

# Staff involvement to improve employee engagement, service quality and resource use

## Lessons of international experience in health care

### 1. Introduction

This report explores international experience of staff involvement processes to improve employee engagement, service quality and resource use in health care services. It discusses the relationships between staff involvement, employee engagement and organisational performance, drawing on published literature yielded by brief online and journal searches of articles in English. It also draws on Public World's own experience and primary research in several countries.

The report distinguishes between *employee engagement* as a *state* and *staff involvement* as a *practice* that can enhance that state.

Of the many definitions of 'employee engagement', our understanding in this report is based on the definition advanced by the [Chartered Institute of Personnel and Development \(CIPD\)](#), which holds that employee engagement involves "thinking hard about the job and how to do it better" (intellectual engagement), "feeling positively about doing a good job" (affective engagement) and "actively taking opportunities to discuss work-related improvements with others at work" (social engagement).

We define *staff involvement*, on the other hand, as a management practice that enables employees to develop, express and act upon their ideas about improving performance through systematic collective processes.

The report has three sections:

- Evidence from the literature
- Three case studies
- Ten lessons of experience

This report was commissioned by [NHS Employers](#). It is based on a brief online literature review as well as drawing on Public World's experience in a number of sectors in several countries, including Denmark, Germany, the Netherlands and Sweden in Europe, and Canada, the United States and New Zealand.

For further information visit the [NHS Employers staff engagement toolkit](#), and [www.publicworld.org](http://www.publicworld.org)

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## 2. Evidence from the literature

The international research evidence about the relationship between staff involvement and improved resource use, service quality and employee engagement in health care services is strong in quality but weaker in quantity. There is a growing literature on the relationship between employee engagement and organisational performance in general, and some of this focuses on health care services in particular. That literature strongly suggests (as do the results of the annual NHS staff survey) that employee engagement and wellbeing correlate positively with each other and with organisational performance.

There is much less, however, on how staff involvement leads to better employee engagement and organisational performance. Perhaps surprisingly, moreover, to the extent that the relationship between staff involvement and organisational performance has been explored in published research, little is specifically focused on health care.

Capacity constraints in the production of the present paper did not allow a systematic full literature review, but searches using the British Library books and journals catalogue and Google yielded little material from the last five years. The fullest exploration of the international evidence yielded by those searches was a 2010 publication from Ireland's National Centre for Partnership and Performance, *Participative Governance: An Integrated Approach to Organisational Improvement and Innovation in Ireland's Health Care System*.

It is striking that this report referenced much of the same material as was referenced in a 2006 literature review by Public World for the New Zealand Department of Labour's Partnership Resource Centre, and published as *Partnership and Productivity in the Public Sector: a Review of the Literature*. It also reached quite similar conclusions, albeit expressed in different ways.

Otherwise, the best case study material discovered was in a report compiled for the 'Partnership Under Pressure' session of the NHS Employers 2011 conference, compiled by the Social Partnership Forum.

Both the 2006 and 2010 reports referenced above drew from the reviewed literature to focus on the particular conditions that appear to enable improved staff involvement to lead to improved organisational performance in public services. The 2010 report expresses the challenges involved in doing so as follows:

“Researchers have long attempted to establish the nature of the relationship between organisational performance and productivity on the one hand and a range of human factors such as employee involvement, employee engagement and quality of working life on the other. Cumulatively, the research shows beyond much doubt that a positive relationship does exist. However, the quest is fraught with methodological and conceptual dilemmas.

Much of the research focuses on the role of governance and management systems, including policies and practices for human resource management, the role of front-line management, as well as systems of indirect or representative involvement such as workplace partnership. The result is a complex body of knowledge that requires careful interpretation. The impact of people on performance is mediated by a wide range of contextual factors: in short, there is no simple algorithm.”

“The research evidence demonstrates beyond doubt that the way in which work is organised makes a very significant impact on the ability of employees to enhance performance.”

