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Participation in staff engagement campaigns at large healthcare organisations: a focus group study

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ABSTRACT

Introduction Healthcare organisations work better with an engaged workforce, and staff-engagement campaigns offer a method to build this engagement. Leeds Teaching Hospitals NHS Trust (LTHT), one of the UK's largest Trusts, provides an example of where an organisation-wide engagement intervention has been used in a healthcare setting. This study aimed to understand why staff participate, or do not participate, in staff-engagement campaigns, supporting healthcare leaders to increase participation in future campaigns.

Methods Scenario-based focus groups were carried out across five different organisational units within LTHT. The data from these were transcribed, coded and analysed using reflective thematic analysis.

Results Participation in staff-engagement campaigns is dependent on campaign awareness, staff perceptions of the campaign and the practicalities associated with participation. Perceptions of the campaign are further subdivided into the campaign's perceived effectiveness, purpose and relevance.

Conclusions Staff engagement was a powerful driver of participation, which presents a conundrum: how do you encourage participation in staff-engagement campaigns, if engagement is a prerequisite for participation? The answer lies in taking advantage of organisational belongingness and visible leadership, supported by communications that take control of the narrative around the campaign. Behavioural science models may guide leaders across the organisation in mapping where these approaches can have the greatest impact within their existing spheres of influence. Further, considering inequalities around participation across different groups may help target action to the areas of greatest need. Accordingly, the research provides pragmatic guidance for leaders in thinking about how to use staff-engagement campaigns more effectively.

WHAT IS ALREADY KNOWN ON THIS TOPIC

⇒ Improving staff engagement can improve the performance of healthcare organisations. Campaigns may offer one way to rapidly foster this engagement, however, healthcare leaders do not yet fully understand how to maximise staff participation.

WHAT THIS STUDY ADDS

⇒ This study explores why staff do or do not participate in staff-engagement campaigns, finding this is dependent on campaign awareness, perceptions and practicalities.

HOW THIS STUDY MIGHT AFFECT RESEARCH, PRACTICE OR POLICY

⇒ This study supports leaders in pragmatically increasing participation in campaigns, to help build an engaged workforce.

INTRODUCTION

Increasing staff engagement can improve the performance of healthcare organisations.[1–3] Given the challenging context within which healthcare leaders are currently operating, the value of this potential 'silver bullet' is increasingly being realised.[4–6] This paper first considers what we mean by 'staff engagement', explores its relevance within healthcare and looks at an example of a campaign designed to increase staff engagement, to understand why staff do, or do not, take part.

Defining staff engagement

Staff engagement can be thought of as a connection or involvement between an employee and their employment.[7] Despite a 'sterile and unrewarding' debate as to exactly what this means,[4] for work relating to healthcare, the National Staff Survey (NSS) provides a pragmatic solution. The NSS defines staff engagement as engagement with work (through 'motivation') and engagement with the organisation (through 'advocacy' and 'involvement').[3 8] Motivation is seen as 'enthusiasm for and psychological attachment' to a job, advocacy as the 'belief that an organisation is a good employer', and involvement as the ability to 'suggest and make improvements'.[8]

Improving staff engagement

Leadership and management theory highlights staff engagement as a means by which leaders can improve organisational performance.[6 9 10] Evidence from healthcare settings supports this approach, and increased staff engagement has been linked to a reduction in turnover, sickness, and burn-out, and an increase in staff well-being and satisfaction, patient experience, and care quality commission outcomes.[1 2 4] This begs the question; how can leaders develop staff engagement? Healthcare research often focuses on building engagement in specific, 'disengaged' groups such as doctors and nurses.[11 12] There is evidence from other sectors that engagement can be built effectively across the entire organisation.[10 13 14] However, it remains uncertain how healthcare leaders can effectively engage their workforce in the challenging context within which they currently operate.

