improved as the principal objective. Staff who report high levels of engagement communicate this to patients in the way they deliver care and the outcomes that

³ A public service mutual is an organisation that has left the public sector (also known as ‘spinning out’) but continues to deliver public services. Mutuals are organisations in which employee control plays a significant role in their operation

are achieved. Continued high levels of reported bullying, harassment and abuse are an alarm bell sounding throughout corridors the NHS. We urgently need to start listening to it.

9. An important starting point is for NHS boards to dedicate greater time and attention to staff engagement, commensurate with all of the evidence that higher engagement will improve services for patients. Recent research led by Professor Michael West assessed board priorities and board level innovations amongst 71 Trusts and Foundation Trusts over an 18-month period from 2010 to 2012. In their survey responses, 38% of boards reported that staff engagement was one of their board-level priorities. However, the researchers found evidence that staff engagement was a focus of innovation in only 15% of the 71 Trusts based on a review of their board minutes. Professor West's assessment was that staff engagement had not been completely neglected, but the level of board activity in the area was not high and there was huge scope for improvement.⁴
10. The more frequent use of staff surveys in the NHS is a timely and welcome initiative and should provide a basis for regular board discussions of levels of engagement, the reasons for them, and differences within individual organisations. Leaders at all levels within NHS providers need to track staff engagement on a regular basis and act on the results. Regulators need to support providers to make the changes that are needed.

Empowering frontline staff

11. Each of the successful providers we visited during this review had developed its own strategy. However, one consistent theme was the efforts leaders had made to devolve both accountability and decision-making to the staff responsible for delivering services, whether that related to improving quality, addressing safety concerns or responding to financial challenges. In devolving responsibility, many of these providers had also invested in staff through leadership and management development and training in areas such as quality improvement skills and methods.
12. As part of the review, we visited a number of public service mutuals delivering NHS services (including Spiral, SEQOL, Provide, Bromley Healthcare and City Health Care Partnership CIC) who described passionately and persuasively the sense of liberation from operating within a flatter hierarchy with speedier decision-making. We also heard how successful providers, including some Foundation Trusts and Trusts, had stripped out layers of bureaucracy, devolved budgets to frontline services, or created semi-autonomous business units within a large organisation. There was a stark contrast with the experience of staff in other providers, where enthusiasm and

⁴ West *et al* (2013)

initiative appeared to be stifled because they did not feel empowered to make the service improvements they felt patients needed.

13. Another key feature of successful providers was the determination to support staff in addressing service challenges rather than imposing solutions on them. Salford Royal's Quality Directorate gives staff technical support to trial and evaluate new clinical processes. Others, such as University Hospitals of Leicester NHS Trust and some 50 other Trusts and Foundation Trusts, have used the Listening Into Action programme to support staff in delivering service change, often producing striking levels of improvement in key elements of staff engagement.⁵ Meanwhile, a growing number of providers, including the Countess of Chester Hospital NHS Foundation Trust, Blackpool Teaching Hospital NHS Foundation Trust and Hinchingsbrooke Health Care NHS Trust, are demonstrating the value of empowering frontline staff to deliver financial turnaround. Supporting staff and investing in them needs to be a much higher priority across the NHS to turn aspirations on engagement into practice.

Governance and accountabilities

14. Foundation Trusts were established with the aim of increasing the autonomy available to their leaders and shifting the locus of accountability within the NHS. Specifically, the intention of the last Labour Government was that Foundation Trusts would be accountable to a range of local stakeholders, including staff, through their distinctive governance arrangements involving a board of governors as well as a board of directors, alongside accountability to national regulators and their commissioners. An explicit purpose of Foundation Trusts was to strengthen their links with local communities through membership of trusts and to introduce elements of mutuality into the mainstream of the NHS⁶ in place of the traditional accountability of NHS organisations to the Secretary of State for Health.
15. We interviewed leaders of Foundation Trusts who described experiencing a higher degree of scrutiny and intervention by national regulators than expected, restricting their autonomy and leaving limited space to develop their accountability to local stakeholders. This is a reflection of the difficulty for politicians in 'letting go' when they retain accountability to Parliament for the performance of the NHS. Increasing financial and service pressures have also resulted in regulators tightening their grip on both Trusts and Foundation Trusts.
16. We interviewed leaders of mutuals, who reported that there were important differences working in an employee owned and governed organisation compared with Trusts and Foundation Trusts. We were struck by their testimony that the

⁵ Listening into Action is a staff engagement programme developed by Optimise Ltd

⁶ Department for Health (2002)

same people working in quite different organisations behaved and performed quite differently. While the Government's intention was to develop a consistent regulatory framework for all providers, the leaders of mutuals delivering NHS services described themselves as having more headroom to develop accountability to staff and local stakeholders.

17. Accountability in these mutuals is closer to that of organisations such as the John Lewis Partnership where a staff council oversees a professional, PLC-style board and holds the Chairman to account for performance. These strong relationships between leaders and staff appear to influence management styles and behaviours throughout the organisation. More engaged staff also bring benefits for patients such as faster innovation, more patient-centred care, and improved performance.
18. Staff in mutuals delivering NHS services tend not to hold a substantive financial stake in their organisation or necessarily receive a share of profits. Nevertheless, it is evident that many feel a powerful sense of psychological and emotional ownership of their organisations. We heard examples of staff taking greater initiative, from highlighting the prices of items in a store cupboard (at SEQOL) to saving thousands of pounds by switching to better value suppliers (at Care Plus Group) and improving patient care. The best-performing Foundation Trusts have been able to develop a similar sense of staff engagement and ownership. More evidence is needed on how they have achieved this and how the lessons from successful public service mutuals and Foundation Trusts can be disseminated and emulated.
19. Given the current state of knowledge, the Panel concluded that there should be greater freedom for organisations to become staff owned and governed, on a strictly voluntary basis, following detailed consultation with staff and staff-side trades unions, and where leaders and staff both have an interest in doing so. As a start, we should be clearer about the scope for giving staff a stronger staff voice within the existing Foundation Trust model. This might include learning from the John Lewis Partnership and other successful mutuals on the mechanisms for recruiting staff representatives and supporting them in delivering their roles effectively.
20. During the course of the review, we met a number of NHS leaders who were interested in going further by their organisations becoming staff-owned and led organisations, through legal forms such as a community interest company or community benefit society. This included within the acute sector where there is currently much less diversity of ownership models than in other sectors of care. The improvements in care that are needed within the NHS could be accelerated by adapting the arrangements that already exist in community and mental health services where Foundation Trusts and Trusts co-exist with various other organisational types. For example, although it would require changes to current legislation, Trusts could be given the choice

of adopting mutual status as an alternative to becoming a Foundation Trust once they have completed an appropriate authorisation process with similar rigour to the Foundation Trust authorisation process.

21. A variation would be to enable the establishment of an employee owned and led mutual for a particular group of services or as a joint venture bringing together services from different organisations to develop more integrated care. Consideration would need to be given to the inter-relationship between these and other services, and the need to ensure sustainability of services elsewhere in the organisation and local health economy. One attraction of this model for integrated services is the opportunity to establish a new mutual organisation with multiple partners, such as GPs, local authorities and the third sector, with no one organisation appearing to dominate the process. Such an approach would draw on the strengths of different types of organisation to support the emergence of new models of care. This is likely to be particularly attractive in relation to integrated care because of the important contribution of third sector organisations to the development of this form of care.
22. A period of 'accelerated evolution' and evaluation of alternative models would enable further evidence to be gathered about the impact of different organisational forms on staff engagement and performance. This would shed light on a core question on which opinion was divided within the Panel, namely the relative importance of ownership and governance in comparison with other critical factors such as leadership, culture, and ways of working in securing a highly engaged workforce. Both are clearly important and now is the time to encourage and support alternative approaches where NHS leaders and staff are keen to do so. Testing different models would also clarify whether the promising early reports from mutuals delivering services in the NHS and the benefits seen from mutuals in other sectors could be replicated in acute providers operating on a much bigger scale than the community providers that have chosen to go down this route so far.
23. It will be important to maintain a consistent regulatory approach for all providers as a wider range of organisations deliver NHS services. Under the new system, mutuals delivering NHS services will, just like Foundation Trusts, be subject to Care Quality Commission (CQC) oversight to maintain quality, and Monitor's regulation to protect continuity of services. New public service mutuals might therefore need, in due course, to be brought fully within the NHS special administration regime. A strong message from the review was the importance of developing a more proportionate regulatory system and lessening the burden of upward reporting for all NHS providers. Leaders across the NHS must have the headroom to lead and to dedicate greater attention to their relationships with patients, staff and other local stakeholders on the basis of presumed autonomy.

24. In putting forward these recommendations, the Panel is conscious of the desirability of avoiding further top-down restructuring. In practice, some organisational change is unavoidable given the need to resolve the future of the 98 Trusts yet to achieve Foundation Trust status, and the innovations emerging spontaneously from local discussions of integrated care. These developments will impact on Trusts and Foundation Trusts through mergers and takeovers, the development of joint ventures and debate about the potential role of chains of providers.⁷ Bottom-up organisational change of this kind is quite different from government-mandated restructuring across the NHS which needs to be avoided at all costs.
25. At a time when there is growing debate about future provider models,⁸ it is opportune for the place of employee owned and governed mutuals within the NHS to be considered seriously alongside other ways of strengthening staff engagement throughout the NHS. This would enable the journey of mutuality that started with the creation of Foundation Trusts in 2004 to be continued and extended in a wider range of organisations and settings. It would also enable there to be greater devolution of decision-making in the NHS if accompanied by changes to the regulation of providers of the kind we outline later in this report. It will be important to provide advice and practical support to NHS organisations wishing to become mutuals to ensure a smooth transition to a more diverse provider environment.

⁷ The Secretary of State for Health recently appointed Sir David Dalton to lead a review into new models of hospital care

⁸ See for example: *Health Service Journal* (2014) and Milburn (2014)

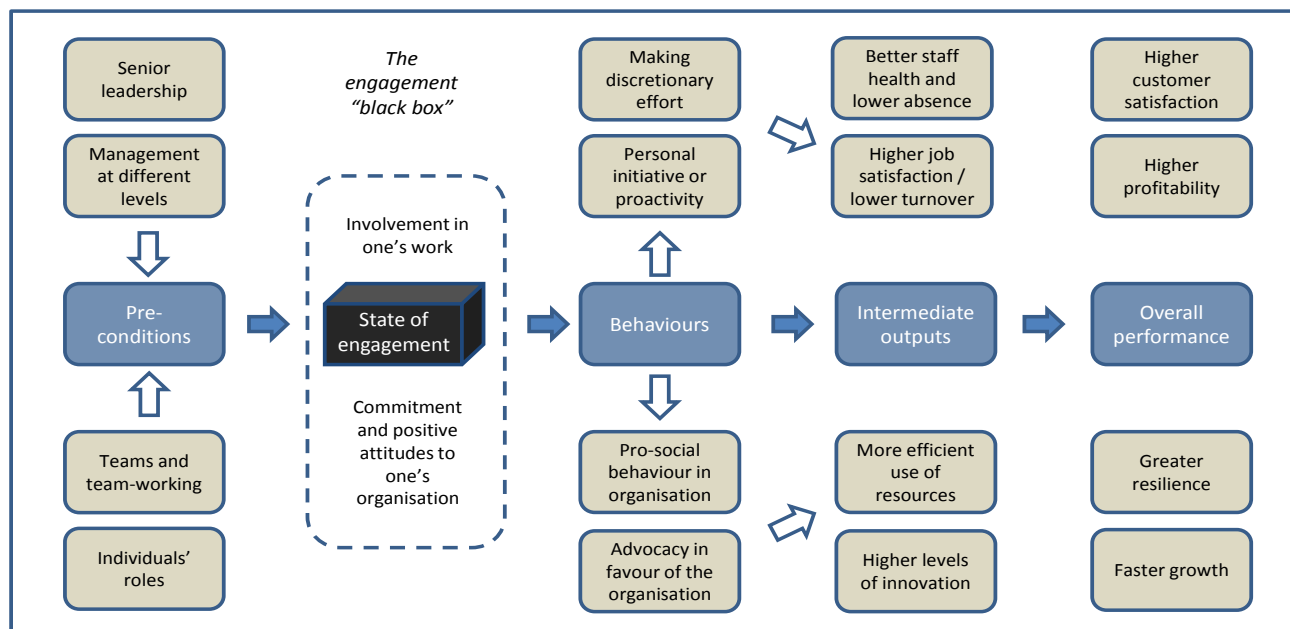
The case for engagement

26. By common consensus, the NHS is facing the greatest set of challenges in its history with imperatives to improve quality, safety and integration, growing service pressures and tightening finances. The list of providers in special measures or approaching serious financial deficits is increasing. Against this backdrop, some might question whether now is the right time to divert scarce management time and resources to renewed efforts to engage the workforce. Our answer is to point to the sheer weight of the evidence linking staff experience to patient experience, quality of care, innovation and productivity. A fuller summary of this evidence can be found in appendix 4 to this report.

What is employee engagement?

27. Academics and HR practitioners have defined and measured staff engagement in different ways. Most recent research agrees on the concept of engagement as a psychological state associated with feelings of commitment and loyalty to one's organisation and involvement in one's work. According to this research, engagement is at the centre of a set of causal relationships in which certain conditions affect employees' levels of engagement, which in turn affects their behaviour, and consequently influences overall performance.

Figure 1: Engagement as a 'black box' or catalyst which drives particular behaviours and outcomes



Engagement, staff well-being and staff costs

28. Highly engaged employees are healthier and happier, with lower sickness absence and lower staff turnover. In the NHS, West and Dawson have shown that organisations with highly engaged employees have significantly lower levels of absenteeism. Those organisations with levels of involvement in the top third had absenteeism of 3.6%, in comparison with 4.8% for those at the bottom. For the average trust, an increase of one standard deviation in engagement equates to an average saving of £150,000 from lower staff absence.⁹

Engagement and quality of care

29. Highly engaged employees are more likely to deliver high-quality care. West and Dawson have demonstrated the link between employees' job satisfaction and lower patient mortality rates, with an increase of one standard deviation in levels of satisfaction associated with a 2.4% drop in patient mortality. There is also a small but significant reduction in health care-acquired infections in Trusts where a large proportion of staff believe they can contribute to improvements.¹⁰

Engagement and performance

30. Highly engaged employees have fewer accidents, make better use of resources, and deliver better financial performance. Looking at a range of industries, Towers Perrin and Gallup showed that firms with higher levels of engagement delivered much higher productivity, profitability and growth.¹¹ In the NHS, West and Dawson have demonstrated a link between higher levels of staff engagement and strong financial performance in the former Healthcare Commission's annual health checks.¹²

Engagement and innovation

31. Highly engaged employees are more likely to think creatively and innovate at work. According to one Gallup survey, 59% of engaged employees, against just 3% of disengaged employees, said that their job brought out their most creative ideas.¹³ It is difficult to make direct comparisons between levels of engagement and innovation in the NHS, since we do not have quantitative data on levels of innovation across providers. However, others have pointed to a potential link between engagement and innovation to explain differences in outcomes between NHS providers, such as lower infection rates or better financial performance.¹⁴

⁹ West and Dawson (2012)

¹⁰ West and Dawson (2012)

¹¹ Gallup Organisation (2006)

¹² West and Dawson (2012)

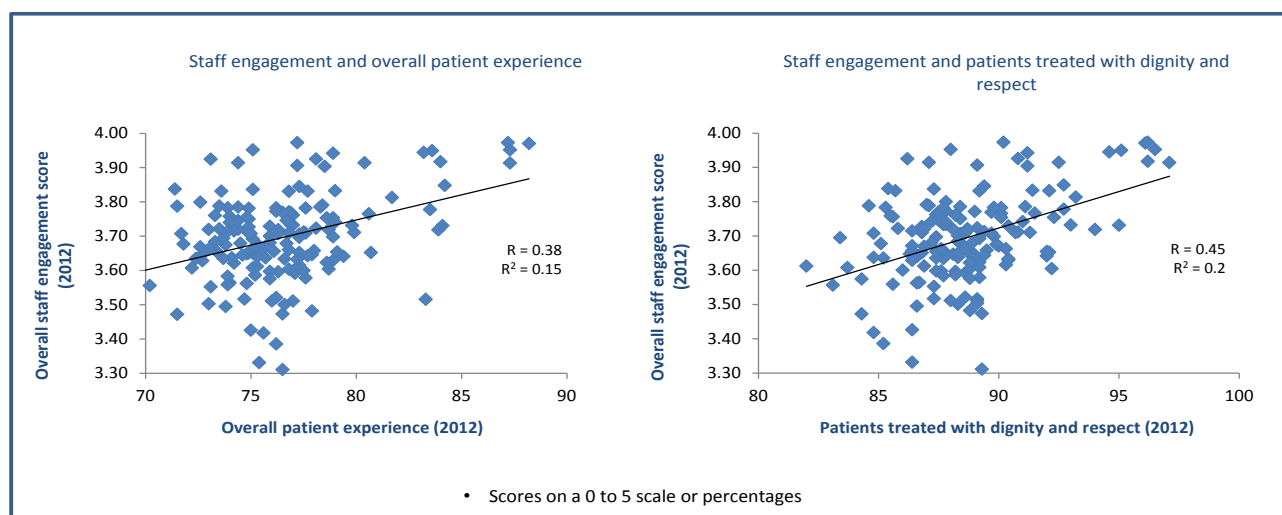
¹³ Krueger and Killham (2007)

¹⁴ West and Dawson (2012)

Engagement and compassion

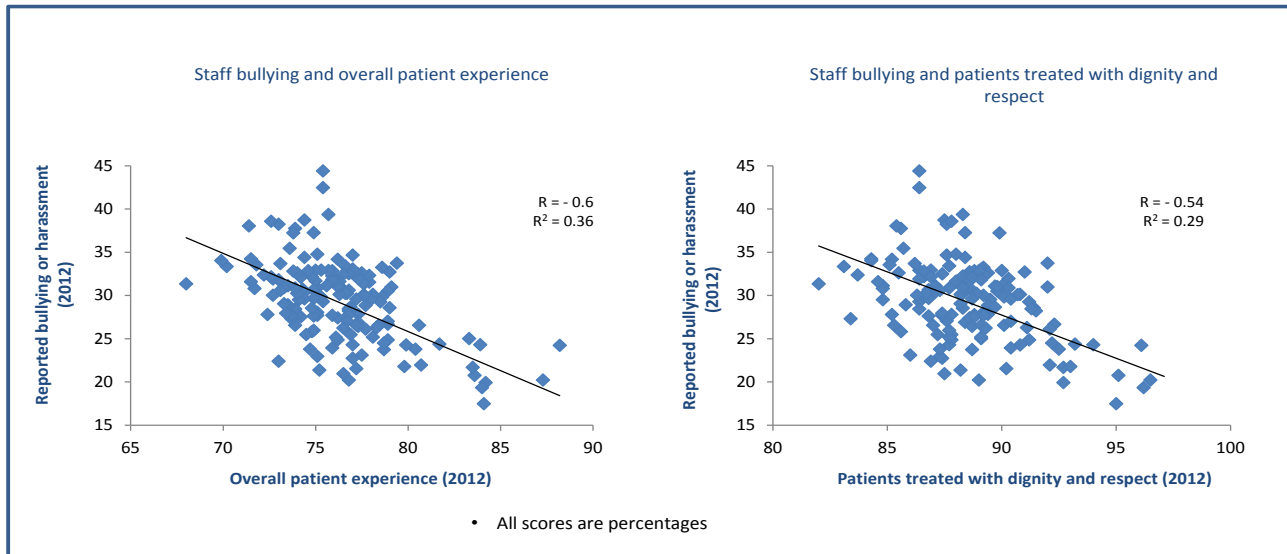
32. Engaged staff should be more likely to have the necessary psychological resources to show empathy and compassion to patients, despite the challenges of working in pressured environments and risk of compassion fatigue. Our analysis of the NHS staff and patient surveys indicated that high engagement is positively correlated with better patient experience and a larger proportion of patients reporting that they were treated with dignity and respect (see figure 2). Looking at simple correlations, we found a moderate positive correlation between overall levels of staff engagement and overall patient experience in 2012. We found a strong positive correlation between overall levels of staff engagement and whether patients reported being treated with dignity and respect in 2012.