Both the 2006 and 2010 reports tried to break down what is meant by ‘staff involvement’ or ‘employee involvement’, and in particular the relationship between *representative* and *participatory* workplace dialogue. As the 2010 report notes the importance of some of the variable factors, traces the discourse about them and cites the sources involved, it is worth quoting at length:

“ West, Borrill and Unsworth (1998) found that health care teams with clear objectives and high levels of staff participation make a critical contribution to effectiveness and innovation in health care, while enhancing team members’ well-being. A further well-known study claimed that post-surgical mortality could be reduced by the combined effect of a bundle of practices including teamworking, training and appraisal (West, Borrill, Dawson, Scully, Carter, Anelay, Patterson and Waring, 2002).

However, Bartrum, Stanton, Leggat, Casimir and Fraser (2007) argue that there are limitations with these studies: first, direct causal links between specific HR practices and patient outcome are difficult to prove due to the presence of so many other potential variables; and second, patient mortality alone is an unreliable measure of performance.

Several authors also show that effective teamwork, particularly in health care settings, has been difficult to achieve because of barriers and perceived status differentials between professional groups such as doctors and nurses. Gender issues, multiple lines of management, and the lack of organisational systems and structures for supporting and managing teams act as further inhibitors (Borrill, West, Shapiro and Rees, 2000; McNulty, 2003; Ferlie, Fitzgerald, Wood and Hawkins, 2005).

In short, the research evidence demonstrates beyond doubt that the way in which work is organised makes a very significant impact on the ability of employees to enhance performance – both in terms of traditional variables such as productivity and in terms of the rate of product, process and service innovation on which the sustainability of organisations increasingly depends.

It also suggests that representative partnership can create an organisational climate conducive to discretionary effort as well as the conditions within which participative work practices are likely to develop – though further research is certainly needed to elaborate this latter dimension in greater detail.

Above all, the research suggests that the greatest impact on performance is found where there is a systemic approach in which representative partnership, participative forms of work organisation and supportive HRM practices combine in ways which encourage employees at all levels to contribute their tacit knowledge and competencies to the full.”

The latter paragraph is clearly the most important not only as a distillation of the evidence from the studies cited but also because it highlights the need for alignments that can be achieved only through challenging and lengthy processes. It suggests that, while it is certainly possible to secure some discrete improvements even if staff involvement is fairly marginal in organisational practice and culture, the more it is supported from all sides and develops into an integrated governance approach the greater its achievements are likely to be.

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One of the insights yielded by the research for our 2006 report addresses the issue of how to build and sustain the trust that is required to make long term and increasing progress. It points to the need for management and staff sides to initiate and continue to base participatory staff involvement activities on what it called ‘procedural and substantive guarantees’, but could be better expressed as procedural and substantive agreements to be reached at the outset of systematic staff involvement processes.

*Procedural agreements* set out the scope and -- importantly -- limitations of the role of the involvement processes in organisational decision making, so that there is flexibility and freedom of discussion and action within secure and acknowledged boundaries of authority. *Substantive agreements* are mutual commitments about how the product of the involvement processes will be used, and typically involve agreement that identification of efficiency improvements will lead to benefits for the organisation without undermining, and preferably in ways that improve, staff wellbeing.

On that basis, it is possible to mobilise the tacit knowledge within the workforce -- which is likely to be making a strong but hidden contribution to finding ways around inefficient work processes already -- to improve work processes systematically. This involves a focus on tackling specific operational problems by identifying how the organisation of work needs to change, and enabling participatory design of those changes.

The 2006 report offers an Irish example of such concrete issues, and discusses how both immediate service improvements and better relationships and systems to achieve further improvements over the long term can arise from such a focus:

“In the context of a regional Health Board’s quality improvement initiative, two public health nurses suggested that it would be effective to move to a clinic system for the treatment of leg ulcers rather than treating patients in their homes. This idea was pursued via a steering group involving both staff and managers and led to the establishment of a nurse-led clinic.

The nurses involved now have much greater autonomy and report greater job satisfaction. The clinic operates flexibly, extending opening hours when necessary to deal with excess demand for treatment. Patient outcomes have improved because the clinic offers opportunities for more effective treatment, as well as greater clinical consistency and opportunities for staff to learn from each other.”