Context

Leeds Teaching Hospitals NHS Trust (LTHT), one of the UK's largest healthcare organisations,

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provides an example of where staff engagement has been prioritised across an entire organisation.[15] In 2014, the Trust was a financially, reputationally and clinically struggling organisation.[15] A staff-engagement campaign involving 45 000 contributions from 4000 members of staff led to the development of 'The Leeds Way' (TLW), describing the organisation's goals, values and culture.[16] The campaign was perceived as a success; lasting improvements were seen in metrics relating to staff satisfaction and clinical outcomes, and the culture created paved the way for further organisational improvements.[13 15] However, the 2019 COVID-19 pandemic changed the context within which staff were working and coincided with a reversal in these trends. In response, LTHT launched the 'Summer of Connecting' in 2022. This staff-engagement campaign used an online platform, which staff could login to, to put forward ideas, comments and reactions around three areas: reflecting on TLW, connecting to TLW and committing to TLW.[17]

Rationale

Data collected as a part of the 'Summer of Connecting' showed not only lesser participation than in 2014 (10 000 contributions from 1600 staff) but disproportionate participation across different staff groups, known as 'Clinical Service Units' (CSUs). Given the success of prior campaigns, Trust leaders wanted to understand why fewer people took part in 2022, to help increase and interpret participation rates in future staff-engagement activities.

Research question

This exploratory study aimed to understand why staff participate, or do not participate, in staff-engagement campaigns in large healthcare organisations.

METHODS

Data were collected from CSU-specific focus groups and analysed through constructivist reflexive thematic analysis (RTA).[18]

Data collection

The platform used to facilitate the Summer of Connecting recorded which CSU participants belonged to, enabling the ranking of CSUs by the proportion of staff who participated. Purposive sampling, developed with the director of HR, was used to select from the highest-ranking and lowest-ranking CSUs that met the following criteria:

1. Inclusion of at least one clinical CSU with high and low participation, as they comprise a large proportion of the overall workforce.
2. Exclusion of CSUs in which participation was not feasible due to insufficient size (management executive) or inability to fairly remunerate (bank staff CSUs).
3. Joint focus groups (finance and HR) across corporate CSUs with similar proportions of participation to increase feasibility despite their smaller size.

This led to focus groups being carried out in the CSUs outlined in table 1, before thematic saturation was reached.[19 20]

Recruitment within each CSU was voluntary, through emails sent out to whole-CSU staff-distributions, and promotion at relevant team meetings. Sign-up to focus groups was on a first-come-first-served basis. Staff were ineligible if they were directly involved in developing the campaign.

40 min focus groups were planned to run with 6–8 participants at locations within the trust specific and familiar to each CSU. Given concerns about unpredictable staff availability, and the impact of over-recruitment on CSU capacity, groups aimed to proceed with four or five participants in the event of non-attendance.[21]

Table 1 Purposively selected CSUs

CSU	Percentage of workforce	Percentage of CSU participating in campaign
Estates and facilities	10.2	2.0
Training grade doctors ('clinical')	4.2	2.8
Head and neck ('clinical')	1.3	12.9
Research and innovation	1.7	15.5
Finance combined with HR ('corporate')	2.4	29.9 (finance) 31.4 (HR)

CSU, clinical service unit; HR, human resources.

Groups involved in discussion of a hypothetical scenario (online supplemental appendix 1) modelled around the 'Summer of Connecting', encouraging objective discussion and preventing any perceptions of judgement around actual participation. The scenarios focused on a subject, chosen in consultation with CSU leads (table 2), who would be relatable to CSU staff. Questions were developed with support from broader behavioural theory,[22] and insights held within the Trust; for each group, HR and staff-engagement leads were consulted to tailor questions to CSU-specific cultures and hypothesised issues around participation (table 2).

Data were collected to support a further research question around campaign impact considered in a separate paper. Additional questions were asked outside those in table 2 relating to this study.

The lead researcher facilitated all groups; gaining written consent, describing the scenario, asking preprepared questions (including those around CSU-specific issues), and probing to encourage elaboration where required. To prevent deanonymisation, demographic details of participants were not collected.

Data analysis

Data were analysed through RTA, conducted by the lead researcher in line with the six steps laid out by Braun and Clarke, from a constructivist epistemological perspective.[18 23] From the study conception, there was a desire to think about staff engagement through a 'public health lens', and the reflexive methods chosen facilitated the public health specialty registrar appointed as lead researcher in doing this.[18] The researcher spent time with senior leaders across the Trust to shape the analysis into something useful to other healthcare leaders operating in a similarly challenging environment.