Figure 2: Staff engagement and patient experience



33. Conversely, bullying, discrimination, and overwork lead to disengagement and are likely to deprive staff of the emotional resources to deliver compassionate care. Looking again at simple correlations, we found a strong negative correlation between whether staff report harassment, bullying or abuse from other staff in the NHS staff survey and overall patient experience in 2012. We also found a strong negative correlation between whether, in the NHS staff survey, staff reported harassment, bullying or abuse from other staff and whether patients reported being treated with dignity and respect (see figure 3).

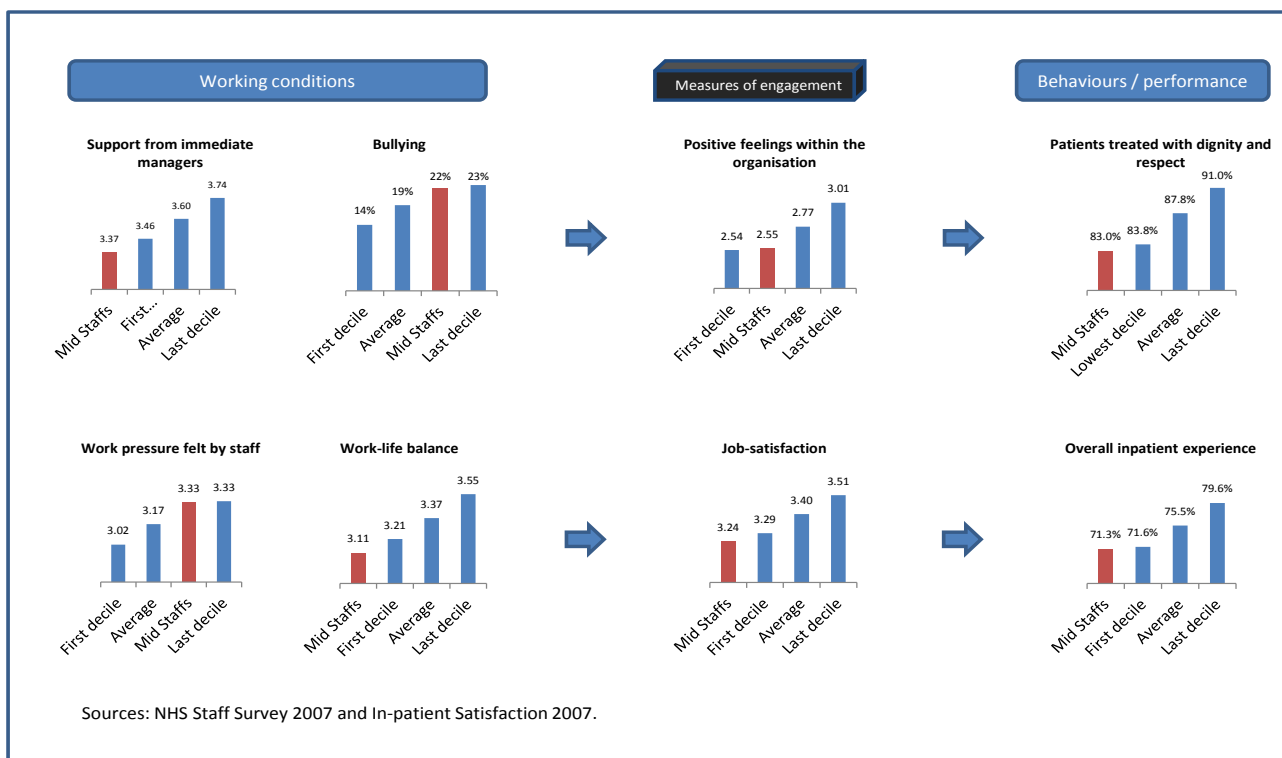
Figure 3: Engagement as a ‘black box’ or catalyst that drives particular behaviours and outcomes



Engagement and whistleblowing

34. Engaged staff are more likely to intervene to raise concerns about safety or address poor behaviours. Our analysis of the NHS staff survey shows a strong positive correlation between staff engagement and the percentage of staff reporting that they reported errors, near misses or incidents in the past month in the NHS staff survey for 2012 (with an R of 0.42 and an R^2 of 0.18). These results appear consistent with research from a range of sectors that highly engaged staff are more likely to take the initiative to address concerns about quality and safety, and the link between levels of engagement and accidents at work (see appendix 4). Engaged staff may provide our most efficient mechanism for addressing negligence or poor standards of care.
35. Evidence from Mid Staffordshire NHS Foundation Trust demonstrates graphically the correlation between low levels of staff engagement and poor care (see figure 4). This shows clearly that providers in which staff are not supported by managers, experience bullying and work pressure, and have a poor work–life balance are at risk of not treating patients with dignity and respect and not delivering a positive patient experience. It is for this reason that NHS boards need to review the results of staff surveys regularly and act when concerns arise.

Figure 4: Working conditions, staff engagement and compassionate care at Mid Staffordshire NHS Foundation Trust (2007)

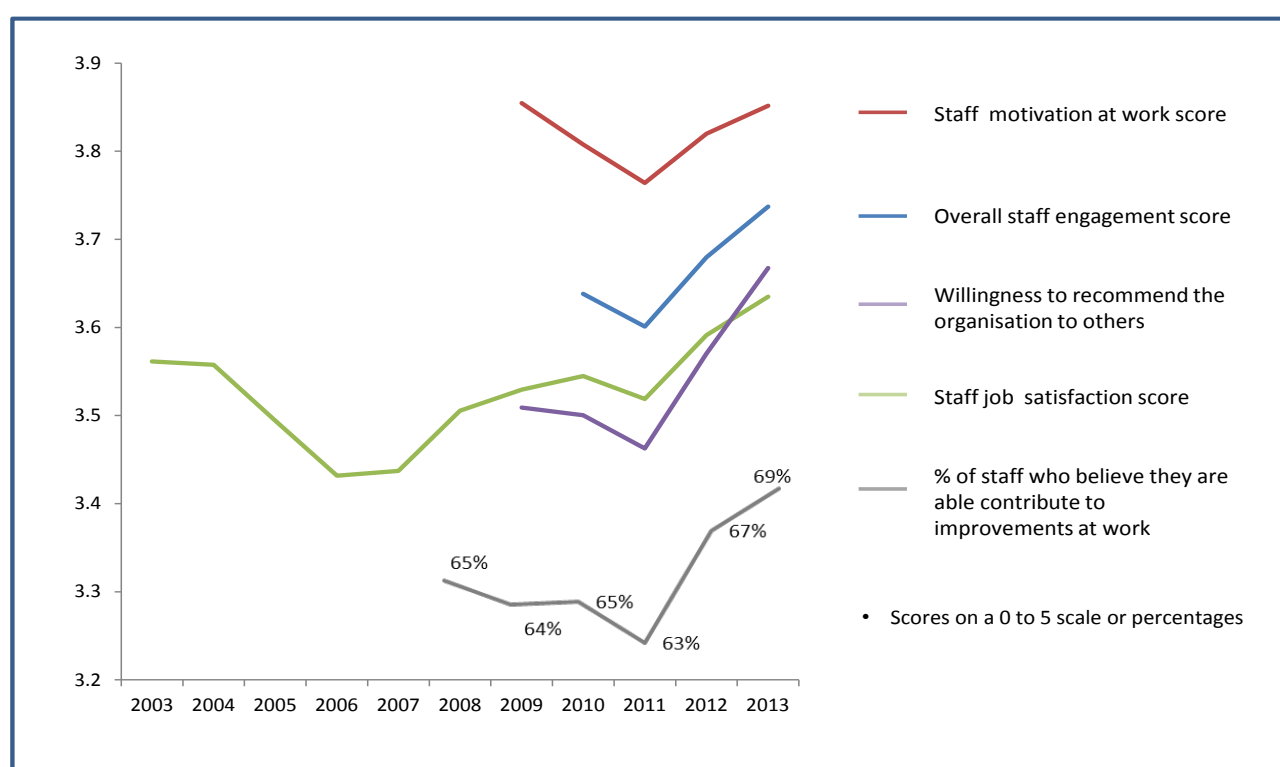


Numbers refer to an aggregate score out of five in response to the 2007 NHS staff survey and in-patient satisfaction survey, and percentages refer to the proportion of respondents providing a positive response to the statement. The average column illustrates the average score across all those completing the survey, and the first and last deciles illustrate the average result for those in the top and bottom 10% of scores respectively.

The state of engagement in the NHS

36. According to the NHS staff survey, levels of staff engagement in the NHS have been increasing over the past four years, after a dip towards the end of the past decade. Overall levels of staff engagement (an aggregate score comprising scores for staff motivation, perceived ability to contribute to improvements at work, and willingness to recommend the organisation as a place to work or receive treatment) increased from an average of 3.6 (on a five point scale) in 2011 to 3.7 in 2013. There was an increase in the average scores for each of these underlying metrics and in the scores for job satisfaction. (For further information, see NHS Employers' analysis of recent trends based on the survey.¹⁵)

Figure 5: Average NHS staff survey scores for engagement and job satisfaction (2003 to 2013)

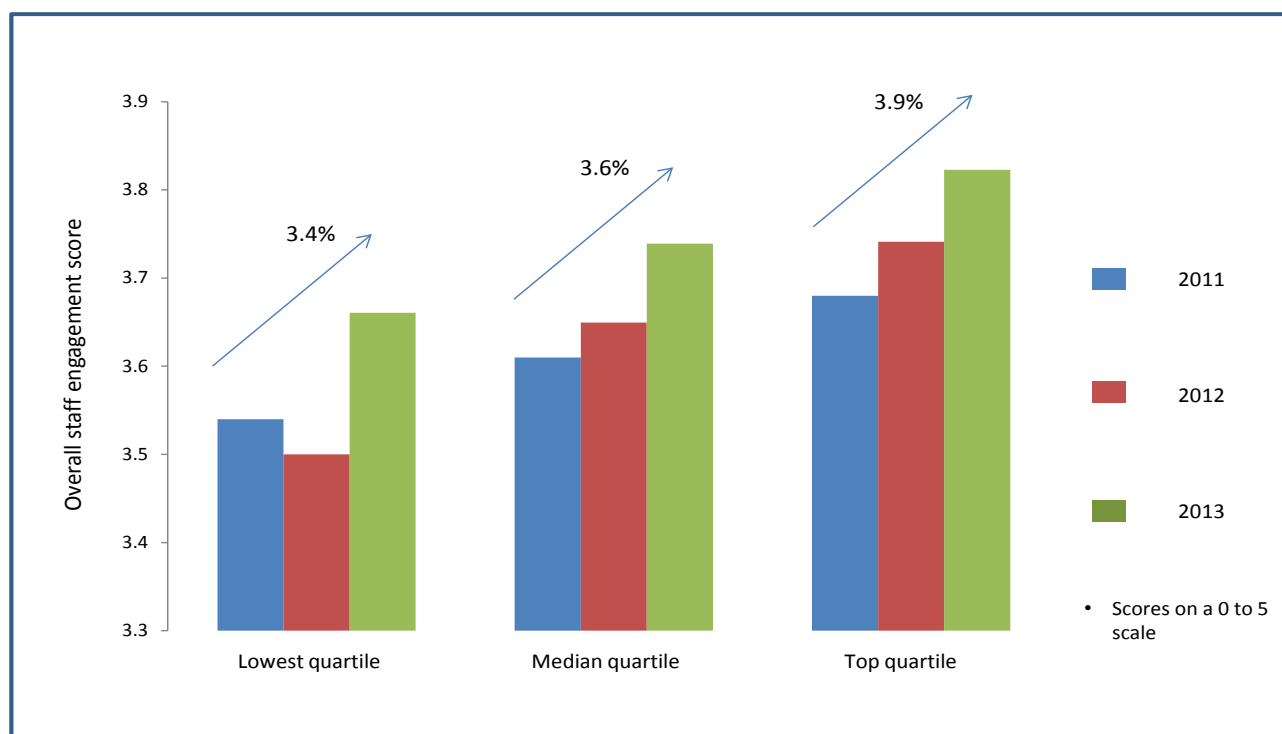


Disparities between providers

37. However, the disparities between providers participating in the survey appear to have increased over at least the past four years. While the average overall engagement score increased across the NHS from 2011 to 2013, growth has been faster within providers with scores in the median and top quartiles. (The variance in overall engagement scores increased by 65% from 0.02 to 0.033 from 2011 to 2013.) So the distance appears to be widening, with those providers with lower levels of staff engagement falling further behind the leaders.


¹⁵ <http://www.nhsemployers.org/your-workforce/retain-and-improve/staff-experience/staff-engagement/nhs-staff-survey>

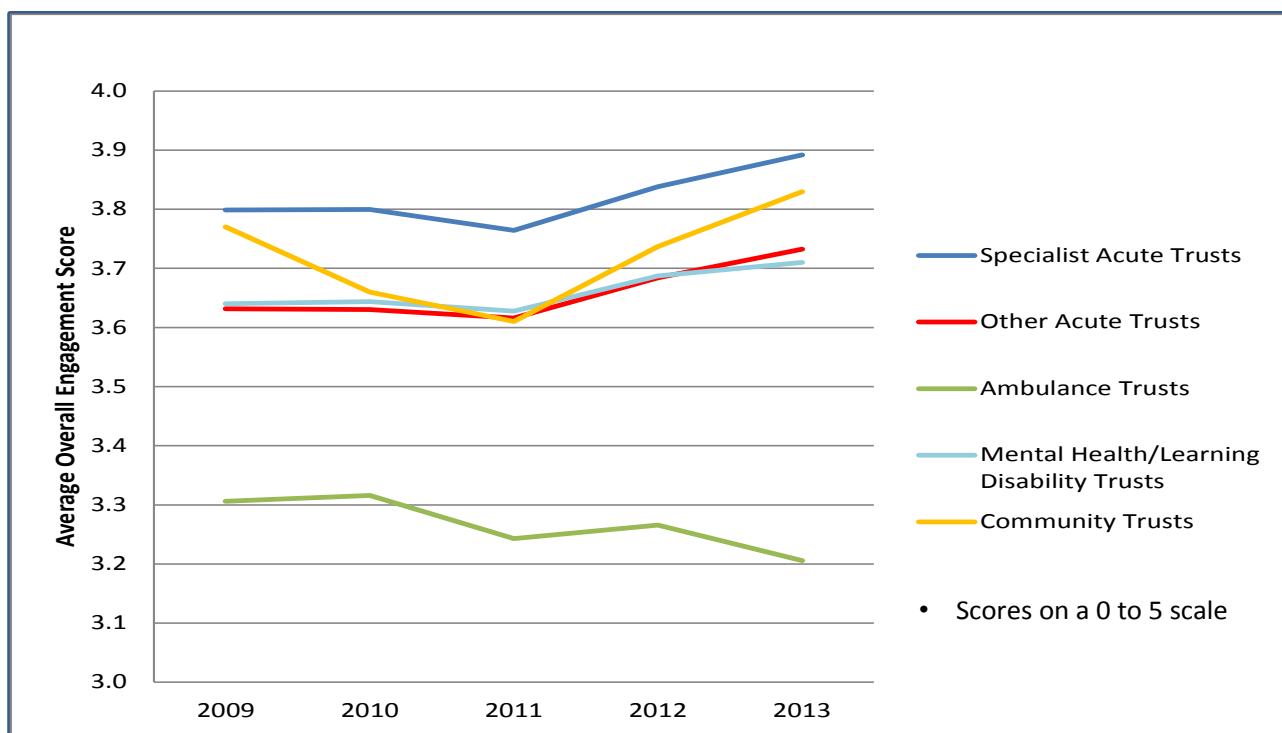
Figure 6: Overall staff engagement score by quartile (2011 to 2013)



Levels of engagement in different types of services

38. Specialist Acute Trusts have consistently higher levels of engagement than other Trusts and Foundation Trusts in the NHS staff survey. Meanwhile, Ambulance Trusts have much lower levels of engagement.
39. The data from the staff survey does not demonstrate any clear relationship between levels of staff engagement and organisational size. However, almost all of the participants in the survey are large or at least medium-sized organisations. (Even Specialist Acute Trusts, while slightly smaller than most Acute Trusts, have an average of more than 150 beds.) It is unclear from the survey whether being a much smaller provider is associated in itself with higher or lower levels of engagement.

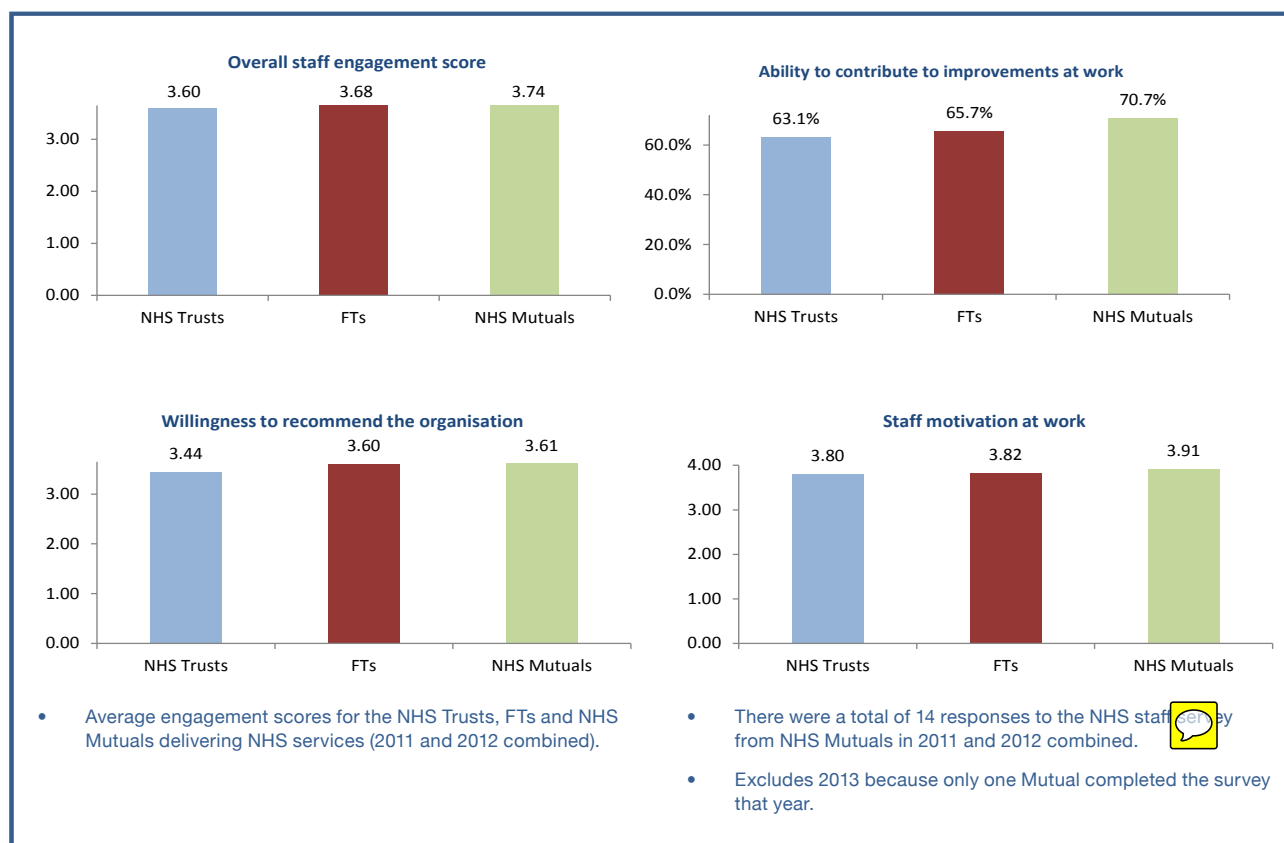
 Figure 7: Staff engagement scores for different types of NHS service



Levels of engagement in different types of NHS provider

40. Data from the NHS staff survey shows that Foundation Trusts outperform Trusts on staff engagement, but the differences between the two types of organisation are marginal and have not changed over time. We only have very limited comparable data on engagement within the mutuals delivering services in the NHS. Only a small proportion of these organisations have completed the NHS staff survey, with the majority preferring to carry out their own internal surveys. We have 14 data points for 2011 to 2012 inclusive. These mutuals show levels of engagement above the average for both Foundation Trusts and Trusts, with slightly higher levels of motivation at work and more substantial increases in the proportion of staff who believe they can contribute to improvements in work. While the differences appear to be small, we know from West and Dawson's work that differences of this magnitude in levels engagement are expected to have a discernable impact on measures of performance.