The 2010 report, echoing one of the conclusions of its predecessor, states that both the international literature review and primary research in Ireland “suggest that participative forms of work organisation are clearly associated with improved performance and outcomes”

### 3. Three case studies

#### *Guastalla Hospital (Italy)*

In February 2000, the public health agency (AUSL) of Reggio Emilia and the health care workers’ and doctors’ unions joined together to start an organisational improvement project in the Guastalla hospital. It was a three stage process, involving the use of work groups and other processes to develop a long-term vision, design a feasibility plan and adopt an action plan.

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This collaborative approach was supported by a working group comprising professionals, management representatives and unions, all coordinated by outside consultants. There was particular focus on enabling experimentation to learn how to change work organisation and promote greater integration and collaboration across professional and departmental boundaries.

Key aims included “valuing the professionals better, listening to them, developing their ideas and making them participants in an organisation that depends on each individual’s potential,” states a report on the experience published by the European Foundation for the Improvement of Living and Working Conditions (Eurofound), a European Union agency. That source reports that the project focused on:

- redesigning work organisation and the integration of diverse professional profiles around the same working process;
- improvement in cooperation and mutual learning;
- redesigning work organisation and reducing vertical hierarchy and segmentation;
- organisation of activities according to flows;
- improvement in the quality of care and services;
- reduction in lead-times and inefficiency.

Showing the importance of procedural and substantive agreements in enabling such a process to flourish, the Eurofound accounts notes:

““ The partnership created between management, trade unions and workforce is normalised in an agreement between the hospital management and the union representatives around the premises and scope of the project, methodology and activities. In this specific case, two agreements were signed: one by the physicians’ union and the other by the public employees’ union.

The agreements focused on the reorganisation of productive and working processes; the increase in process efficiency; the improvement in the quality of services and working conditions; and participation in the dialogue, negotiations and change processes. The involvement of the union representatives was particularly relevant in order to legitimise the process and guarantee the operative management of the project.

Some difficulties occurred due to tense relationships between partners, political elections, change in the hospital management, etc. However, the tense relations between the social partners, especially between management and unions, were managed through meetings, often promoted by the consultants.”

The outcome was several specific projects to change work organisation through self-organised groups of staff, co-ordinated by an internal leader. Examples of improvement and change include:

- A project on patient experience has been developed by improving ICT and enlarging and restructuring the hospital following a review of the patient experience.

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- A group of professionals began a review of the requests for specialist consultancy, with the aim of optimising resource use.
- A project on involving GPs in specialised care phases was developed by setting up primary care departments that consolidated relationships between hospital professionals and the region.
- Further dialogue produced projects in care continuity and patient discharge.

### *Kaiser Permanente, USA*

Kaiser Permanente (KP) is the biggest non-profit health care organisation in the United States and has received a great deal of attention from European health care policy makers for its high standards and cost effectiveness, particularly in integration of primary and acute services. Less widely reported is the high level of trade union and employee involvement that underpins these achievements, driving the introduction of multidisciplinary team working and other service innovations.

KP's Labor Management Partnership (LMP) involving managers, physicians and other staff is the largest and most comprehensive agreement of its kind. It was established in 1997 after years of industrial relations turmoil and with growing competitive pressures in the sector. Two years earlier, 26 local unions representing KP workers had joined together in the Coalition of Kaiser Permanente Unions to coordinate bargaining strategy more effectively. KP and the Union Coalition created the LMP as a means of transforming their relationship and the organisation as a whole.

The employment security agreement is one of the most important components. The agreement states:

“It is our belief that workforce engagement is critical to the success of changing the way we do work, resulting in better quality, greater efficiencies and increased growth. It is unrealistic, however, to expect employees to participate in process improvements if as a result they redesign themselves out of a job or if the result is their co-workers lose their jobs.”

On that basis, workplace social dialogue at KP takes place at three interdependent levels: *strategic and policy level* for whole systems change and continuous improvement; *meso level* in relation to day-to-day operation of the business; and the *microsystems level*, which is comprised of Unit Based Teams (UBTs).