Data were collected through audio recordings of focus groups and transcribed by the lead researcher. Transcripts were checked back against audio recordings, re-read to familiarise the researcher with the data and reviewed using Microsoft Word to generate initial semantic and latent codes.[18] Coding was iterative, beginning after the completion of two focus groups and repeated across all available transcripts after the completion of each additional group until thematic saturation (calculated through a 5% new code threshold) was reached.[19 20]

Printouts of codes were combined into themes and subthemes. Themes were conceptualised iteratively, through repeated testing against the original transcripts, and the criteria laid out by Braun and Clarke.[18] Themes were then named, described and discussed in the context of the research question, underpinning rationale and wider literature.

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Table 2 Focus group topic guide summary

CSU	Estates and facilities	Training grade doctors	Head and neck	Research and innovation	Finance and HR
Scenario subject	Ward housekeeper	CT2 in acute medicine	Staff nurse	Clinical trials assistant	Management accountant
Acronym	WH	CT2	RN	CTA	MA
'All CSU' Areas of Questioning	Do they know that this campaign is taking place? Do they want to take part in the campaign? What might prevent them taking part in the campaign?				
Hypothesised Issues	Technology Anonymity Disconnect with management	Survey fatigue Belonging (Trust) Time	Trust Belonging (CSU) Belonging (Trust)	Communication Transparency Belonging (CSU)	Survey fatigue Anonymity Technology

CSU, clinical service unit; CT2, Core Trainee; HR, human resources.

RESULTS

Five focus groups were conducted, with 31 initial respondents, of which 25 then attended, with a minimum of 4 and maximum of 6 attendees per group. RTA led to the identification of 54 codes which were developed into three themes: campaign awareness, staff perceptions and practicalities (online supplemental appendix 2).

Campaign awareness

Centralised communications were disproportionately effective in reaching staff to inform them about the campaign, with preferences expressed for locally tailored alternatives. While corporate roles viewed reading trust communications as a part of their job, and felt these were an effective channel for communications, those in all other roles did not (table 3). Clinical participants agreed they deleted or ignored centralised communications. Such participants attributed a combination of lacking time, email access or relevance and felt that staff received too many Trust emails already. Although there were broad themes across CSUs as to preferred alternatives, such as emails from CSUs, notice boards, CSU-specific digital platforms, line-manager meetings, social media and drop-ins, there was no consensus around a single method. Instead, there was recognition that a flexible and localised approach was required.

Beyond preferences around the pathway of communications, there were preferences around their style, with a universal preference for accessibility and transparency (table 3). It was felt that the language used was too corporate, even in corporate CSUs, with further concerns about the length of messages, especially given the busy workloads of staff.

Finally, there were clear preferences as to how the content of communications could affect participation, with a desire to know specific details about the campaign (table 3). First, staff wanted to know why the campaign was being carried out, and exactly what was wanted from them. Second, they wanted to know how this linked up to previous campaigns, and other work around staff-engagement such as the NSS. Finally, they wanted some evidence of potential effectiveness, including examples of action that has followed prior engagement campaigns.

Table 3 Supporting quotes—campaign awareness

Source	Quote
MA blue	'[MAs assured of] pretty much everyone's access to email'
CT2 purple	'Directed them [Trust emails] into my junk'
CT2 blue	'It's not for me [Trust emails], it's for the permanent staff'
RN grey	'You can get you know two or three [Trust emails], whatever, delete, delete, delete'
MA orange	'Not engaging, it has a corporate feel'
CT2 red	'Where does this information go, who looks at it, do they value it, who's doing this'
WH red	'[Would like to know] the key things that we've achieved since the previous survey'

CT2, core trainee; MA, management accountant; RN, registered nurse; WH, ward housekeeper.

Staff perceptions

Staff perceptions of the campaign were divided into subthemes around its perceived effectiveness, purpose and relevance.

Perceived effectiveness: will this lead to any kind of change?