Figure 8: Average engagement scores for NHS Trusts, Foundation Trusts, and mutuals delivering NHS services (2012 to 2013)



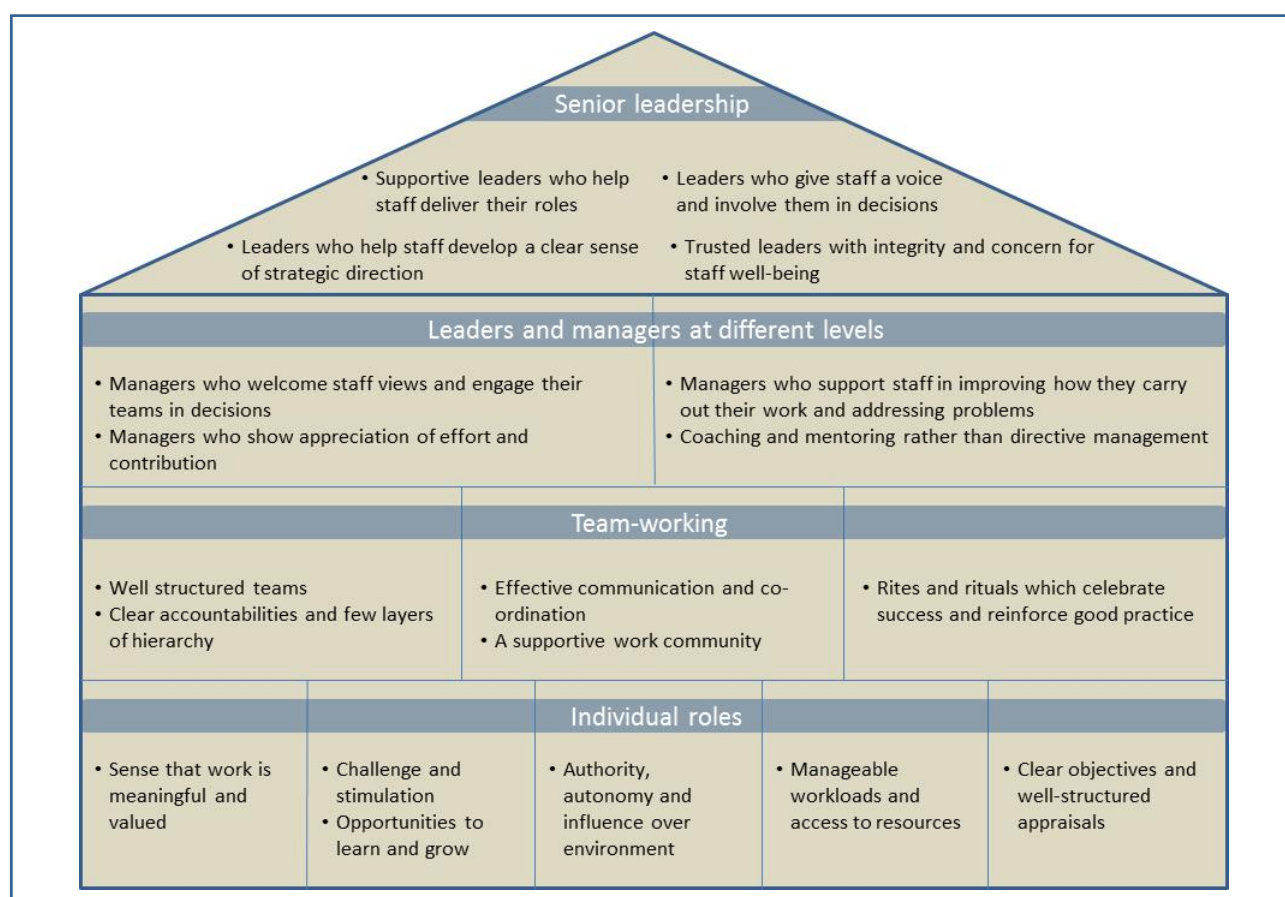
41. Some public service mutuals delivering NHS services shared with us the results of in-house staff surveys, which showed significant increases in levels of engagement in their first few years of operation. For example, one organisation demonstrated an 18% increase in the number of staff recommending the organisation as a place to work, and a 13% increase in staff feeling satisfied with the extent to which the organisation valued their work.
42. Research conducted for the Cabinet Office also suggested an increase in staff engagement following the transition, with the vast majority of organisations included in the study reporting lower levels of sickness absence and lower staff turnover in their new structures.¹⁶ While we cannot use this data to make precise comparisons between mutuals and other providers, it confirms the impression of improvements in levels of engagement after the transition to the new model.

¹⁶ Boston Consulting Group (March 2013)

Developing high staff engagement across the NHS

43. There is already a body of evidence from the NHS and other sectors on the types of behaviours, structures and processes that influence engagement. One message from this work is that achieving high engagement depends on sustained effort throughout an organisation including, potentially, changes to leadership styles, team behaviours, individual roles and HR practices. Our discussions with providers during the review highlighted a number of themes which appear particularly important in the NHS. These relate to: the roles of leaders; the authority given to frontline staff; the importance of values and integrity; and the need for a degree of stability and continuity for leaders and staff to develop a high engagement model.

Figure 9: One model for a highly engaged organisation

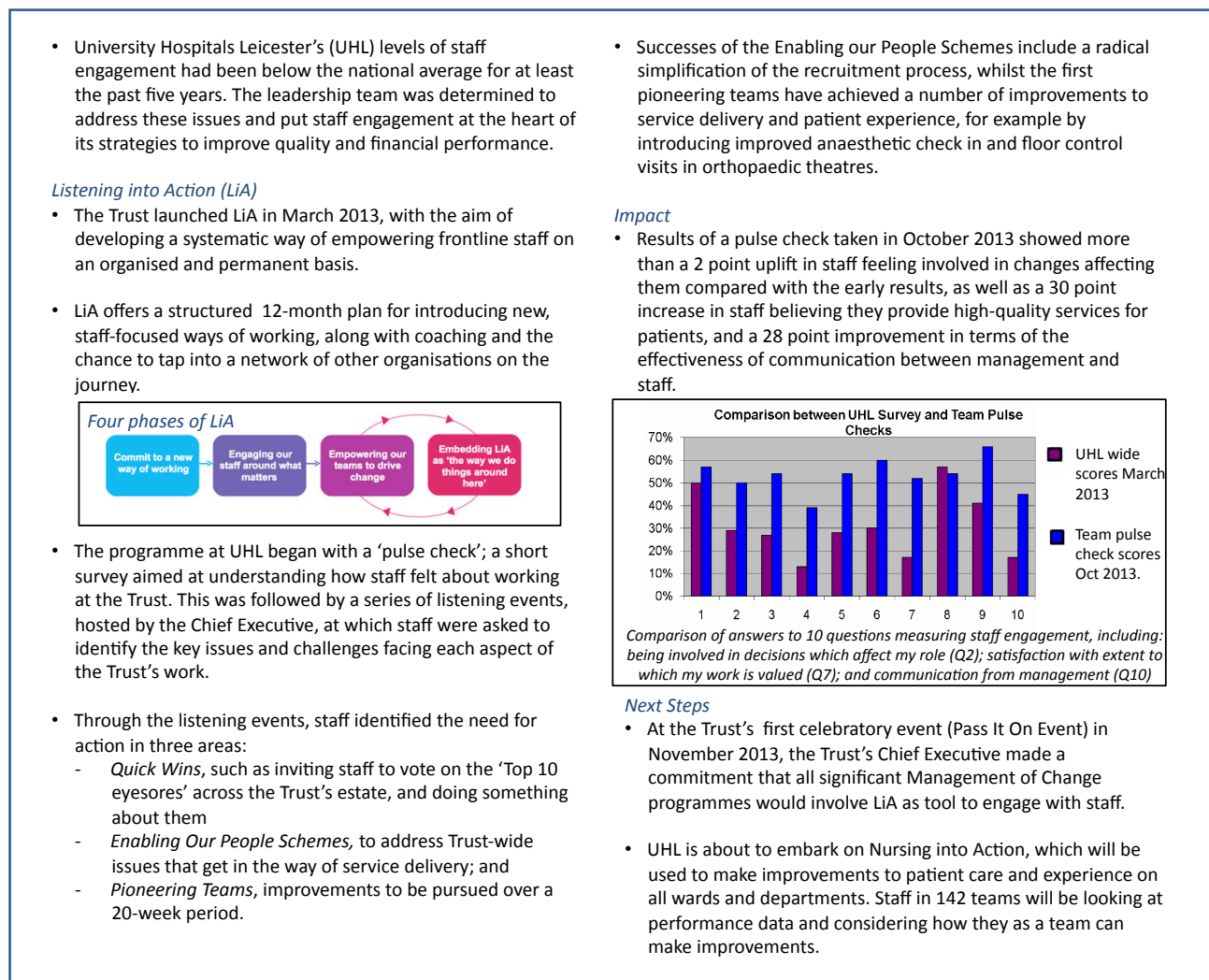


Developing a shared strategic direction

44. Many successful leaders have involved staff in developing a compelling strategic narrative and shared objectives for the organisation. In some cases, there has been a conscious shift away from developing a vision at the top, for diffusion to staff, in favour of bottom up processes which allow staff to identify the organisation's challenges and devise the right approach for addressing them (see figure 10 on

University Hospitals Leicester's experience below). According to one interviewee, the aim was to break down barriers between leaders and staff and create a social movement to deliver the strategy.

Figure 10: Listening into Action at University Hospitals Leicester NHS Trust



Supportive and inclusive leadership styles

45. Studies have shown that NHS leaders favour pace-setting styles, typified by leading from the front and laying down demanding targets, often combined with a reluctance to delegate and a lack of focus on collaboration.¹⁷ There may be a place for these styles in some circumstances, but we know that leadership styles which undermine employees' sense of authority and autonomy in their roles run the risk of disengaging staff. According to the Commission on Dignity in Care for Older People, this top-down culture contributes directly to poor-quality care: 'If senior managers impose a command and control culture that demoralises staff and robs them of the authority to make decisions, poor care will follow'.¹⁸

¹⁷ Storey and Holti (2013)

¹⁸ Local Government Association, NHS Confederation, Age UK (June 2012)

46. The most successful leaders deploy a range of leadership styles depending on the circumstances, but with less reliance on directive or pace-setting styles, and greater reliance on affiliative and coaching styles, where the focus is on building a consensus in favour of change and supporting staff at different levels in implementing it. Many of the NHS organisations with the highest levels of staff engagement have made a conscious decision to develop these more inclusive and supportive leadership styles. For example, both Salford Royal NHS Foundation Trust and Oxleas NHS Foundation Trust have invested significant resources in coaching and mentoring schemes.

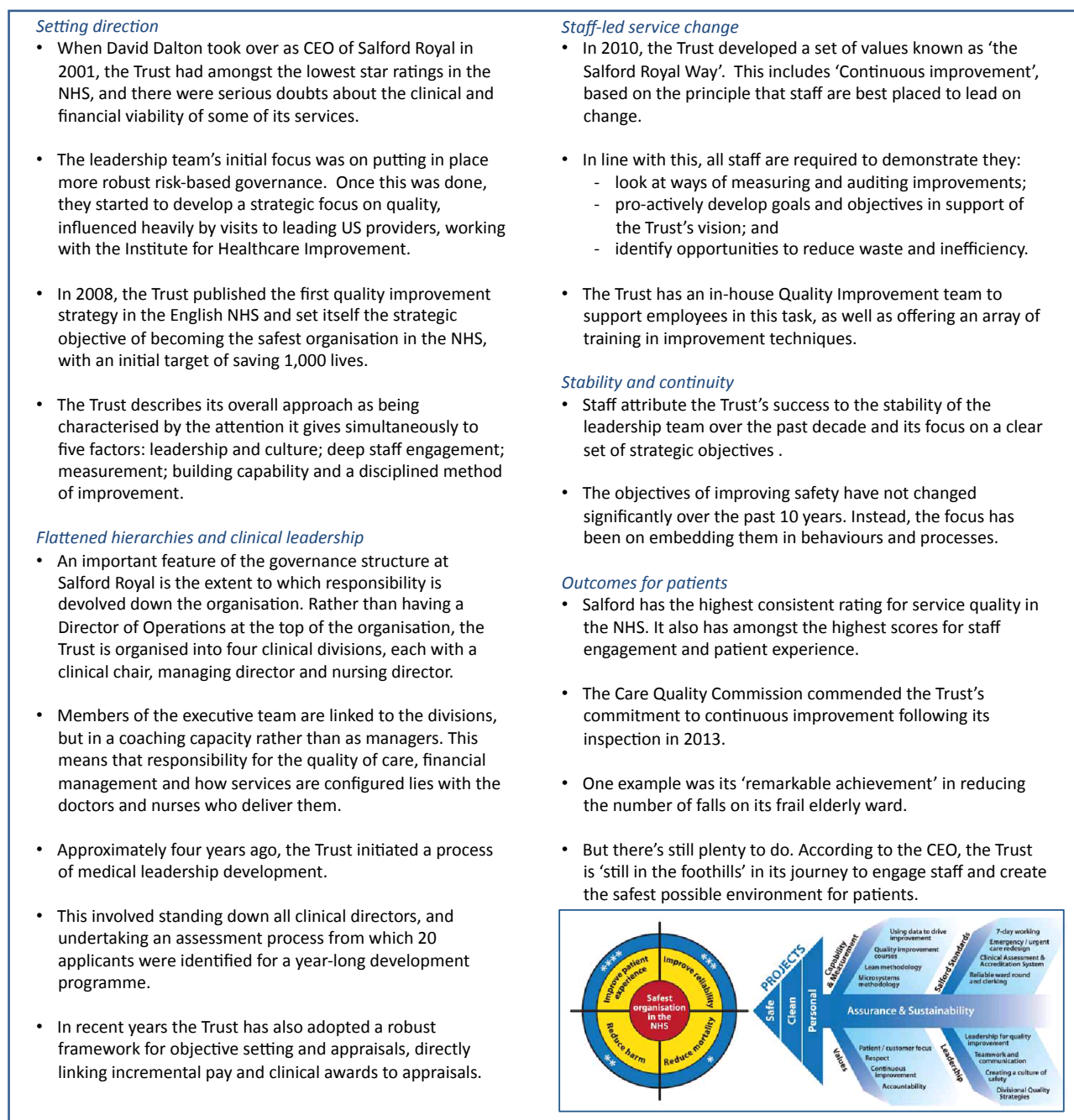
Distributed leadership and devolved decision-making

47. As part of the review, staff reported their frustrations at working in overly bureaucratic environments with multiple layers of hierarchy and control. At one Trust, staff shared the difficulties they had faced in gaining approval to hire air conditioners to improve ward conditions during a recent heatwave. The business case for what was a very small amount of money required approval from three separate committees, and the heatwave was over well before all the necessary permissions had been gained.
48. Almost all of the successful NHS providers we talked to during the review had at some stage made a concerted effort to devolve decision-making and accountability for performance to the staff responsible for delivering services. (See figure 11 for an overview of Salford Royal NHS Foundation Trust's approach.) This is in line with research showing that staff are more engaged when they work within flatter hierarchies, as well as research showing that hospitals that give clinicians and staff greater autonomy deliver better care and higher productivity.¹⁹
49. There is no single blueprint for delivering the change. However, many successful providers of NHS services have removed layers of control either at the top or middle of their organisations. Many have also attempted to break down the divisions between clinicians and managers, either by creating paired teams of clinicians and managers, or by training clinicians to take on combined clinical and management roles. (We know that doing so is a powerful strategy for achieving higher levels of medical engagement, another powerful contributor to better outcomes.²⁰) In most cases, successful Trusts have devolved budgets to lower levels. Some have created more fully autonomous groupings within large organisations.

¹⁹ See for example, Dorgan *et al* (2010)

²⁰ See for example, Ham and Dickinson (2008)

Figure 11: A clear focus and flatter hierarchies at Salford Royal FT



Supporting staff in leading service transformation

- As part of this devolution, successful providers have introduced programmes to support frontline staff in delivering service transformation. In many cases, there has been a conscious decision to move away from top-down change management, such as bringing in external teams to re-design a service or develop a blueprint for frontline staff to follow. However, as Don Berwick's report²¹ on patient safety explained, frontline staff need career-long support to learn, master and apply modern methods of quality improvement.

²¹ National Advisory Group on the Safety of Patients in England (2013)

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51. For example, Salford Royal NHS Foundation Trust puts together teams of frontline staff from across division boundaries to lead service improvement activities as part of its four-year quality improvement strategy. Staff are supported by the Trust's Performance Improvement Directorate which provides expertise specifically in how to trial and validate proposed improvements. Circle's Academy delivers a similar role, developing the leadership skills and technical expertise for staff to test and implement service change, as in the work being done at Hinchingsbrooke NHS Trust.
 52. Other Trusts have brought in outside help to support service transformation, but in ways that support rather than disempower frontline staff. For example, Wrightington, Wigan and Leigh NHS Foundation Trust has worked in partnership with Unipart to deliver programmes to reduce reliance on temporary staff, reduce sickness absence and improve hospital theatre productivity. The focus is on supporting staff with the tools, techniques and resources to design and implement changes rather than imposing solutions.

Figure 12: Involving staff in service change at Wrightington, Wigan and Leigh NHS Foundation Trust

- The staff engagement journey at Wrightington, Wigan and Leigh NHS Foundation Trust (WWL) started more than 15 years ago, and has involved different approaches:

Staff Involvement Delivers (SID)

- Jointly developed by the Trust's Human Resources department and Staff Side, this involved 'Conversations with Directors' events in which staff could raise issues and Directors respond, and walkabouts, giving Directors the opportunity to integrate with frontline staff, and staff opportunities to talk to the senior team.