The UBTs are a relatively recent innovation in the process, but have become its basic building blocks and show the trajectory of the process towards frontline employee involvement. The 90,000 employees are in 34,000 UBTs, and every employee is expected to be involved. Each UBT includes all the participants in a natural work unit or department, including supervisors, union stewards and staff members, physicians, dentists and managers. The team supports the regional business strategy and goals for performance, service quality, efficiency and growth.

Among the specific improvements attributed to UBTs have been major reductions in sepsis, and the design and implementation of an integrated IT electronic patient record system. As the Social Partnership Forum report puts it:

“It is unrealistic ... to expect employees to participate in process improvements if as a result they redesign themselves out of a job or if the result is their co-workers lose their jobs.”

“Unit Based Teams tap the creativity, skills and experience of their members in a process that consistently engages frontline workers in improving performance. The LMP ensures the quality of dialogue and participation at team level through a system of Inclusion Control and Openness. Unions credit the arrangement not only with improving patient care and satisfaction, but in making Kaiser Permanente a better place to work.

The significance of KP for this study is that it demonstrates the way in which workplace social dialogue can permeate the whole organisation even in a context where partnership is somewhat antithetical to the national system of industrial relations. Representative partnership in the form of the LMP acts as both the stimulant and guardian of direct participation at the frontline with demonstrable benefits for organisational performance, staff and patients.”

#### *The municipality of Ostersund, Sweden*

After its political leaders had decided that savings of five percent had to be found over the following year if its in-house services were to remain competitive, a staff involvement process was agreed between them and the staff union concerned, Kommunal. It involved 147 ‘tutors’ being elected from among 1,800 employees for a project in health and social services facilitated by the trade-union owned social enterprise, Komanco (now Alamanco).

The process produced more than 800 ideas for large and small changes, and exceeded the objectives intended by the employer. (For a fuller account, and source of the following quotation, see [Cutting Costs and Improving Services in Sweden](#), Brendan Martin, Public World, 2011.)

One tutor commented:

“We have now nearly forgotten that this was a process started by our project - it is now so natural for employees to take responsibility. It has led to a big change in job content for employees, and a big change in attitude. People no longer reject the need for change. As an employee, you now take responsibility for your own ideas.”

Another said:

“We feel we have a different view of our job now - more responsibility, more confidence. If you have more influence, you take more responsibility for quality. It has come as a surprise to us to learn how many savings we could make in this way - we had been suspicious about demands for savings because we had assumed it would only be about cutting staff, as before. Some workers had had incentives to keep costs hidden.”

And a manager echoed their views:

“There is no way I would have been able to solve the problems myself that this process has solved. We are increasing productivity and what has been clearly crucial has been the participation of the employees.”

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Alamanco has distilled the experience and lessons of scores of similar projects into a methodology called The Best Workplace, which is now being offered in Britain through Public World. (See [The Best Workplace: How staff involvement can transform health care](#), Public World, 2013.)

Alamanco chief executive Lars-Ake Almqvist explains the important relationship between improving resource use and improving service quality:

“Every employee needs to know how his or her costs relate to the costs of the whole organisation. It is only on this basis that you can have a dialogue between the chief executive and the auxiliary nurse. Then you can define the limits within which you must operate and go on to identify how to be successful within these boundaries. The members become researchers in their own jobs.

The workplace groups break down their organisation’s budget into its smallest components, to enable everyone to understand it and see where the money goes. They measure the costs of specific tasks, so that each person knows the costs associated with their own job and develops ways of reducing them. They discuss how to improve quality, where responsibility lies and should lie.”

#### 4. Lessons of experience

##### a. Involve the whole workforce

Substantial and sustainable workplace change only occurs with the involvement of all of those who are affected. The challenge for an organisation and its management and staff representatives and leaders is to develop ways of connecting the whole workforce to the initiatives in ways that enable real contributions and commitments to be made.

##### b. Secure leadership support

This is obviously a precondition of any change process, but in staff involvement initiatives there are several specific ways in which leadership support needs to be shown. These include ensuring access to information, providing financial support for external facilitators when necessary, and covering management and staff representatives for time spent in the process.