Staff were motivated to participate if they thought the campaign would effect change. There was a perception previous campaigns had been ineffective, which decreased motivation to participate in the future, especially in longer-serving staff (table 4). Staff felt similarly around a perceived lack of prior acknowledgement and follow-up, devaluing not just the contributions made, but the act of contributing itself.

Staff highlighted alternative modes of engagement perceived as being more effective, most frequently involving face-to-face sessions, conversations with line managers and national surveys. Face-to-face engagement with local, CSU and trust leaders was desired across all groups, although there was no consensus as to how this was best organised. There was a greater contrast in views around the use of national surveys and discussions with line managers. Those who felt their line managers wouldn't listen (core trainees (CT2s)), felt national surveys offered a safe space for critical feedback. Those who felt their line mangers

Table 4 Supporting quotes—staff perceptions

Subtheme	Source	Quote
Subtheme 1	CT2 blue	"We've had lots of conversations… …and nothing's ever changed'
	MA orange	'Why haven't I completed it, because they didn't do anything about it the last time I completed it'
Subtheme 2	WH red	'They [managers] are trying to engage with staff, you feel that is happening more than in the past'
	RN grey	'[Management] live in another land'
	CTA red	'Stuff is not going to be listened to'
	CT2 blue	'It [negative feedback] would come back to you'
Subtheme 3	RN purple	'[We'll] participate, if it's regarding workload'
	CT2 blue	'I belonged to my CSU, but I don't really belong to the Trust'
	WH blue	'We're all part of the trust, and part of the team'
	MA purple	'We want to be seen that we're contributing'
	CT2 yellow	'Bribe people to come with food'

CT2, core trainee; CTA, clinical trials assistant; MA, management accountant; RN, registered nurse; WH, ward housekeeper.

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were best able to enact their ideas (ward housekeepers, WHs) felt national surveys and potentially campaigns such as this, were superfluous. However, despite the preference for varied methods, the frequency of surveys and campaigns relating to engagement compounded frustrations around inaction, leading to survey apathy.

Perceived purpose: will this lead to the right kind of change?

Prior experiences affected how staff perceived management structures, which in turn altered perceptions about the underpinning purpose of the campaign. The campaign was seen as a 'box ticking exercise', especially in clinical CSUs. These views were frequently associated with stories of negative experiences with undifferentiated 'management'. On further challenge, personal interactions with known managers were generally described as positive (table 4). Grievances were usually with management that was disconnected and non-visible, especially with CT2s, registered nurses (RNs) and clinical trials assistants (CTAs) (table 4). The impact of negative experiences was shared and amplified by staff linking them to identities they believed were devalued in favour of the perceived majority. Identities around lower pay banding, non-clinical roles, satellite sites, rotational contracts and race were all provided as examples of groups that felt excluded.

Experiences of mistrust were especially important in determining the perceived riskiness of participation, with fears of reprisals. Despite the promise of anonymity, there were widespread concerns as to its validity. This concerned some groups, especially the CT2s, because of prior examples of colleagues being labelled as troublemakers, as a result of deanonymised contributions to national surveys (table 4). Mistrust led to the belief that contributions could negatively impact team relationships and career progression. These concerns were highest at a local and CSU, rather than Trust, level.

Perceived relevance: will this lead to change that effects what I care about?

For the campaign to be relevant, staff had to feel a sense of belonging to the trust or see evidence of relevance in subsections of the trust to which they did belong. Several staff groups felt the campaign was irrelevant because they did not work clinically, they were not permanent staff or they deprioritised the perceived objectives (table 4). These feelings stemmed from disconnects between the groups to which staff felt they belonged, and the groups to whom they felt the campaign was relevant. Belonging to a local team appeared near universal but was variably present at a departmental, CSU and Trust level. CT2s felt they belonged to their CSU, but not the Trust, while WHs felt a greater sense of belonging to the Trust as a whole (table 4). Where belongingness was lacking, there was a perception that different people were working towards different goals. However, in contrast to negatively weighted perceptions around effectiveness and purpose, if the campaign appeared relevant to any of the groups to which staff belonged, they felt motivated to participate. Those who felt belonging towards the trust as a whole felt this was a chance to bypass ineffective middle management. While those belonging to the CSU did not want to let their group down if they knew CSU leaders valued participation (table 4). Where no chain of belongingness existed, participation was seen as transactional (table 4).