Listening into Action (LiA) programme

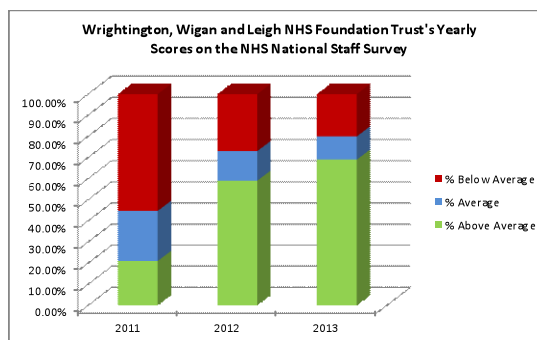
- This included large-scale staff listening events, led by the Trust's Chief Executive and other Directors, to provide a focus for quick-win and bigger system changes aligned to the needs of staff.
- LiA also initiated a 'Pioneer Teams' programme aimed at embedding staff engagement at team level, with staff running their own listening events and implementing changes locally.

Unipart

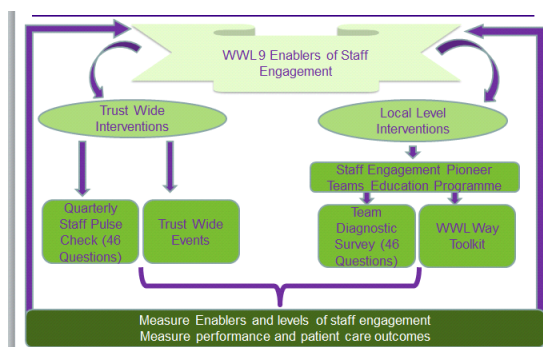
- Unipart's approach seeks to unlock the potential of employees so that they are not only a source of information, but set the tone for the organisation.
- WWL's Trust's partnership with Unipart is helping it to develop lean ways of working through team communication cells, visual management tools and a strong emphasis on metrics and devolved problem-solving.
- Teams are encouraged to come together for 15 minutes a day to discuss their priorities, give updates, address issues and to celebrate successes.
- They also record their progress visually at a central point visible to the whole team.
- For example, the World Class Theatres Project has resulted in a £121k cost improvement and a 22% reduction in clinical cancellations, as well as an increase in staff satisfaction.

'The WWL Way' and future plans

- The Trust has now combined these different but complementary approaches into its own unique brand of staff engagement – 'the WWL Way'.
- The impact of the WWL Way is clear. In addition to major improvements in the Trust's staff survey scores, it has seen significant reductions in sickness absence (from 4.62% in April 2012 to 4.17% in Dec 2013) and expenditure of temporary staff (from £15m in 2011/12 to £12m in 2012/13)



- Building on its experience, the Trust has developed a framework for understanding the enablers of staff engagement more deeply.
- This involves measuring several factors such as working relationships, staff recognition, personal development and mind-set to help identify factors which may be driving or inhibiting engagement in a particular area.



- The Trust also uses feedback from its staff pulse check surveys and listening events to focus efforts, and respond to changing staff engagement needs.
- For example, it is currently exploring with staff how to improve recognition and reward.
- WWL is clear about the need to continually develop its approach to staff engagement. The Trust recently launched six new values, developed through conversations with staff, as part of a wider strategy for organisational development, and is aligning staff engagement to these values.
- WWL has seen one of the largest increases in levels of engagement over the past four years, with its overall engagement score of 3.53 in 2009 rising to 3.81 in 2012/13.

Cultures based on values and integrity

- Leaders and managers at different levels have a central role to play in creating the right cultures for maintaining an engaged workforce. Research from a range of industries has highlighted the need for staff to have confidence in the integrity of their leaders, the fairness of their organisations' procedures, and to feel valued and supported at work. Conversely, we know from the NHS staff survey that staff are more likely to want to quit in organisations where there are high levels of perceived bullying or discrimination.

54. The leaders of many providers with high levels of engagement are focusing on how to embed the right values within their organisations, sometimes through mission statements or articulating their standards, but also through their objective setting and appraisal processes and the rites and rituals for celebrating success. Some such as Salford Royal NHS Foundation Trust and Oxleas NHS Foundation Trust are also focusing on how to reduce levels of perceived staff bullying, suggesting there is scope for improvement even in some of the most successful NHS providers.
55. One test of culture is how leaders and staff react when things go wrong. We know that staff are more engaged if they feel they are working in a supportive work community. Don Berwick's report argued for leaders across the NHS to abandon blame as the response when there are failings in patient safety. Some of the providers we visited, such as Hinchingsbrooke in its partnership with Circle (see figure 13), were developing more open procedures for reporting errors and actively supporting staff who raised concerns, so that mistakes became an opportunity to engage staff in learning and service improvement.

Figure 13: Stopping the line at Hinchingsbrooke NHS Trust

<p><i>'Stop the line'</i></p> <ul style="list-style-type: none"> Hinchingsbrooke's Stop the line initiative gives staff at all levels the right and the duty to stop procedures to protect safety. The slogan is borrowed from Toyota, where every worker on the shop floor has the power to bring the production line to a halt if they sense any risk to safety. The aim is to empower frontline staff across the organisation to take a zero-tolerance approach to medical errors, and to create a culture in which all staff hold themselves and each other to account for improving care. <p><i>The process</i></p> <ul style="list-style-type: none"> The principles of Stop the line are very simple. Any member of staff, at any level, has the right to stop procedures if there is a risk of any patient harm. If staff 'stop the line', the CEO, Medical Director and Nursing Director are informed immediately. If there is a false alarm, the individual who 'stopped the line' is never blamed. Within 24 hours, the clinical team must report to the CEO and decide what action to take. Within 25 days, clinicians must discuss the report and decide what permanent changes need to be made. The Trust offered Stop the line training in May and June 2012 and appointed 70 Stop the line champions to coach and inform their colleagues. 	<p><i>Stop the line in action</i></p> <ul style="list-style-type: none"> Two weeks after the initiative was launched, staff saw the first proof of Stop the line in action: <ul style="list-style-type: none"> A junior nurse interrupted a major abdominal surgery because she insisted a swab had been left in a patient. The lead consultant had already carried out additional tests and had decided to close the patient. But the nurse nevertheless had the right to stop the line. A radiographer was called who carried out further tests. The missing swab was eventually found behind the patient's liver. Stopping the line prevented a 'never event', one which would have put the patient at serious risk, required additional surgery and imposed significant associated costs. <p><i>The impact so far</i></p> <ul style="list-style-type: none"> Staff at the hospital talk of the impact that this and other early decisions to stop the line had on attitudes in the hospital. They proved that staff at all levels really did have the right to intervene to protect patients, even if this meant challenging the views of more senior staff. They also give senior leaders an opportunity to prove that they really were committed to swift action to improve safety and to celebrating those who spoke up rather than silencing them Staff have stopped the line a further [xx] times since the process was introduced. The Trust sees Stop the Line as one of the main reasons for a 50% drop in serious incidents in its first year. Engagement scores have also risen, although they still remain slightly below the NHS average.
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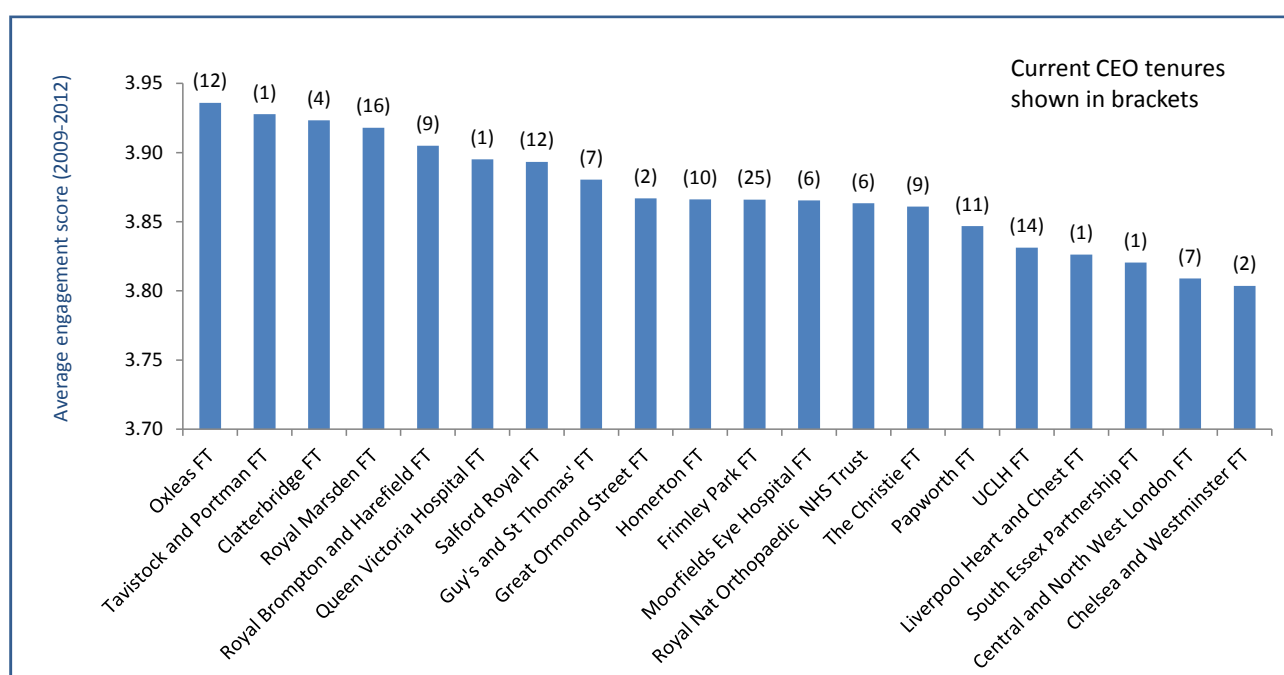


The Stop the line logo, seen throughout the hospital

Stability and continuity

56. One recurring message from the review was the importance of a degree of stability and leadership continuity in developing an engaged workforce. The CEOs of the 20 Trusts and Foundation Trusts with the highest levels of engagement have been in place for an average of just under eight years. However, the average from this snapshot is skewed by a small number of recent leadership changes. In many cases, as shown below, CEOs in the top 20 have been in post for much more than a decade. This is important in enabling leaders the time to make the changes necessary to reach and sustain high levels of performance in organisations like large acute hospitals and diversified community services which tend to be more complex than many of the organisations found in other sectors (see figure 15 for a case study of the role of leadership continuity at Frimley Park Hospital NHS Foundation Trust.)

Figure 14: CEO tenures for the 20 NHS Trusts and FTs with highest staff engagement scores²²



57. By contrast, we know that the average tenure for CEOs of Trusts and Foundation Trusts is much lower and, according to some research, less than two years.²³ Many of the providers in greatest difficulty have struggled to appoint permanent CEOs at all, relying instead on a succession of interims on short-term contracts. Interims have also been used to fill other executive director roles in NHS organisations reflecting the shortage of well-qualified candidates for these roles and the failure of talent management and succession planning in parts of the NHS. The implication of

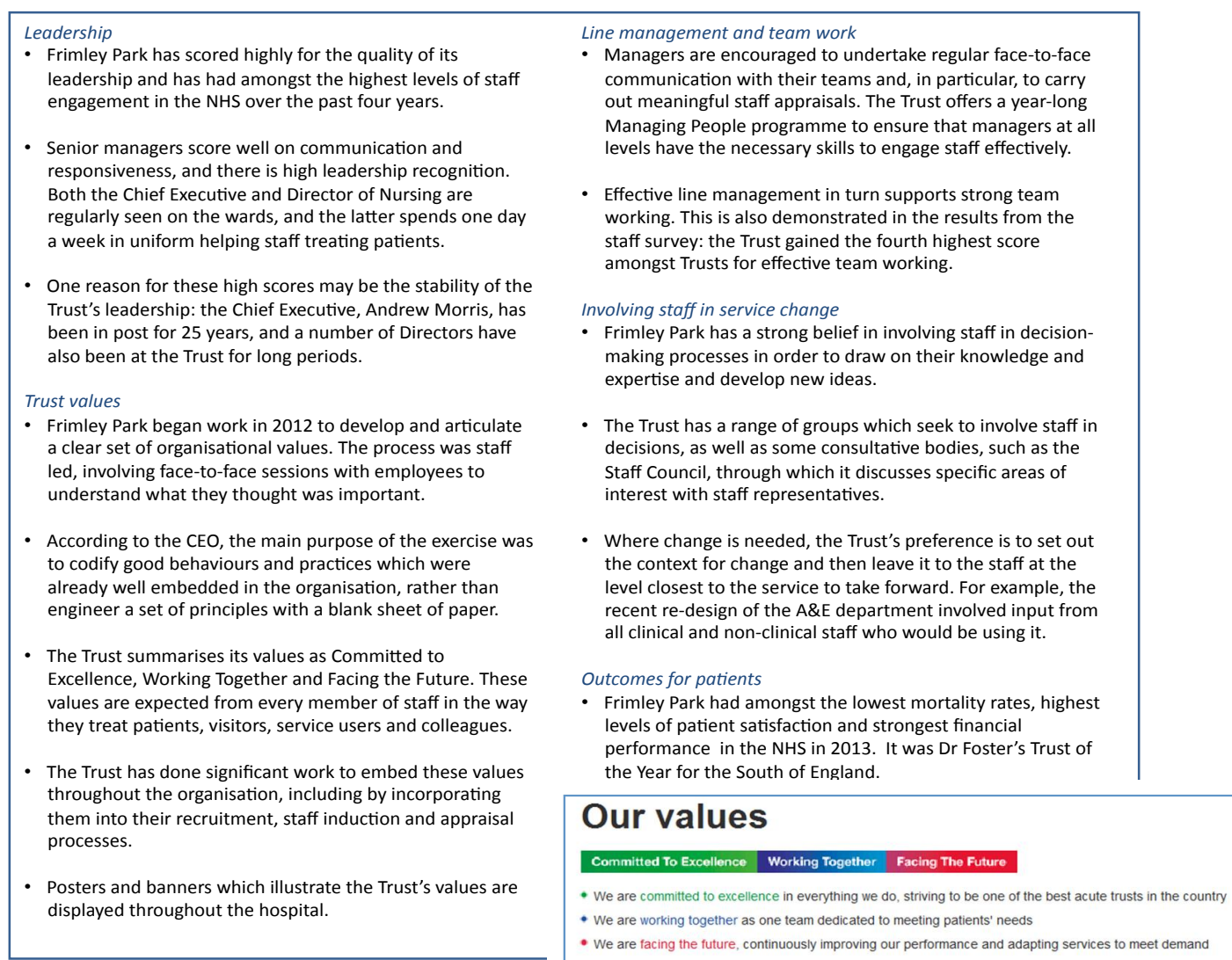
²² The 20 Trusts are those with the highest average engagement scores for 2009 to 2012. Information on CEO tenures taken from the Trusts' websites

²³ Hoggett Bowers (June 2009)

rapid turnover and interim appointments is that these providers are unlikely to have sufficient stability and continuity to develop high engagement practices.

58. This relationship between leadership stability and levels of engagement is consistent with other research on the importance of long-serving leaders for performance.²⁴ The Panel sees an urgent need for greater stability and continuity across the NHS and in particular within those providers facing the greatest challenges. The NHS needs to recognise that many of the most challenged Foundation Trusts and Trusts face long-standing and deep-seated challenges, many arising from within their wider health and social care economy, that will take a considerable amount of time to address. A third of new CEOs report that they received no support when taking on their roles.²⁵ Newly appointed CEOs in challenged organisations also need to have support available from experienced coaches and mentors.

Figure 15: Stability and values at Frimley Park Foundation Trust



²⁴ Baker (2011)

²⁵ Capita and Veredus (2012)

Stronger governance and clearer accountabilities

59. As part of the review, we visited a number of new staff-owned and led public service mutuals in the health and care sectors. Recurring themes from those we met included the sense of liberation in owning and running their own services and the impact of new ownership and governance structures on behaviours throughout these organisations. While it is clear that enlightened leaders have been able to develop high engagement cultures within many types of NHS providers, the emerging evidence from mutuals delivering NHS services, supported by evidence from mutuals within other sectors, suggests that ownership and governance also play a valuable supporting role.

The Foundation Trust governance model

60. The last Labour Government's initial plans for Foundation Trusts were strongly influenced by stakeholder theories of corporate governance and 'modelled on co-operative societies and mutual organisations'.²⁶ The original conception was to increase the autonomy available to their leaders and shift the locus of direct accountability to staff, patients and other local stakeholders, as well as to national regulators and their commissioners, in place of the traditional accountability of NHS organisations to the Secretary of State for Health.
61. An explicit purpose of Foundation Trusts was to strengthen their links with local communities through membership of Trusts, thereby introducing elements of mutuality into the mainstream of the NHS. According to Alan Milburn in 2002, 'There is a well-established tradition of co-operation and mutualism, which is at the heart of the founding of our party and the wider labour movement. In terms of their governance [Foundation Trusts] will be firmly grounded in those traditions. They will be owned and run by members of the local community'.²⁷ Hopson and Morgan have recently articulated some of the benefits that have resulted from the introduction of Foundation Trusts.²⁸
62. Acknowledging these benefits, the performance of Foundation Trusts varies and they have experienced many of the same difficulties as Trusts in delivering acceptable standards of care within budget. Foundation Trusts have also found themselves subject to a greater degree of scrutiny and intervention by national bodies than expected, restricting their autonomy and leaving limited space to develop the accountability to local stakeholders that many hoped for. This reflects in part the political compromises that accompanied the creation of Foundation Trusts whose independence was constrained from the outset. It also reflects the difficulty for

²⁶ Department of Health (2002)

²⁷ Hansard (2002)

²⁸ Hopson and Morgan (2014)

politicians in ‘letting go’ when they retain accountability to Parliament for the overall performance of the NHS. Increasing financial and service pressures have resulted in regulators tightening their grip on both Trusts and Foundation Trusts.

63. Employees have a formal role in the governance of Foundation Trusts to the extent that they elect a number of representatives to provide a staff voice on the Council of Governors. However, staff typically represent a small proportion of the Council. This means that their influence is unlikely to be comparable to successful public service mutuals, and other mutuals such as John Lewis Partnership, where staff representatives play the primary role in holding the board to account, for example, by voting annually on the performance of the Chairman and whether he should continue in role.²⁹
64. Reviews have suggested that staff and other governors in Foundation Trusts may struggle to exercise significant influence. For example, research by the London School of Hygiene & Tropical Medicine found that the skills of staff members and governors were under-used in Foundation Trusts’ governance structures.³⁰ Monitor’s review of Foundation Trust governors in 2011 suggested that only 10% of the staff members were ‘active members’ of the organisation.³¹ (We note that there is now a requirement under the 2012 Act to develop Foundation Trust governors’ capability, and that the Foundation Trust Network’s GovernWell programme is helping Foundation Trusts to do this.)
65. Monitor continues to oversee the governance of Foundation Trusts, in addition to its regulatory functions in relation to the full range of NHS providers. This includes powers to issue directions, appoint interim directors, and to suspend, dismiss or disqualify directors. On leaving Monitor in 2010, its founding chair, Bill Moyes, suggested that strong continuing relationships with central Government limit Foundation Trusts’ ability to innovate.³² His views are echoed in independent research which suggests that Foundation Trusts have found it difficult to exercise greater autonomy, possibly as a result of continued central control and unclear policy and financial regimes.³³
66. During our review, Foundation Trust leaders described the disempowering effect of the degree of regulatory scrutiny that they currently experience. They also gave examples of continuing to be part of the performance management regime in the NHS, for example, by being required to submit information on performance to NHS England in response to concerns in government about areas of care such as access

²⁹ We note that current government policy acknowledges similarities between Foundation Trusts and mutuals but does not consider Foundation Trusts to be public service mutuals (See, for example, Francis Maude’s speech to the Foundation Trust Network of 17 May 2012.)