##### c. Build a shared vision for lasting change

Quality and productivity improvements won’t be sustained unless the process produces a shared view of the future for the workplace. This requires the workforce to recognise and accept that it has a key role in building the workplace and its success – i.e. “the workplace is more than the place that pays my the salary” and “as employees we are responsible for working with the management to improve what we do and how we do it”.

Equally, for managers it means accepting that you don’t have a monopoly of knowledge and don’t have all the answers. It also means moving from “I know the best way to do this thing” to “I know how we can work out how to solve this problem”.

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#### *d. Take an integrated approach*

This might seem obvious but can be overlooked, and often is. Staff involvement does not replace HR functions, but to achieve scale and sustainability it must involve HR, must be supported by HR and must integrate well with HR operations.

#### *e. Be clear about the scope and limitations of the dialogue*

The procedural agreement discussed earlier involves understanding the real and significant difference between communication, consultation, negotiation and cooperation. All are important but each has its own rules and expectations. Yet they are often confused with each other, sometimes because they are occurring at the same time.

Communication of some information can occur at the same time as opening consultation about some aspect of the matter concerned -- but the boundaries between them must be clear. Conversely, consultation should occur only when those consulted have a chance to influence a decision: if a communication exercise is dressed up as consultation it can be counter-productive and lead to disappointment and disenchantment with the whole process.

Consultation is also different from negotiation: while consultation might concern whether or not a particular course of action will occur, negotiation is about the terms on which it will occur.

Cooperation is different again: it involves active participation in the design, planning and/or implementation of a course of action.

#### *f. Be clear about purpose and goals*

The substantive agreement discussed earlier involves creating conditions in which staff feel secure about drilling down into the specific meanings in different contexts of words such as quality and productivity. Part of the point of staff involvement is to identify what they mean concretely in specific work contexts and activities, and building shared understandings of what this implies in operational practice. But if staff feel the results might be used against them or their colleagues in some way, rather than enabling them to do a better job, they will not feel able to contribute in the same way.

This can also involve the clarification of boundaries between the purpose and goals of the staff involvement initiatives and other industrial relations and HR matters that can come with a procedural agreement about the process. There needs to be acknowledgement that, alongside common purposes and goals, there are differences in some interests and that some are beyond the scope of the process, but are dealt with in other ways.

#### *g. Openness and transparency*

Effective staff involvement requires not only communicating well about the whole process but also that information about the organisation and its business arrangements are freely available. This includes financial information, data about service delivery problems and events, complaints, external threats and opportunities, etc. Openness and transparency are conditions of honest dialogue,

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and a variety of communication approaches need to be used to ensure that people are reached in suitable ways.

#### *h. Work on easy issues -- and hard ones*

It can make sense to pick ‘low hanging fruit’ at an early stage of staff involvement processes, not only so that those readily available successes can be achieved quickly but also to build confidence, trust and enthusiasm for the process. But staff involvement can and should help to tackle tougher and longer term challenges too, and while timing is important those should not be excluded.

#### *i. Don't neglect the quality of work and employment*

The route from staff involvement to major and sustained performance improvement goes through changes in work organisation and operational processes. If these are to be sustained the quality of working lives also needs to improve. Indeed, in some cases that needs to be the primary or even sole objective of a particular change initiative within the staff involvement process, for three reasons:

- because of the intrinsic value of improving jobs;
- because of the relationship between staff wellbeing and morale and performance; and
- to build trust in the process and its fairness.

#### *j. Changing the organisation's culture*

Although staff involvement initiatives aim at improving productivity and quality through changes in large and small operational practices, they are sustained and multiplied by enabling the way in which the process works to shape “how we do things round here”.

While it can be necessary at the outset to work with the organisational culture as it is, and to build trust by starting at the margins and on a small scale, opportunities to enable the lessons of the experience to seep into the rest of the organisation's activities, both consciously and unconsciously, should be in the minds of process leaders, and acted upon in thoughtful ways.

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