³⁰ Allen *et al* (2012)

³¹ Monitor (2011)

³² Timmins (2010)

³³ Exworthy, Fosini and Lorelei (2011)

in A&E departments and recruitment of key groups of staff like health visitors. We would add that Foundation Trusts have not always made the most of the opportunities available to them to innovate, for example, through varying staff terms and conditions. It is therefore timely to consider how the undoubted achievements of Foundation Trusts might be consolidated and extended by continuing the journey of mutuality that started in 2004.

Governance in the mutuals delivering NHS services

67. The leaders we interviewed from amongst the 40 new mutuals delivering services in the NHS reported that they were accountable first and foremost to staff and to other stakeholders. Staff in these organisations, usually constituted as community interest companies, typically own a nominal ownership stake, such as a £1 share, and have a strong governance role, including rights to appoint a proportion of the non-executives, to determine board members' pay, and to dismiss the Chair or CEO if a significant majority vote in favour.
68. Most of the new mutuals we spoke to also actively involve other stakeholders in governance. At Navigo, for example, the non-executives include a staff representative, a community representative, a local councillor, and the CEO of the local hospital. At Spiral, the board includes two staff representatives, a director of the local acute hospital, and two public representatives. In community benefit societies, patients and other stakeholders may be eligible, along with staff, to become members of the mutual and to sit on the council of governors. At Care Plus Group, the governors include eight staff representatives, two local councillors, two volunteer representatives and two public representatives.
69. The leaders of these mutuals argued that these ownership and governance arrangements had fundamentally altered their relationships with staff and other stakeholders. The governance system helped to ensure a continued dialogue with staff on strategic direction and to underpin more inclusive ways of working throughout the organisation. See figures 16, 17 and 18 for a discussion of the impact of governance on behaviours and performance at Care Plus Group, Bromley Healthcare and City Health Care Partnership. The testimony we heard suggested that it felt quite different to working within an NHS organisation where hierarchical controls and upwards accountability were strong.
70. As part of the review, Sir Charlie Mayfield described the virtuous circle in the John Lewis Partnership where engaged staff deliver great customer service which in turn produces good results from which staff benefit through annual profit sharing and other rewards. Mutuals delivering NHS services have not usually chosen to reward staff financially through a dividend when they make a surplus, although they have

recognised employees' contribution in other ways. Nevertheless, it was clear that many staff do have a strong emotional and psychological sense of ownership of their organisations. As co-owners, they felt a much stronger right to express their views about the organisation's challenges and an obligation to participate in addressing them. They also reported a much greater sense of empowerment to raise and resolve problems and find innovative solutions.

71. This is supported by the emerging evidence that many of the mutuals created under Transforming Community Services are achieving higher levels of staff engagement, lower absenteeism and lower staff turnover. We cannot, as yet, isolate the precise impact of their ownership and governance on levels of engagement. There might be other reasons, unrelated to ownership or governance, such as benefits for some services in operating within smaller, more manageable organisations with a clearer focus, rather than as small services lost within very large providers. It is also too soon to be sure that these higher levels of engagement will be sustained over time. Nevertheless, the early experience of these mutuals indicates that this is a model that deserves wider application and testing.

Figure 16: Staff ownership, behaviours and performance at Bromley Healthcare

- Bromley Healthcare was created on 1st April 2011, as an NHS spin out, and a mutual. Approximately 750 staff moved across from the PCT without incident due to the efforts of those leading the 'right to request' to seek broad support from staff at the beginning.

Our values and our story

- From the start, the organisation has sought to retain the best of the NHS (a focus on patient care) but to modernise in every possible way to be safer, more effective and more efficient.
- This has meant a huge amount of change for a staff group unused to it. This has been done partly through systems and processes. For example, there has been a very deliberate effort to give staff true accountability for their services, and a huge push on getting information on performance (down to an individual clinician level).
- More importantly, there has been a concerted effort to continually talk to staff about the situation Bromley Healthcare is in (a competitive one!). Not only has this meant a huge amount of visible leadership, but also the creation of a story about the organisation that makes sense to staff. Bromley Healthcare continuously tells its staff a simple story - that in a competitive world each individual must seek to do three things:
 - To continually improve the services
 - To treat people as they would like to be treated themselves
 - To hit targets
- The organisation is clear that if all staff do this every day, it will provide great services to our patients and prosper.
- Although talking to staff isn't easy, Bromley Healthcare believes it is fundamental. It takes time, and a variety of approaches, for example, from an anonymous on line forum with the CEO, to staff governors to represent staff views.

Ownership and governance structures


- 85% of staff have signed up for shares in Bromley Healthcare. Surpluses have been used to build up reserves (the organisation started without any) and to reinvest in services. For example, £50k is put into an equipment fund each year, and staff bid for funding from it for equipment they want.
- There are three main groups involved in the governance of Bromley Healthcare - staff shareholder, council of Governors, board of Directors

Flexibility of the mutual model

- According to Bromley Healthcare, the mutual model has given the organisation the **freedom** to write the rules of the organisation from scratch – it has not had to follow a template, and isn't weighed down by expectations of how things are done. For example, the organisation is actively hiring people without NHS experience to increase the diversity of its workforce. It is also actively looking at international best practice to see what can be learnt from abroad.

Performance

- Bromley Healthcare's performance has improved dramatically (and it aims to improve more). For example – leg ulcer healing rates down from 21 weeks to 5, productivity up by 20%, and "Did Not Attend" at clinics down (through active management) from 13% - 3.5%. The organisation has also been successful at winning tenders, with 16 new contracts awarded over a period of that last 18 months.
- In terms of staff engagement, Bromley Healthcare scores very similarly to the very best NHS organisations, and has achieved this whilst restructuring virtually every department in the organisation. The organisation believes that at all times, it is key to remember that it is people not structures that matter.



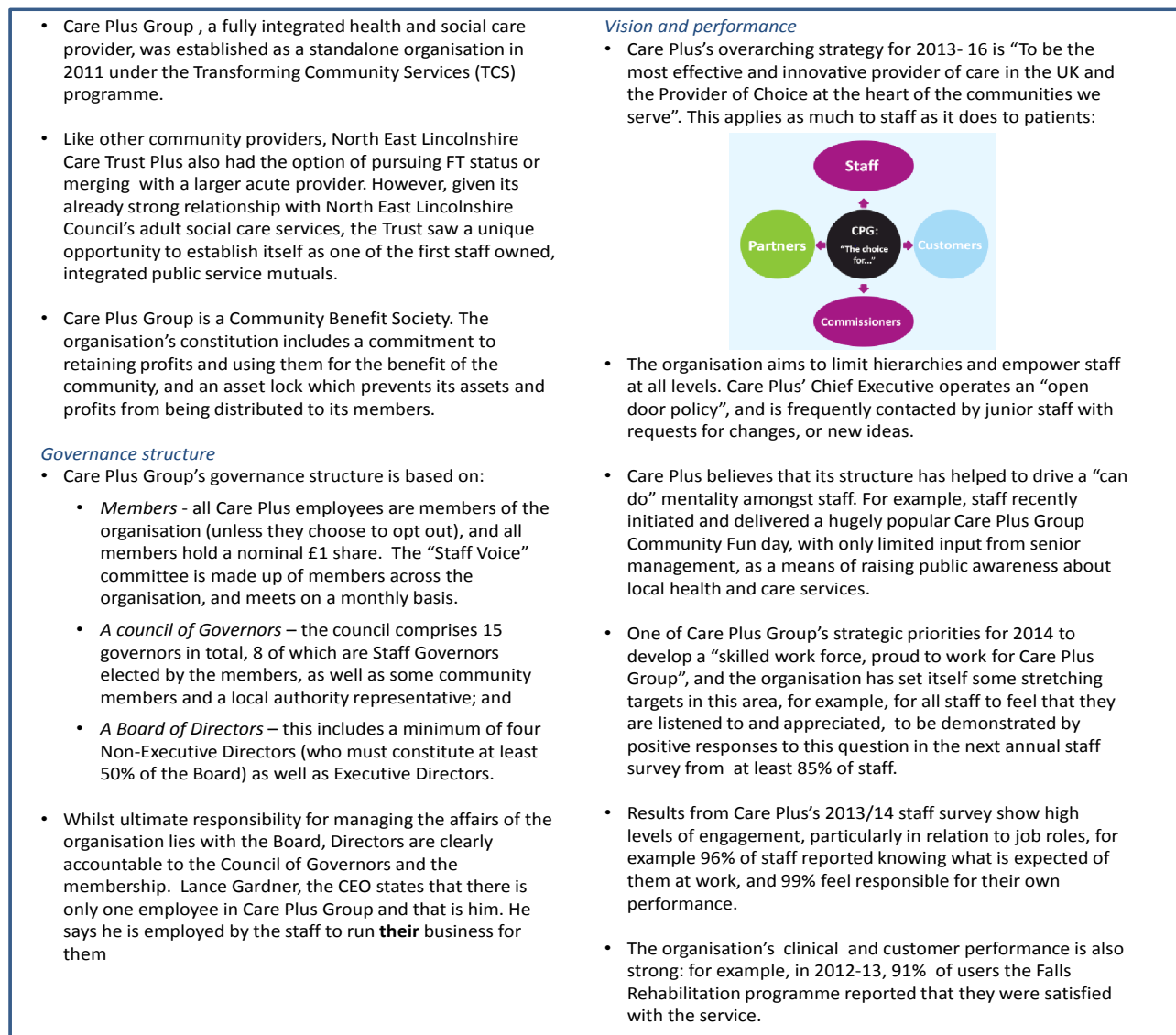
72. The emerging evidence from mutuals delivering services in the NHS is in line with data on the impact of staff ownership and staff-led governance in other sectors. Matrix Evidence's review found that employee commitment tends to be stronger in employee-owned businesses.³⁴ The Nuttall review of employee ownership highlighted the evidence that employee ownership leads to enhanced employee well-being, reduced absenteeism and greater innovation.³⁵
73. Cass Business School found that employee-owned firms were more resilient in the recent downturn, but only if employee ownership was combined with a meaningful staff governance role. It is perfectly possible to achieve high engagement in conventional firms as well as within Foundation Trusts and Trusts. But a strong staff role in governance appears to provide a particularly credible and stable foundation for developing good engagement practices in an organisation.

³⁴ Matrix Evidence (2010)

³⁵ Nuttall (2012)

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74. The Co-op's recent difficulties have highlighted potential risks of some mutual governance arrangements. Consumer-led co-operatives like the Co-op are of course different from staff-owned mutuals of the kind discussed in this report. Not only do customers typically have less at stake in terms of outcomes, but they are further removed from the day-to-day operation of the business, limiting their ability to identify and intervene when problems arise. This is fundamentally different to staff-owned and led mutuals, where employees are heavily invested in the service, feeding directly into the running of the organisation. Nonetheless, the Co-op's experience highlights some important issues for mutual governance arrangements, including the risk of ineffective staff representatives on the board and an inability to make tough decisions.
75. During this review, Sir Charlie Mayfield described the balance struck at the John Lewis Partnership which combines corporate discipline through a PLC-style board with effective staff governance. Successful mutuals need professional non-executives and appropriately selected and trained staff representatives (who do not necessarily need to be members of staff themselves), with powers to hold the board to account at particular points, but without the ability to overshadow it. They also need to ensure that the voice of customers and users is heard to avoid the risk of provider capture. Ensuring that the interests of patients and the public are taken into account in the governance of staff-owned mutuals is therefore essential.

Figure 17: Staff ownership, behaviours and performance at Care Plus Group



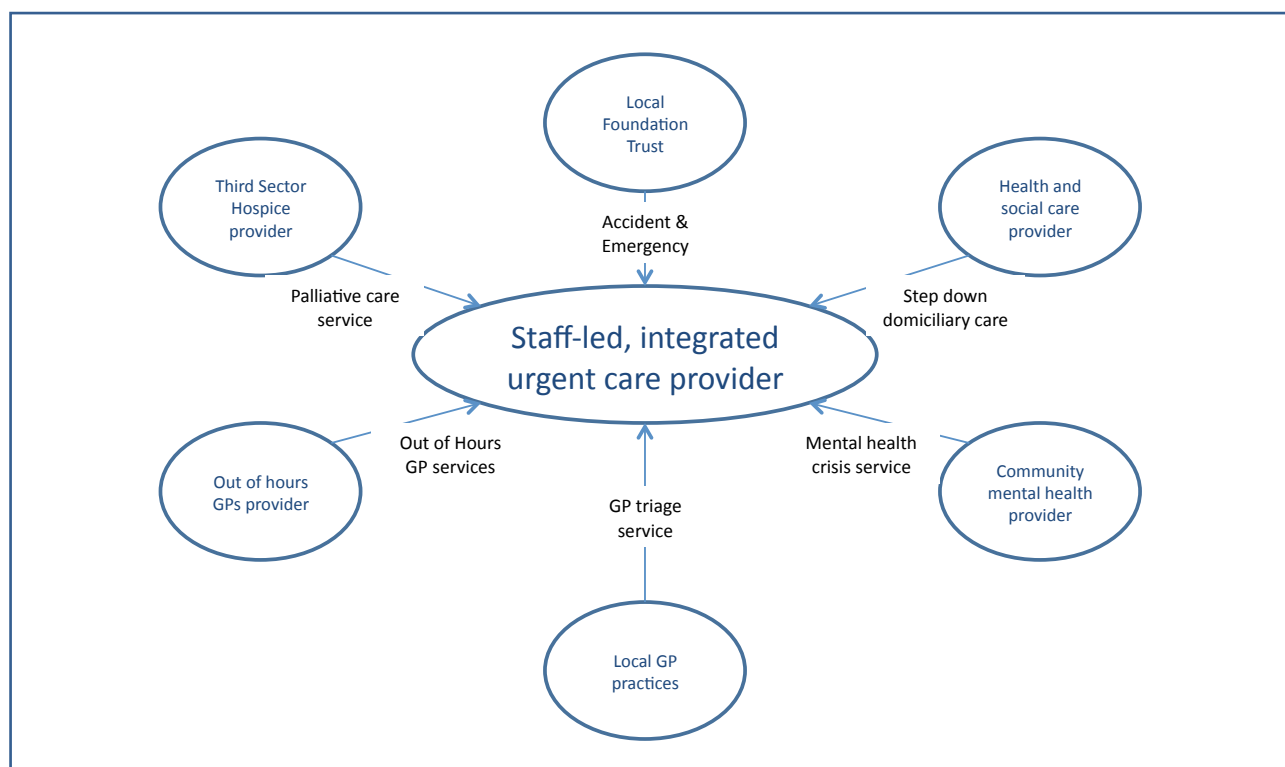
Alternative provider models in the NHS

76. As part of the review, we met a number of NHS leaders and staff who were interested in exploring these models. One possibility was for Trusts or Foundation Trusts to give staff a stronger voice within the Foundation Trust model, beginning with a clearer understanding of the freedoms that currently exist. For example, current or future Foundation Trusts might mirror more closely some of the arrangements in John Lewis or other successful mutuals, where staff nominate colleagues for election rather than putting themselves forward, where trained staff representatives sit on the board, and where the staff council holds the board to account.
77. Some of the leaders and staff we spoke to were interested in making a clearer break from Trusts or Foundation Trusts and following the path charted by mutuals, many of which are community interest companies or community benefit societies. There are

strong similarities between Foundation Trusts and community interest companies or community benefit societies, including the requirement to invest profits and use other assets to deliver the organisation's social purpose. However, these vehicles offer greater flexibility to model governance on successful mutuals and, potentially, scope to make reality of the aspirations to increase autonomy and change accountability arrangements that accompanied the creation of Foundation Trusts.

78. A number of those we talked to saw employee ownership as a way of bringing together services across traditional organisational boundaries. SEQOL in Swindon is a current example of a successful staff-owned and led mutual that integrates services from the NHS and social care. One provider we met had developed plans to bring together GPs, acute hospitals and community providers to deliver integrated mental health services. Another was developing plans to bring together GP practices, out of hours services, A&E and step-down services to create an integrated urgent care organisation. A further option would be to establish mutuals to provide services such as maternity care by bringing together services currently delivered through different organisations across a county or large city.
79. A particular attraction of employee-ownership and control in these mutual models is the opportunity to establish new organisations in which a number of partners such as councils, the NHS, GPs and the third sector have a stake, rather than any one organisation dominating or having to acquire others – an approach which we know to be fraught with difficulties in health and other sectors.

Figure 18: Model for a staff-led integrated urgent care provider



A proposed way forward

80. Given the current state of knowledge, the Panel believes that, as well as redoubling efforts within NHS organisations to engage staff more effectively, there should be greater freedom for organisations to become employee owned and led, on a strictly voluntary basis, where leaders and staff both have an interest in doing so. This should include allowing Foundation Trusts to vary their governance arrangements to include a stronger staff voice. It should also include allowing Trusts, Foundation Trusts or groups of services from these and, potentially, other providers, to become community interest companies, community benefit societies or similar organisations. If a Trust decided to pursue this route as an alternative to becoming a Foundation Trust, it should still be required to complete an appropriate authorisation process with similar rigour to the Foundation Trust authorisation process. This would require changes to existing legislation.
81. As discussed above, we only have limited data on the performance of the 40 mutuals delivering NHS services in their first few years. Moreover, we do not know how effective the model will be for much larger and more complex providers, including those delivering at least some monopolistic services with less threat of competition. The data from other sectors suggests that mutual governance models can be effective for a wide range of different companies including larger organisations,³⁶ although

³⁶ See for example, Fakhfakh, Perotin and Gago (2012)

the challenges of effectively engaging staff in the governance of mutuals appear to increase with size.³⁷ At this stage, we believe that the right starting point is to support a number of enthusiastic providers in trialling mutual models on a strictly voluntary basis as pathfinders, following detailed consultation and with the active participation of staff, staff-side trades unions and other stakeholders. Testing different models will shed further light on the impact of ownership and governance on levels of engagement and their effectiveness in different contexts, including in acute sector providers.

82. The leaders of enthusiastic Trusts and Foundation Trusts will need to dedicate significant resources to engaging with staff, developing their new models, and overseeing the transition. Cabinet Office currently provides guidance and support to services considering establishing themselves as public service mutuals through the Mutuals Support Programme.³⁸ Given the wider benefits of testing alternative approaches, we believe that the Government should make additional funding and support available for the pathfinders, building on the strengths of existing programmes, so that they can prepare effectively, engage closely with staff and staff-side trades unions, and access advice on the technical issues involved in transitioning to a new organisation form. It should make the lessons learned widely available so that others can replicate the pathfinders if they so wish.
83. We also see strong benefits in partnering the pathfinders with mutuals delivering services in the NHS and established mutuals from other sectors. These organisations are particularly well placed to coach NHS leaders in the different leadership styles and ways of working needed and to advise on governance models. Support and advice should be available to staff so that they can develop robust business cases. Those we spoke to were willing to provide this support.
84. The Panel believes that staff should be encouraged to develop their own plans for mutuals, where there is an interest in doing so, and to present them to their parent organisations. Trusts and Foundation Trusts should support staff groups wishing to develop proposals to create mutuals for specific services (as in the example of Spiral in Blackpool) and give serious consideration to their business cases. In doing so, they will need to consider a range of factors in reaching a decision, including the inter-relationships between different groups of services and the risk of care becoming fragmented.

³⁷ See for example, Lampel, Bhalla and Jha (2012)

³⁸ The Mutuals Support Programme is a £10 million fund which provides guidance and support to services and organisations considering spinning out. Support includes a resource-based website and two classroom-based training programmes. The fund is also used to procure access to detailed professional support to help new mutuals overcome the barriers to spinning out and develop the skills to succeed

Working with staff representative bodies


85. Trades unions have a well-established role in all NHS organisations, contributing to policy development and undertaking negotiations concerning local policies, terms and conditions, as well as in representing individual staff. Partnership working between the leadership and staff-side representatives within any organisational structure can lend significant strength to the processes of engaging staff. Wrightington, Wigan and Leigh NHS Foundation Trust (WWL) cites the establishment of a joint approach between staff side and management as an important factor in its success in engaging staff to date, and a fundamental part of the 'WWL way'.
86. In the context of exploring new ownership and governance models, early and regular engagement of staff representative bodies will be critical. Whilst our proposals do not conflict with the well-established role of trade unions, it will be important for local leaders to liaise closely with local union representatives as the evolution we have described progresses and in particular, to consider how new mutual governance structures which strengthen the role of staff can work in an effective and co-ordinated way with existing arrangements for staff representation and negotiation.

Changes to policy and legislation

87. Developments in government policy over the past few years have made it possible for staff in Trusts and Foundation Trusts to transfer to new organisational forms while retaining their current employment contracts and terms and conditions. Under the Government's New Fair Deal guidance, published in October 2013, staff whose employment is transferred from the public sector to independent providers of public services will also now have a right to continued access to relevant public service pension arrangements.
88. However, the Government will need to develop policy on a number of outstanding issues. First, it will need to decide whether to transfer property and other assets to new mutuals delivering NHS services. In community services, the approach has usually been for public sector property companies to retain the assets and lease them back to the new provider, and we heard mixed reports on how well this is working. It is unclear whether these arrangements will be suitable for acute hospital services which depend on a larger and more complex asset base. If it decides to transfer assets, the Government will need to decide whether to require an 'asset lock' restricting how profits or surpluses can be used and providing assurance to those with concerns that assets will be used for the public benefit.

89. The Government will also need to decide whether to offer acute sector mutuals access to public capital on the terms offered to Trusts and Foundation Trusts. It is unclear whether mutuals delivering acute hospital services would be able to make the appropriate investments for patients if they were required from the outset to raise capital from commercial investors at commercial rates. For one thing, there is no capital element to the tariff and the higher costs of commercial borrowing would not currently be reimbursed. In this context, we note that the Government has already intervened to address market failures and support existing public sector mutuals in accessing finance through the Social Enterprise Investment Fund and its successors.
90. It will be important to maintain a consistent and proportionate regulatory approach for all providers as a wider range of organisations deliver NHS services, in particular to maintain minimum quality standards, protect access to services, and protect patients' and taxpayers' interests in the event of failure. Public service mutuals delivering NHS services are, just like Foundation Trusts, subject to CQC oversight to maintain quality standards. Under the new system, they are also required to hold Monitor's provider licence and are subject to the continuity of service regulation within Monitor's licensing regime. If public service mutuals deliver 'Commissioner Requested Services', they will be subject, like Foundation Trusts, to regulation to protect patients' access to those services, including requirements to continue providing the services, restrictions on the disposal of assets and on borrowing.
91. Central Government and Monitor will also need to consider bringing new public service mutuals fully within the NHS special administration regime to protect patients and taxpayers in the event of insolvency. This will be necessary in any event, given that a more diverse range of providers, including some existing mutuals, are starting to deliver essential NHS services.
92. Finally, some interviewees during the review drew attention to the inconsistencies in the treatment of public service mutuals and public sector providers within the tax system, including in relation to corporation tax and VAT rebates. We note that there is ongoing work across Government to address these inconsistencies and to create a fairer playing field.

Figure 19: Staff governance and empowerment at City Health Care Partnership CIC

<p><i>Overview</i></p> <ul style="list-style-type: none"> City Health Care Partnership CIC (CHCP CIC) is a provider of community health and integrated social care services. Formerly part of NHS Hull, CHCP was officially formed in June 2010 under the Right to Request Programme. As a Community Interest Company, all of CHCP's profits are invested into services, staff and local communities. Its mission is to be a socially responsible commercial business which contributes to its community, from which high-quality services are delivered, and where people love to work. <p><i>Ownership and governance structures</i></p> <ul style="list-style-type: none"> CHCP is a co-owned organisation which gives all permanent staff the opportunity to purchase a £1 share. Whilst the share is primarily symbolic in financial terms, it is considered key to building a psychological contract between the staff and the organisation. CHCP's governance structure includes a Community Partnership Forum, made up of representatives from staff, community and voluntary organisations. The link between staff and the development of the organisation is also strengthened through the appointment of shareholder representatives, who attend a Shareholder Forum three times a year and a shareholder representative from the Forum also sits on the Executive Board. <p><i>Flexibility</i></p> <ul style="list-style-type: none"> According to CHCP, operating outside the NHS has helped drive a less risk-averse culture, with greater freedom to innovate. For example, the acquisition of two pharmacy businesses is helping to drive sustainability and cost 	<p>efficiency whilst simultaneously giving the business an extended window into the community across all services.</p> <ul style="list-style-type: none"> It has also enabled CHCP to introduce a range of benefits to reward its staff, such as the introduction of 'Flextra', the staff benefits scheme. CHCP identifies the loss of the NHS 'safety net' as a key part of the shift in culture. Staff know that the future of their organisation depends on maintaining excellent patient care to win and retain contracts. CHCP has been able to recruit experienced, professional Non Executive Directors, ensuring a strong board which is focused on service quality, but understands the pressures on a commercial organisation. <p><i>Performance</i></p> <ul style="list-style-type: none"> CHCP's 2013 Patient Survey results show that 96% of all respondents would recommend its services based on their overall experience. CHCP's 2013/14 Social Accounts demonstrated a return of £33 for every £1 spent; a figure which small grant beneficiaries value as the wider social impact to the local community. Other productivity indicators include staff sickness rates, which have decreased significantly, the delivery of 4% efficiency savings per year since leaving the NHS and the continuing delivery of high-quality, safe services. 
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Regulators and the wider system

93. Leaders and managers throughout the NHS must play the leading role in developing a highly engaged workforce. Nevertheless, one clear message from the review was that the Government and regulators could and should do more to support them in this endeavour, including by role-modelling the right behaviours, carrying out their functions in ways that support good practice, and creating a more permissive environment for innovation to flourish.

Recognising the importance of engagement

94. This report has set out the strong evidence base on the importance of staff engagement for quality, safety and financial performance. Monitor, the NHS Trust Development Authority (NHS TDA) and the CQC should recognise the critical role of engagement in contributing to performance when carrying out their functions. The regulators should place staff engagement at the heart of their discussions with providers on how to improve performance, attaching much greater importance to staff engagement, and recognising its close relationship with patient experience. The Panel welcomes the work being done by CQC to assess the quality of leadership, culture and staff engagement in its new inspection regime. We also welcome Monitor's commitments to consider staff satisfaction, staff absenteeism and staff retention rates in its new Risk Assessment Framework.

Role-modelling the right behaviours

95. It will be equally important for the regulators to role-model the types of leadership behaviours that deliver high engagement, both to set the tone and encourage effective leadership in the sector and to increase the effectiveness of their regulatory oversight. Regulators need to reduce reliance on directive leadership, where the focus is on instructing organisations to make the required changes, in favour of more facilitative styles which aim to support leaders and staff in addressing their organisations' challenges. The new emphasis on levels of staff engagement within providers should be a basis for supportive discussions on how to develop a more engaged workforce, rather than seeking compliance with an externally imposed standard.

Giving leaders headroom to lead

96. The most recent reforms have sought to distance Ministers from local NHS organisations through the establishment of an arm's length commissioning organisation in the form of NHS England and to introduce a clearer separation of responsibilities for purchasing, providing and regulating services. The original plan

was also to end Monitor's governance role in relation to Foundation Trusts and rely instead on a single framework of economic regulation for all providers, although this plank of the reforms was removed during the Health and Social Care Bill's passage through Parliament.

97. These latest reforms are still at a very early stage. However, many leaders we spoke to reported that Trusts and Foundation Trusts continue to operate in a burdensome reporting environment. This includes having to account for performance to multiple bodies with overlapping responsibilities, for example, reporting similar information to commissioners, Monitor or the NHS TDA and the CQC on health care-acquired infections and other quality issues. The evidence we heard is in line with research on the degree of administration and reporting burdens faced by NHS providers.³⁹
98. The risk in such an environment is that leaders and staff in NHS organisations focus too much of their limited management time and energies on upward reporting to external bodies. This then has the effect of restricting their promised autonomy and of frustrating efforts to refocus accountability on local stakeholders, particularly in the case of Foundation Trusts. There is a strong case for the Government and regulators to develop a simpler, streamlined and more proportionate regulatory regime to enable leaders of NHS organisations to have sufficient headroom to lead their organisations, based on the principle of presumed autonomy. Moving away from an over-centralised approach to the management of the NHS is a prerequisite of the transformational changes in care that are urgently needed.

Creating a supportive environment for innovation

99. The Government and regulators also need to simplify layers of control and create a more permissive environment so that it is easier for organisations to test more innovative approaches, including the ownership and governance models discussed in this report. There needs to be a presumption that providers are free to innovate, rather than that they need to gain political support or regulatory approval before doing so. The Government and regulators need to remove checks, simplify processes, overcome system blockages and support providers in completing regulatory processes where these are needed. We welcome Monitor's commitments in this area in its new strategic plan, including on helping to reduce current barriers to innovation.⁴⁰

³⁹ See for example, The King's Fund (2011)

⁴⁰ Monitor (2014)

Intervening in the right way, where needed

100. A final message from the review was on the potentially disempowering effects of top-down regulatory intervention when this is needed to protect patients or taxpayers. In the case of financial failure, for example, the regulators typically apply a series of measures, such as requiring Trusts to appoint an interim turnaround director, hiring external consultants to develop a turnaround strategy, sending in a contingency planning team, or, as the ultimate sanction, appointing a special administrator to replace the board. Similarly, in the case of concerns about the quality of care, the CQC, Monitor and the NHS TDA are all involved in Trusts and Foundation Trusts placed in special measures, with external consultants and advisers often involved too.
101. Both theory and practical experience point to the drawbacks of these approaches. We know that excessive top-down intervention runs the risk of disempowering and disengaging the leaders and staff who will ultimately be responsible for making a success of the turnaround plan. Many NHS organisations have now been the subject of repeated interventions, yet continue to face financial difficulties and in some cases have concerns about the safety and quality of care. The Panel would expect that regulators would use more supportive interventions, along the lines of those that seem to be developing following the Berwick and Keogh reviews, rather than adding to the pressures already felt by providers in difficulty. Far from being a ‘soft’ response to problems in the delivery of care, supportive intervention would be one way of modelling the kinds of behaviours that underpin the cultures of engagement that we have argued for.
102. Research by the Nuffield Trust on the response to the Francis Inquiry has raised concerns about the pressure exerted by regulators and performance managers in seeking to assure quality of care and the way in which a burdensome regulatory approach is at odds with efforts to develop an open, quality-focused culture.⁴¹ At worst, this regime felt punitive and based on attributing blame rather than seeking to offer practical support at times of organisational distress. Some of those interviewed by the Nuffield Trust reported that efforts to bring about cultural change within their organisations could be undermined by the wrong kind of regulation and performance management. These findings are a wake-up call to national leaders to ensure that their interventions do good and not harm.

41 Thornby *et al* (2014)

Conclusions

103. The evidence we reviewed and the testimony we heard provide compelling evidence of the importance of staff engagement in the NHS. The priority now should be to build on recent progress in Trusts and Foundation Trusts, learn from successful examples, share good practices, and test the alternative approaches we have described. A period of ‘accelerated evolution’ and evaluation of existing and alternative models would enable further evidence to be gathered about the impact of different organisational forms on staff engagement and performance. This would shed light on a core question on which opinion was divided within the Panel, namely the relative importance of ownership and governance in comparison with other critical factors such as leadership, culture and ways of working in securing a highly engaged workforce. Both are clearly important and now is the time to encourage and support alternative approaches where NHS leaders and staff are keen to do so.
104. In putting forward these recommendations, the Panel is conscious of the desirability of avoiding further top-down restructuring. In practice, some organisational change is unavoidable given the need to resolve the future of the 98 Trusts yet to achieve Foundation Trust status, and the innovations emerging spontaneously from local discussions of integrated care. These developments will impact on Foundation Trusts and Trusts through mergers and takeovers, the development of joint ventures and debate about the potential role of chains of providers. Bottom-up organisational change of this kind is quite different from government-mandated restructuring across the NHS which needs to be avoided at all costs.
105. At a time when there is growing debate about future provider models,⁴² it is opportune for the place of employee owned and led mutuals within the NHS to be considered seriously alongside other ways of strengthening staff engagement throughout the NHS. This would enable the journey of mutuality that started with the creation of Foundation Trusts in 2004 to be continued and extended in a wider range of organisations and settings. In the next phase of evolution, it is essential that there is much greater devolution, recognising the impossibility of managing an organisation as large and complex as the NHS from Whitehall and Westminster. Freeing up leaders to bring about long-overdue transformations in the delivery of care, through a variety of organisations able to harness the skills, commitment and compassion of the 1.4 million people who work in the English NHS, is the best way to secure the long-term future of the NHS.

⁴² See for example, *Health Service Journal* (2014) and Milburn (2014)

Recommendations

Developing high staff engagement within NHS organisations

NHS organisations need to renew their efforts to strengthen staff engagement, building on progress in recent years and narrowing the gap between high and low performers.

Staff engagement cannot be strengthened by setting targets and managing their implementation but depends on leaders showing their personal and visible commitment to engagement.

NHS boards should set aside time to discuss the results of staff surveys and to act on the results, taking advantage of the more frequent use of surveys.

NHS organisations should devolve more responsibility to staff for delivering services, removing unnecessary layers of management and empowering staff to take decisions.

Staff should be supported to improve care through investment in leadership and management development and training in quality improvement skills.

A stronger role for staff in governance and ownership structures

There should be greater freedom for NHS organisations to become employee owned and led, on a strictly voluntary basis, where their leaders and staff wish to do so.

One option would be for Foundation Trusts to vary their governance arrangements to give staff a stronger voice, beginning with a clearer understanding of the freedoms that currently exist.

It should also be possible for Trusts and Foundation Trusts to become employee owned and led mutuals, learning from the experience of the mutuals set up under the Transforming Community Services policy and from mutuals in other sectors.

A variation would be to make it possible to establish employee owned and led mutuals for emerging integrated care providers which bring together services from different providers.

Staff should be encouraged to develop their own plans for mutuals and to present them to their parent organisations, and Trusts and Foundation Trusts should give serious consideration to their business cases.

As a first step, the Government should launch a programme of pathfinders, using expertise within Cabinet Office and established mutuals, to support Trusts and Foundation Trusts wanting to test this model.

Financial and technical support should be provided to organisations seeking to become mutuals, including partnering with mutuals in other sectors.

Support provided by regulators and the wider system

A consistent and proportionate system of regulation and performance management of all providers of NHS services is needed, including staff-owned and led mutuals, based on presumed autonomy.

There should also be much greater devolution of decision-making within the NHS to create headroom for leaders to bring about the improvements in care that are needed.

Changes should be led from within the NHS and should avoid the distraction of a further period of top-down restructuring.

These changes would enable the journey of mutuality that started with the establishment of Foundation Trusts in 2004 to be continued.

More work is needed on ownership of assets and ensuring these are used for the public benefit, and on access to capital.

Appendix 1: Terms of Reference for the Review

Review of staff engagement and empowerment in the NHS through provider models and other approaches

There is a broad body of evidence that organisations which give staff a voice and a stake in their work deliver better performance.

In the NHS, the most forward-thinking providers, including recently established social enterprises, are finding new ways of engaging and empowering staff to improve patient care. However, we know that there is a considerable distance between the best and the worst providers.

The purpose of the review is, therefore, to consider options for strengthening employees' voice and stake in NHS provider organisations through provider models and other approaches, so that they are empowered to deliver efficient, high-quality services centred on the needs of patients.

The aim is to ensure that staff in all organisations delivering NHS services can make the greatest possible contribution to the delivery of efficient services and high-quality care.

Scope of the review

The review will:

- Present the evidence that engaging and empowering NHS staff leads to improvements in the delivery of services and quality of patient care;
- Assess the range of options for further empowering staff and strengthening their voice in their organisations through innovative provider models and other approaches;
- Identify the cultural, regulatory and other barriers preventing some NHS providers from engaging and empowering staff and developing more effective models;
- Outline good practices within the NHS and other sectors and the ingredients within these practices, including the role of leaders;
- Make recommendations to the Government on how to facilitate the development of these models, including where appropriate through developing proof of concept before more widespread implementation.

The review will not reconsider issues that have already been exhaustively examined in the Government's response to the second Francis report on care at Mid Staffordshire Foundation Trust, or in the associated separate independent reviews. Its recommendations will be aligned and consistent with the Government's response to the second Francis report.

The purpose of the review is not to consider matters relating to pay, pensions or other terms and conditions of employment for NHS staff.

Approach and method

The review will be carried out according to the following principles:

- It will bring together the broad range of existing evidence and commission new research where necessary, drawing on learning from within the NHS, other health systems and other sectors;
- It will engage a wide range of stakeholders to share best practice and in the development of proposals, including public sector providers, new mutual and social enterprises and the private sector;
- The review will look in detail at the hospital sector. However, it will also consider primary and community care and inter-relationships with social care;
- It should make recommendations to support NHS providers in developing effective approaches rather than seeking to impose particular models.

Outputs

- The review should make recommendations to the Government by April 2014.

Appendix 2: List of Review Panel Members

The review was chaired by Professor Chris Ham, CEO of The King's Fund. Professor Ham was supported by an expert panel comprising the following :

Name	Title	Organisation
John Adler	Chief Executive	University Hospitals of Leicester NHS Trust
Anna Bradley	Chair	Healthwatch England
Andrew Burnell	Chief Executive	City Health Partnership
Craig Dearden Phillips, MBE	Managing Director	Stepping Out
Nita Clarke	Director	Involvement and Participation Association
Andrew Foster, CBE	Chief Executive	Wrightington, Wigan and Leigh Foundation Trust
Chris Hopson	Chief Executive	Foundation Trust Network
Celia Ingham-Clark, MBE	National Clinical Director	NHS England
Julian Le Grand	Richard Titmuss Professor of Social Policy	London School of Economics
Jonathan Lewis	Chief Executive	Bromley Healthcare
Sir Charlie Mayfield	Chairman	John Lewis Partnership
Sir Robert Naylor	Chief Executive	University College London Hospitals Foundation Trust
Graeme Nuttall	Partner	Field Fisher Waterhouse
Angela Pedder, OBE	Chief Executive	Royal Devon and Exeter Foundation Trust
Bob Ricketts	Director of Commissioning Support Strategy and Market Development	NHS England
Cathy Warwick, CBE	General Secretary	Royal College of Midwives
Michael West	Professor of Organizational Psychology	The King's Fund and Lancaster University Management School

Professor Ham and the Review Secretariat led the writing of the report. The Panel members met four times to discuss the findings and recommendations. They advised in a personal capacity rather than as representatives of their organisations.

Appendix 3: Note on methodology

The Panel

1. Professor Chris Ham, CEO of The King's Fund, led the review. The review was supported by an expert panel (including NHS leaders and experts in staff engagement and mutual models) from its start in October 2013 until the report was submitted to Ministers in May 2014. The panel met four times during the review to discuss the scope of the work, the evidence base and emerging themes and the final conclusions and recommendations. Panel members also participated actively in other aspects of the work, including advising on analysis of the data and participating in visits to providers and discussions with the national bodies.

Engagement with stakeholders

2. The review held two workshops to engage with stakeholders across the NHS in November 2013 and February 2014. In total, approximately 150 stakeholders attended, including a large number of representatives from Trusts, Foundation Trusts and new mutuals delivering NHS services, as well as trades union representatives and some of the regulators. During the first workshop, stakeholders explored the range of options for strengthening staff engagement. In the second, the panel presented emerging findings and possible recommendations for stakeholders to comment on.
3. In addition to the workshops, Professor Ham chaired a roundtable discussion between Ministers and 15 NHS leaders in April 2014, including Chief Executives of NHS Trusts and Foundation Trusts interested in exploring alternative organisational models. The main purpose was for Chief Executives to outline their plans, describe the regulatory and other obstacles they were facing, and set out what support they believed they needed from Government to pursue them.
4. The review also engaged with stakeholders outside of these meetings, including attending the Employee Ownership Association's Annual Conference, meeting new NHS mutuals at the Local Partnerships, and participating in three discussions with trades unions at the Department of Health and Unison's Staff Passport Group. We discussed the work on a number of occasions with the NHS TDA and Monitor.

Interviews and visits

5. The Chair of the Review visited six providers to understand their experiences, including Salford Royal NHS Foundation Trust, Blackpool Teaching Hospitals NHS Foundation Trust, Hinchingsbrooke Health Care NHS Trust, Spiral, SEQOL, and Provide. The secretariat carried out interviews with and visits to approximately 30 Trusts, Foundation Trusts and new NHS mutuals during the review to identify examples of best practice, the range of options for strengthening staff engagement, and the obstacles that needed to be addressed. The visits and interviews formed the basis for many of the case studies in the report and supporting evidence for the arguments and recommendations.

Analysis of the NHS staff survey

6. The review carried out its own analysis of trends in levels of staff engagement, differences in engagement between providers and the relationship between levels of engagement and outcomes such as patient satisfaction and mortality. Our results were in line with similar work by NHS Employers and West and Dawson's much more detailed analysis. We carried out simple correlations suggesting links between engagement and compassionate care.

Literature review

7. The early part of the review included a review of the existing literature on employee engagement, including the role of alternative ownership and governance models, in the NHS and other sectors. The results are summarised in appendix 4.

Appendix 4: Summary of existing theory and evidence on staff engagement, including through different provider models

1. This appendix provides an overview of the theory and existing evidence on what drives high staff engagement and the impact of engagement on performance.

What is staff engagement and why is it important?

2. Academics, management theorists and HR practitioners have defined staff engagement in a wide variety of ways, including as a set of working conditions (such as empowering staff to deliver their roles), an attitude (such as involvement in one's role or commitment to the organisation), a set of behaviours (such as 'going the extra mile' or advocating the organisation to others) or particular outcomes (such as greater job satisfaction for staff or agility for the organisation). According to the Institute of Employment Studies, for example, an engaged employee has a positive attitude towards the organisation and its values, is aware of the business context and works with colleagues to improve performance.⁴³
3. However, most academic papers present engagement as a psychological state associated with emotional and intellectual involvement with one's organisation and in one's work. Even within this body of research, academics have presented the state of engagement in different ways, with more recent work distinguishing between engagement with one's role and engagement with one's organisation. For example, Saks presents engagement as a state of attentiveness to work and absorption in one's role.⁴⁴ May *et al* relate engagement to 'flow', the holistic sensation that people feel when they act with total involvement.⁴⁵ Kahn describes engagement as a state where individuals bring their personal selves to their work.⁴⁶ Others have also related the concept to positive attitudes such as commitment to one's organisation.⁴⁷ (Researchers have also measured engagement in different ways, some measuring job involvement or organisational commitment, and others using proxies for engagement such as feelings of empowerment, motivation, job satisfaction or willingness to act as advocates for the organisation.)

⁴³ Robinson, Perryman and Hayday (2004)

⁴⁴ Saks (2006)

⁴⁵ May *et al* (2004)

⁴⁶ Kahn (1990)

⁴⁷ Baumruck (2004)

4. The majority of these models present a set of pre-conditions which lead to higher or lower levels of engagement, including leadership and management, the nature of team and individual work and human resource practices. Where the necessary conditions are in place, high levels of engagement act as a 'catalyst' encouraging particular beneficial behaviours such as proactivity and creativity. West argues that engaged individuals are able to think more flexibly, cope more effectively, feel greater self-control and act less defensively in the workplace.⁴⁸ Others have linked engagement to organisation citizenship or pro-social behaviour, such as supporting and co-operating with co-workers⁴⁹ or having a willingness to make discretionary effort that is not explicitly recognised by the rewards system.⁵⁰
5. Finally, these positive behaviours have been shown to translate into beneficial outputs and outcomes for staff and the organisation. Employees experience intrinsic benefits from higher levels of engagement, including greater happiness and better health which should translate into lower absenteeism and staff turnover. Engagement is also linked to better customer service, use of resources and innovation which should in turn contribute to productivity, profitability and growth.
6. Few studies have attempted to articulate exactly why particular pre-conditions lead to a state of engagement or why this translates into particular behaviours. In most of the models, engagement is a 'black box' which 'mediates the link' between particular conditions of work and behaviours and outcomes.

What are the 'pre-conditions' for highly engaged staff?

7. Researchers have identified a wide range of factors which influence levels of engagement, spanning most aspects of how organisations operate, including senior leadership and management, team structures and team-working, and the nature and conditions for individuals' work. Earlier work focused on the job characteristics needed for individuals to engage with their roles. More recent studies have emphasised the importance of leadership styles, trust and integrity, and employees' voice and influence for employees' engagement with their organisations.⁵¹

48 West (2004)

49 West (2004)

50 West and Dawson (2012)

51 Saks (2006)

Main pre-conditions for employee engagement according to key research and reports

Kahn 1990	Maslach <i>et al</i> 2001	Towers Perrin 2005	Macleod and Clarke 2009	West and Dawson 2012
Meaningfulness of work for individuals	Sustainable workload	Strong leadership	Leadership which provides line of sight from	Culture of trust between leaders and staff
Safety for individuals to bring their 'selves' to their work	Feelings of choice and control over work and environment	Accountability	individuals' work to vision and aims of organisation	Involvement in decision-making
Having the physical and emotional resources needed to bring 'self' into work	Rewards and recognition	Control over one's environment	Managers who offer clarity and appreciation of effort	Relatively flat hierarchies
	Community and social support	Opportunities for development	Employees who feel able to voice their ideas and be listened to	Working in well-structured teams
	Perceived fairness and values		A belief that the organisation lives by its values	Feeling valued, respected and supported
				Rites and rituals to celebrate success
				Learning opportunities

Leaders who support other employees in delivering their roles

9. A number of studies have linked the degree of support offered by leaders and supervisors to levels of staff engagement. Cufaude has argued that managers who employ a philosophy of servant leadership, where their primary role is to support those around them, create environments with higher levels of engagement.⁵⁴ Saks found that employees were more engaged when they perceived that the organisation actively supported them in delivering their roles.⁵⁵ In the NHS, West *et al* also identified the importance of senior leadership playing an active role in supporting staff in addressing system problems and delivering change.⁵⁶

Leaders who give staff a voice and involve them in decisions

10. A body of research has emphasised the importance of giving employees a voice and the ability to input into important decisions. Kingston Business School found that the ability of employees to feed their views upwards and feel well-informed about what was happening in the organisation were key drivers for engagement.⁵⁷ *The Sunday Times* also found that feeling listened to was the most important factor in determining whether staff valued their organisation.⁵⁸ While some research has emphasised the value of voice in and of itself, others have argued that there needs to be genuine sharing of responsibility between employees and management over issues of substance.⁵⁹

⁵² Towers Perrin (2007)

⁵³ Saks (2006)

⁵⁴ Cufaude (2004)

⁵⁵ Saks (2006)

⁵⁶ West *et al* (2013)

⁵⁷ Truss *et al* (2006)

⁵⁸ *Sunday Times* (2012)

⁵⁹ Purcell *et al* (2003)

Well-structured teams and effective team-working

11. A smaller body of research has suggested levels of engagement are influenced by group dynamics in smaller teams. Maslach *et al* found that employees were more engaged if they worked in a supportive work community.⁶⁰ (Similarly, a number of studies have identified a link between blame cultures and disengagement.) In the NHS, West and Dawson found that employees were more engaged if they worked in well-structured teams where team members had clear shared objectives, worked inter-dependently and met regularly to discuss their effectiveness.⁶¹

Meaningful and challenging individual roles

12. A body of theoretical literature has argued that employees actively seek meaning through their work and are likely to be more engaged if they find it. Holbeche and Springett found that people experience a greater search for meaning in the workplace than in life in general.⁶² May *et al* found that the meaningfulness of work was the strongest predictor of levels of engagement.⁶³
13. Saks *et al* found that staff were more engaged when challenged and stretched (although excessive challenge leads to stress and disengagement).⁶⁴ Towers Perrin also found that employees were more engaged if their roles were characterised by challenge and stimulation.⁶⁵ A number of studies have identified a link between opportunities for professional development and engagement. Towers Perrin found that the extent to which employees believed they had improved their skills over the previous year was a powerful predictor of levels of engagement.⁶⁶

Choice, control, workloads and resources

14. Researchers drawing on burnout theories have identified that employees are more likely to be engaged if they have feelings of choice and control over their work. In Finnish health care, Mauno found that employees' control over the timing and approach to their work tasks was the best predictor of levels of engagement.⁶⁷ Conversely, the lowest levels of engagement have been found among hourly workers who, arguably, have least control or influence over their jobs and working environment.⁶⁸
15. Researchers have identified that staff are more likely to be engaged if they have sustainable workloads and access to the necessary resources to deliver their roles.

60 Maslach *et al* (2001)

61 West and Dawson (2012)

62 Holbeche and Springett (2003)

63 May *et al* (2004)

64 Saks (2006)

65 Towers Perrin (2005)

66 Towers Perrin (2005)

67 Mauno, Kinnunen and Ruokolainen (2007)

68 Towers Perrin (2003)

Meanwhile, unmanageable workloads and high levels of stress have been linked to disengagement.⁶⁹

Procedures for defining roles and measuring performance

16. A body of human resource management research has emphasised the importance for engagement of particular practices such as setting clear objectives and carrying out well-structured appraisals of performance. In the NHS, West and Dawson found that employers could improve engagement through ensuring well-structured staff appraisals.⁷⁰

Hierarchical structures

17. Finally, some researchers have found that staff were more engaged in organisations with fewer layers of hierarchy.⁷¹ There is also some evidence to suggest that it is easier to maintain higher levels of engagement in smaller firms. Firms become more bureaucratic as they grow and need to be increasingly innovative in order to engage larger numbers of staff effectively.⁷²

What do we know about the overall impact of staff engagement on performance?

18. Various studies have identified correlations between levels of staff engagement (measured in different ways as discussed above) and particular desirable behaviours (such as acting creatively at work), intermediate outcomes for employees and organisations (such as higher job satisfaction for employees or numbers of accidents or errors for firms) and measures of overall performance for organisations (such as profitability and growth).

Engagement and behaviours

19. A range of studies has linked high engagement with creativity at work. Gallup found a strong correlation between levels of engagement and perceived levels of innovation by individuals. In its survey, 59% of engaged employees, against just 3% of disengaged employees, said that their job brought out their most creative ideas.⁷³ The Chartered Management Institute also found a significant association between engagement and innovation.⁷⁴ According to Gallup's 2006 survey, highly engaged staff were 12% more likely to advocate their organisation to customers.⁷⁵

⁶⁹ Saks (2006)

⁷⁰ West and Dawson (2012)

⁷¹ West and Dawson (2012)

⁷² Lampel *et al* (2012)

⁷³ Krueger and Killham (2007)

⁷⁴ Kumar and Wilton (2008)

⁷⁵ Harter *et al* (2006)

Engagement and intermediate outputs

20. A significant number of studies have identified a link between levels of engagement, staff happiness, job satisfaction, absenteeism and staff turnover. Gallup found that highly engaged employees took an average of 2.7 days' sickness leave per year, in comparison with 6.2 days for disengaged employees. It also found that those with engagement scores in the lower quartile averaged 31% to 35% more employee turnover.⁷⁶
21. In the NHS, West and Dawson also found that higher levels of engagement were associated with lower levels of absenteeism, with an increase of one standard deviation in engagement equating to an average saving of £150,000 from lower staff absence.⁷⁷
22. A number of studies have linked levels of staff engagement with intermediate measures of performance such as numbers of defects, accidents and inventory shrinkage. According to Gallup, firms with engagement scores in the lower quartile averaged 62% more accidents.⁷⁸ In the NHS, West and Dawson found that Trusts had lower infection rates where a large percentage of staff felt they could contribute to improvements at work.⁷⁹

Engagement and overall firm performance

23. The Macleod review cites a range of evidence that employee engagement leads to higher customer satisfaction. For example, the IES found a link between employee satisfaction, customer satisfaction and increases in sales, based on a study of 65,000 employees and 25,000 customers from 100 stores over a two-year period.⁸⁰

Salanova *et al* found a positive link between employee engagement and customer satisfaction in service settings. They suggest that a key driver may be that engaged staff are more able to invest energy in their interactions with clients.⁸¹ Studies of individual companies have produced similar results. For example, Nationwide found significantly higher levels of customer satisfaction in bank branches with high levels of employee engagement.⁸² In the NHS, West and Dawson find a strong positive correlation between employee engagement and patients' experience of in-patient services.

24. In the NHS, West and Dawson found that higher levels of engagement were

⁷⁶ Harter *et al* (2006)

⁷⁷ West and Dawson (2012)

⁷⁸ Harter *et al* (2006)

⁷⁹ West and Dawson (2012)

⁸⁰ Barber *et al* (1999)

⁸¹ Salanova *et al* (2005)

⁸² Macleod and Clarke (2009)

associated with lower levels of mortality, with an increase of one standard deviation in levels of engagement associated with a 2.4% drop in mortality rates at a Trust.⁸³

25. Towers Perrin's 2006 survey found that companies with high levels of employee engagement saw a 19.2% increase in operating income, while companies with low levels of employee engagement saw a 32.7% reduction in operating income over a 12-month period.⁸⁴
26. Gallup found that organisations with engagement scores in the top quartile had an average of 18% higher productivity, 12% higher profitability, and 2.6 times faster growth in earnings per share than organisations with below-average engagement scores.⁸⁵
27. Of course, it is unclear from cross-sectional studies whether higher levels of employee engagement lead to better performance, or whether better performance leads to higher engagement. Both effects might be possible, with higher performance leading to a more positive working environment where employees become more engaged.
28. There have not been any definitive studies establishing a causal link between employee engagement and overall performance, or showing that engagement affects performance more than performance affects engagement. However, Marcus Buckingham, cited in the MacLeod review, concludes from various longitudinal studies that the impact of engagement on performance is four times stronger than the impact of performance on engagement.⁸⁶

What role does organisation form play in staff engagement and performance?

29. Alongside the work discussed above, the literature on employee ownership, mutuals and social enterprises suggests a link between formal structures which give employees a stronger stake in their organisations and levels of employee engagement. While there are a number of competing rationales for these models, much of the recent work focuses on their comparative advantages in creating and sustaining high levels of engagement in the workforce.
30. Theories based on traditional micro-economics have generally emphasised the importance of financial incentives to align the interests of staff and shareholders. If they share in the firm's success, employees should be more engaged in their work and willing to make discretionary effort. If they have a financial stake, staff should also be more willing to monitor their peers and address poor performance, reducing further the need for costly monitoring arrangements.⁸⁷
31. Other work on employee-owned companies and mutuals has emphasised the benefits of arrangements which help to create a culture of shared ownership within

⁸³ West and Dawson (2012)

⁸⁴ Towers Perrin (2007)

⁸⁵ Gallup Organisation (2006)

⁸⁶ Macleod and Clarke (2009)

⁸⁷ Fakhfakh *et al* (2012)

organisations. If staff feel they have a personal ownership stake in the company, they may also be more willing to make additional effort or act proactively or behave co-operatively in their roles. For example, Michie *et al* suggest that employee share ownership through an employee benefit trust might foster ‘a culture of teamwork and a co-operative company spirit’.⁸⁸

32. Much of the more recent work focuses on the role of organisational models in supporting the leadership, team-working and other practices that deliver high engagement. Matrix Evidence links employee ownership with ‘high-engagement’ practices: ‘It is reasonable to infer that the greater degree of employee autonomy, influence and task discretion in employee-owned firms is likely to have a beneficial overall effect on occupational health, given the known negative impact on well-being from lack of control over work and decisions.’⁸⁹ Similarly, the Nuttall review identifies employee financial participation, coupled with structures that promote employee engagement in the company, as a distinct business model.⁹⁰
33. According to this work, models which give staff a stronger formal stake in their organisations may provide a more credible and stable foundation for sustaining the practices that lead to high engagement, with less risk of tokenism and a greater resilience in the face of pressures such as short-term financial challenges or changes such as the introduction of a new leadership team. According to the Mutuels Taskforce, ‘the embedded nature of employee ownership within the legal incorporation and governance of the organisation provides one method of demonstrating on-going commitment to engaging with employees in a clear and transparent manner.’
34. A body of research supports the theories that these models deliver higher levels of staff engagement. The MacLeod review found that ‘employee ownership was a profound and distinctive enabler of high engagement’. Matrix Evidence found that employee commitment tends to be stronger in employee-owned businesses. Pendleton *et al*⁹¹ and Long⁹² both found that employees were more committed to their organisations after the introduction of employee ownership. Burns’ survey of employee-owned companies found that the main perceived benefit of employee ownership was greater employee commitment to the company’s success.⁹³
35. Organisational models which give staff a greater role have also been linked with many of the behaviours or intermediate outputs associated with higher levels of employee engagement. For example, the Nuttall review highlights evidence that

88 Michie *et al* (2002)

89 Matrix Evidence (2010)

90 Nuttall (2012)

91 Pendleton *et al* (1998)

92 Long (1978)

93 Burns (2006)

employee ownership leads to enhanced employee well-being, reduced absenteeism and greater innovation.⁹⁴ The Mutuels Task Force also cites evidence linking mutualisation with lower absenteeism, lower staff turnover and higher innovation.

36. Finally, a body of research associates employee ownership and mutualisation with improvements in overall measures of performance. Both the Nuttall Review and the Mutuels Task Force cite a body of research linking employee ownership and mutualisation with better customer experience and greater customer satisfaction.
37. Matrix Evidence finds that, on balance, the existing studies associate employee ownership with higher productivity. Cass Business School find that employee-owned companies are more resilient in a downturn and that those with fewer than 75 employees are more profitable than non-employee owned firms. (In the Cass study, the benefits of employee ownership tailed off as firms grew.) The Mutuels Task Force cites evidence that mutuals have lower production costs and higher productivity than conventional firms.

What are the features of these organisations that lead to higher staff engagement?

38. However, there are significant differences between employee-owned businesses and between mutuals. While there is broad evidence of the benefits, it is harder to pinpoint the precise features of employee-ownership and mutualisation that deliver higher engagement and improved performance. Most of the existing work has focused on two key parameters: employees' financial participation; and employees' influence over significant decisions.

Employees' financial participation in their organisation

39. The Nuttall Review distinguished between narrow and broad financial participation. In many companies, only senior managers have a financial stake. In some professional partnerships, particular groups of employees have a financial stake. In many mutuals, all employees may share in the firm's profits. If financial incentives play a key role in engaging staff and performance, we might need broad participation to secure the benefits. (The review emphasised the importance of broad participation.)
40. Ham and Ellins distinguish between short- and long-term employee ownership of the company. Share ownership plans give employees the opportunity to take a short-term financial stake in their organisations. However, staff will eventually sell their shares to external investors. In contrast, mutual models with an employee

⁹⁴ Nuttall (2012)

benefit trust can lock in employee ownership for the long term, with shares retained for other employees when staff leave the company.⁹⁵ (These arrangements might be particularly important if the main advantage of employee ownership is to embed 'high engagement' practices and maintain their credibility for the longer term.)

41. The figure below provides a loose spectrum for employee financial participation ranging from minority/short-term employee share ownership (where a small proportion of staff hold shares on a temporary basis) to majority/long-term employee ownership (where a large proportion of staff have a financial stake and employee participation is locked in through an Employee Benefit Trust).

<i>Short term/ minority</i>	Extent of employee's financial participation in organisation		<i>Long term/ majority</i>
<i>Profit or performance related pay</i>	<i>Employee share ownership for a proportion of staff</i>	<i>Employee share ownership for large proportion of staff</i>	<i>Long-term financial participation for large proportion of staff</i>
A minority of employees have a significant financial stake in the organisation through profit-related pay	Some employees are given the opportunity to invest in the organisation on a short term basis through an employee share ownership scheme	A large proportion of staff participate in ownership on a long term basis, with shares held by trust	A large proportion of staff have a financial stake. Staff participation is long term, with shares held by a trust

Employees' influence over their organisation

42. We can also sketch a spectrum for employees' influence over their organisations depending on factors such as whether staff are involved informally or formally in particular decisions, whether they have formal voting rights in relation to particular decisions and, for the latter, the relative power of staff versus other shareholders in making key decisions.
43. The figure below provides a loose spectrum for employee influence from ad hoc or informal consultative arrangements to formal, majority decision-making by staff, either through selecting a majority of the board or through having a majority of staff representatives on the board.

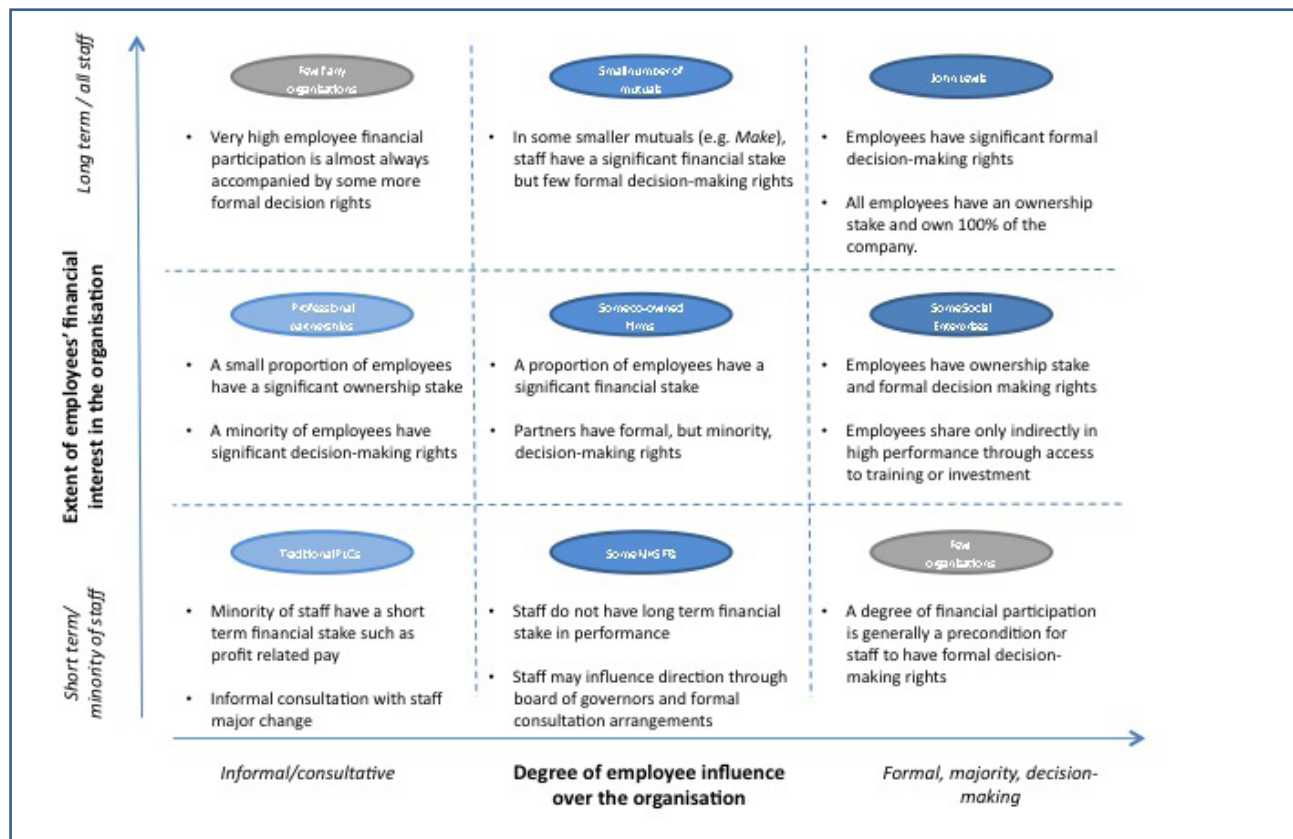
⁹⁵ Ham and Ellins (2009)

<i>Informal consultation</i>	Degree of employee influence over the organisation		<i>Majority decision-making</i> →
Informal consultative arrangements	Formal consultative arrangements	Formal, minority, decision making	Formal, majority, decision making
Informal arrangements for gauging staff views on particular issues such as surveys or ad hoc listening exercises regarding major change	For example, formal commitments to consult staff on particular decisions, possibly through a constitution Established mechanisms for seeking staff views such as an elected employee council	For example, minority voting rights in relation to election of the board or a minority of elected staff representatives on the Board	For example, majority voting rights in relation to the election of the board or a majority of staff representatives on the Board

A matrix for organisational forms

44. We can position organisations on a matrix reflecting the extent of employee financial participation and the degree of employee influence over strategic direction. At one end of the spectrum, traditional PLCs generally combine low levels of employee financial participation with low levels of employee influence. At the other end, some of the UK's most established mutuals such as John Lewis and Arup combine broad, long-term financial participation with significant employee influence over the company. In many of the new mutuals providing NHS services, employees have a limited financial stake but relatively strong formal influence over the organisation.

Impact of different parameters on employee engagement and performance



45. Matrix Evidence cites a number of contradictory studies on the impact of employee share ownership schemes on staff engagement. A small number of studies of individual firms suggest that share ownership, in itself, increases commitment. Other studies of share ownership point to a decline in employee commitment and satisfaction. In some cases, studies have shown staff engagement increases following the introduction of share ownership but this tails off over time. There is a risk that the results are influenced by employee attitudes at a particular point in a firm's evolution, such as flotation following a period of strong performance. Overall, the evidence does not suggest that financial participation, in itself, leads to higher employee engagement. More generally, the research highlights the complexity of designing effective financial incentives and the risk that poorly designed schemes can have negative effects.⁹⁶ As discussed above, staff will be less engaged if they believe that the rewards system is unfair.

46. Overall, recent studies attach greater importance to the role of influence than financial participation. According to Matrix Evidence, 'the evidence supports the view that the primary benefits of employee ownership flow from their influence on managerial decisions.' Lampel *et al* find that employee ownership is associated with improved performance. But the benefits are only seen if employees own 30% or more of the company.⁹⁷ (Their conclusion is that employees need sufficient voting rights

⁹⁶ Matrix Evidence (2010)

⁹⁷ Lampel *et al* (2012)

to influence strategy.) Again, the evidence points to the importance of influence to sustain engagement and deliver improved performance.

47. Many of these studies suggest that a combination of financial participation and employee influence might deliver the greatest benefits. For example, Matrix Evidence cites five studies which show that a combination of financial participation and participation in management decisions increase commitment.⁹⁸ Michie *et al* find that employee financial participation and a vehicle for giving staff a collective voice in decisions are most effective in increasing employee engagement.⁹⁹ Matrix concludes that 'productivity benefits of employee ownership tend to be most noticeable when ownership is combined with participation in decision-making'.¹⁰⁰
48. However, the majority of this research compares employee-owned companies with employee financial participation against other firms. There has been little research on levels of employee engagement or the overall performance of mutuals where employees have few direct financial incentives but significant influence over strategic direction.
49. In summary, the research indicates that financial incentives alone are insufficient to increase engagement. It points strongly in the direction of giving employees significant formal influence over their organisations, including through giving staff formal voting rights. The research is silent on the impact of employee influence on its own. However, if the main benefit of employee ownership or mutualisation is to embed 'high engagement' practices, we might expect influence alone to translate into higher engagement and better performance.

98 Matrix Evidence (2010)

99 Michie *et al* (2002)

100 Matrix Evidence (2010)

Appendix 5: Information sources on staff engagement

The Foundation Trust Network

The FTN website provides resources for NHS leaders including a recent report with Unipart on how to realise the benefits of employee engagement.

<http://www.foundationtrustnetwork.org/resource-library/realising-the-benefits-of-employee-engagement/>

The Involvement and Participation Association

The IPA specialises in assisting organisations in developing effective information and consultation processes and workplace partnership.

<http://www.ipa-involve.com/>

The King's Fund

The King's Fund has published widely on good practice in leadership, staff engagement, medical engagement, board leadership and related subjects.

<http://www.kingsfund.org.uk/topics/leadership-and-management>

NHS Employers

NHS Employers publishes annual updates on staff engagement based on the NHS staff survey and has developed a toolkit for NHS organisations on good engagement practice.

<http://www.nhsemployers.org/your-workforce/retain-and-improve/staff-experience/staff-engagement>

NHS Leadership Academy

The Academy provides resources on how to develop leadership skills and good engagement practice.

<http://www.leadershipacademy.nhs.uk/>

NHS Staff Survey

The NHS staff survey website provides annual data on levels of staff engagement across the NHS and summaries of recent trends.

<http://www.nhsstaffsurveys.com>

The Point of Care Foundation

The Foundation's recent publications include research on effective staff engagement practice.

<http://www.pointofcarefoundation.org.uk/Home/>

Appendix 6: Bibliography

- Allen, Keen, Wright, Dempster, Townsend, Hutchings, Street and Verzulli (2012) 'Investigating the Governance of Autonomous Public Hospitals in England: Multi-site case study of NHS foundation trusts', *Journal of Health Services Research and Policy*, Volume 17
- Baker (2011) *The Role of Leaders in High Performing Healthcare Systems*, The King's Fund
- Barber, Hayday and Bevan (1999) *From People to Profits, The HR link in the service-profit chain*, Report 355, Institute for Employment Studies
- Baumruk (2004) *The Missing Link: The role of employee engagement in business success*, Workspan, Volume 47
- Boston Consulting Group (March 2013) *Mutuals Finance Review*
- Burns (2006) *Good Business: The employee ownership experience*, Job Ownership Limited
- Capita and Veredus (2012) 'Chief Executive Culture Survey', *Health Service Journal*, 22 November 2012
- Cufau de (2004), in Lanphear (2004) Are your Employees Highly Engaged, *Credit Union Executive Newsletter*, 19, 1-2. Credit Union National Association, US.
- Department of Health (2002) *Guide to Foundation Trusts*
- Dorgan, Layton and Bloom (2010) *Management in Healthcare: Why good practice really matters*, McKinsey and the Centre for Economic Performance
- Exworthy, Fosini and Lorelei (2011) 'Are NHS Foundation Trusts Able and Willing to Exercise Autonomy,' *Journal of Health Services Research and Policy*
- Fakhfakh, Perotin and Gago (2012) *Productivity, Capital, and Labor in Labor-managed and Conventional Firms: An investigation on French data*.
- Gallup Organisation (2006) *Engagement predicts earnings per share*.
- Ham (2014) *Reforming the NHS from Within: Beyond hierarchy, inspection and markets*, The King's Fund
- Ham and Dickinson (2008) *Engaging Doctors in Leadership: Review of the literature*, NHS Institute for Innovation and Improvement / Health Services Management Centre, Coventry.
- Ham and Ellins (2009) *NHS Mutual: Engaging staff and aligning incentives to achieve higher levels of performance*, The Nuffield Trust
- Hansard (2002) Alan Milburn reply on foundation hospitals, 3 December 2002, column 750
- Harter, Schmidt, Killham and Asplund (2006) Gallup Q12 Meta-Analysis, Gallup Consulting
- Health Service Journal* (2014) 'David Nicholson Exit Interview: Rules and Structures are Blocking Change,' 19 March 2014

- Hoggett Bowers (2009) *NHS Chief Executives – bold and old*, Hoggett Bowers
- Holbeche and Springett (2003) *In Search of Meaning in the Workplace*, Roffey Park Institute
- Hopson and Morgan (2014) ‘Liberation, preparation and participation, why foundation trust status matters more than ever’, *Health Service Journal*, 22 April 2014
- Kahn (1990) ‘Psychological Conditions of Personal Engagement and Disengagement at Work’, *Academy of Management Journal*, Volume 33, No 4
- Krueger and Killham (2007) ‘The Innovation Equation’, *Gallup Business Journal*, April 2007
- Kular, Gatenby, Rees, Soane and Truss (2008) *Employee Engagement: A literature review*, Kingston University, Kingston Business School, Working Paper Series No. 19
- Kumar and Wilton (2008) Briefing Note for the MacLeod Review, Chartered Management Institute
- Lampel, Bhalla, and Jha (2012) *The Employee Ownership Advantage: Benefits and consequences*, Cass Business School, sponsored by Department of Business, Innovation and Skills
- Lampel, Bhalla and Jha (2010) *Model Growth: Do Employee-owned Businesses Deliver Sustainable Performance?* Cass Business School, sponsored by John Lewis Partnership
- Local Government Association, NHS Confederation, Age UK (June 2012) *Delivering Dignity, Securing dignity in care for older people in hospitals and care homes*
- Long (1978) The Relative Effects of Share Ownership versus Control on Job Attitudes in an Employee-Owned Company, *Human Relations*, September 1978
- Macleod and Clarke (2009) *Engaging for Success: Enhancing performance through employee engagement*, Department for Business, Innovation and Skills
- Maslach, Schaufeli and Leiter (2001) ‘Job Burnout’, *Annual Review of Psychology*, Volume 52, February 2001
- Matrix Evidence (2010) *The Employee Ownership Effect: A review of the evidence*, Employee Ownership Association
- Mauno, Kinnunen and Ruokolainen (2007) ‘Job Demands and Resources as Antecedents of Work Engagement: A longitudinal study’, *Journal of Vocational Behaviour*
- May, Gilson and Harter (2004) ‘The Psychological Conditions of Meaningfulness, Safety and Availability and Engagement of the Human Spirit at Work’, *Journal of Occupational and Organizational Psychology*, Volume 77, Issue 1
- Milburn (2014) ‘Seizing the Opportunity: The next decade for NHS reform’, Speech to the Foundation Trust Network, 1 April 2014
- Michie, Oughton and Bennis (2002) *Employee Ownership, Innovation and Productivity*, A research report for Employees Direct from Birkbeck and The Work Foundation

- Monitor (2011) *Current Practice in NHS Foundation Trust Member Recruitment and Engagement*
- Monitor (2014) *Strategy for 2014 to 2017: Helping to Redesign Healthcare Provision in England*
- Mutuals Task Force (2011) *Our Mutual Friends: Making the Case for Public Service Mutuals*
- Mutuals Task Force (2012) *Public Service Mutuals: The next steps*
- National Advisory Group on the Safety of Patients in England (2013) *A promise to learn - a commitment to act. Improving the safety of patients in England*
- Nicholson (2014) 'Exit Interview: Rules and Structures are Blocking Change', *Health Service Journal*, 19 March 2014
- Nuttall (2012) *Sharing Success, the Nuttall Review of Employee Ownership*, Independent review for Department for Business, Innovation and Skills
- Pendleton, Wright and Wilson (1998) 'The Perception and Effects of Share Ownership, Empirical Evidence from Employee Buy-Outs', *British Journal of Industrial Relations*, Volume 36
- Postlethwaite, Michie, Burns and Nuttall (2005) *Shared Company: How employee ownership works*, Job Ownership Limited
- Purcell, Kinnie, Hutchinson, Rayton, and Swart (2003) *Understanding the People and Performance Link: Unlocking the black box*, Chartered Institute of Personnel Development
- Robinson, Perryman and Hayday (2004) *The Drivers of Employee Engagement*, Report 408, Institute for Employment Studies
- Saks (2006) 'Antecedents and Consequences of Employee Engagement', *Journal of Managerial Psychology*, Volume 21
- Salanova, Agut and Peiró (2005) 'Linking Organizational Resources and Work Engagement to Employee Performance and Customer Loyalty: The mediation of service climate', *Journal of Applied Psychology*, Volume 90, No. 6
- Storey and Holti (2013) *Towards a New Model of Leadership for the NHS*, NHS Leadership Academy
- Sunday Times* (2012) Top 100 small companies to work for
- The King's Fund (2011) *The Future of Leadership and Management in the NHS: No more heroes*
- Thornby, Smith, Williams and Dayan (2014) *The Francis Report: One year on*, Nuffield Trust
- Timmins (2010) 'Centralisation a mistake, says Moyes', Edited transcript of interview with William Moyes, *Financial Times*, January 11 2010
- Towers Perrin (2003) *Working Today: Understanding what drives employee engagement*

Towers Perrin (2005) *European Talent Survey 2004: Reconnecting with employees – attracting, retaining and engaging your workforce*

Towers Perrin (2007) Executive Briefing, Global Workforce Survey, 13 November 2007

Truss, Soane, Edwards, Wisdom, Croll and Burnett (2006) *Working Life: Employee attitudes and engagement*, Chartered Institute of Personnel Development

West (2004) *The Secrets of Successful Team Management: How to lead a team to innovation, creativity and success*, Duncan Baird Publishers

West and Dawson (2012) *Employee Engagement and NHS Performance*, The King's Fund

West, Baker, Dawson, Dixon Woods, Liford, Martin, McKee, Murtagh and Wilkie (2013) *Quality and Safety in the NHS: Evaluating progress, problems and promise*, Final report to the Department of Health, University of Lancaster