Practicalities

Practicalities relating to capacity and technology impacted participation, with differential effects across CSUs. CT2s and RNs felt capacity was already stretched, and participation inside work hours was not possible without dedicated protected time (table 5). The online nature of the platform presented some staff with barriers in access. Some staff did not have a National Health Service (NHS) email address, especially WHs, others did not have access to adequate information technology at work (WHs, RNs and CT2s) and others (self-ascribed to being older) felt they would lack the required skills to navigate the platform (table 5). Some CT2s found these barriers so significant that they were entirely put off participating. Others expressed preferences for more accessible alternatives, involving face-to-face interactions with line managers (WHs), CSU managers (CT2s) or the Trust leaders behind the campaign (RNs, CTAs, management accountants).

Table 5 Supporting quotes—practicalities

Source	Quote
CT2 blue	'[Around ability to participate at work] putting myself in the CT2's shoes, I was watching TV doing it'
WH red	'If you haven't got a NHS email address, you can't use your personal login'

CT2, core trainee; WH, ward housekeeper.

DISCUSSION

Summary of findings

Participation in staff-engagement campaigns is dependent on staff knowing about the campaign; perceiving it as effective, well purposed and relevant; and having the required time and technology to take part. While this largely conforms with existing research, the findings present leaders with insights that can inform action.[11 24] Discussion of these implications reflects the underpinning rationale for this research: how can organisations increase overall participation, how can they increase the equity of participation and what wider inferences can they make from participation data?

Increasing participation: solving the engagement conundrum

Staff engagement was a powerful driver of participation, which presents a conundrum: how do you encourage participation in staff-engagement campaigns, if engagement is a prerequisite for participation? There is a close relationship between the components of engagement as defined by the NSS, and the perceptions underpinning participation: advocacy and purpose; involvement and effectiveness and motivation and relevance. This appears problematic for healthcare leaders, implying that staff-engagement campaigns might only be of use in a workforce that is already engaged. The dominance of negative experience over positive experience in shaping perceptions compounds this issue.

Solving the conundrum: belongingness

Belongingness appears as an important exception to the pervasiveness of negativity, and a way in which engagement can be rapidly fostered. Belongingness is the need to 'form and maintain strong, stable, interpersonal relationships' and can act as a 'powerful, fundamental and extremely pervasive motivation'.[25] If staff belonged to the group within which negative experiences occurred, they appeared not to generate negative perceptions about that group. Experiences were either seen as unavoidable, 'managers are human and they struggle' (RN blue) or associated with actors outside of the group. Contrastingly, positive experiences appeared more likely to lead to positive perceptions, with most comments about managers and leaders that belonged to the

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same group as the individual being favourable. Prior research confirms the importance of belongingness in building an engaged workforce, although this study helps leaders in making more of this apparent link.[5 25–27] Suggested solutions focused around visible leadership (discussed below), and better harnessing existing belongingness by integrating units of belonging into organisational structures.

Solving the conundrum: visibility

Visibility at the right level allows leaders and managers to better use belongingness as a tool to increase both participation and engagement. For managers, this was achieved through being visible within pre-existing staff groups, demonstrating and sharing belief in the campaign's value. For leaders, this was achieved by personally sharing and exemplifying the campaign, creating new belongingness around existing management structures (eg, CSUs, 'The Trust'). The WHs, who described close relationships with known managers at multiple levels, felt 'part of the trust and part of the team' (WH blue) and that despite 'the size of this organisation, it does feel very local' (WH green). In contrast, some RNs, CT2s and CTAs felt they could not put a face to managers and leaders, correlating with discourse about 'bad experiences with management' (CT2 blue) and 'management's agenda' (CT2 red). Literature exploring how to create belongingness aligns with this approach, with potential solutions focusing on visible, authentic and personal leadership.[28] However, the role of 'middle' managers in harnessing existing belongingness through greater integration into teams and networks appears to be an underappreciated line of further enquiry.

Solving the conundrum: setting the narrative

Communications around the engagement campaign had the potential to shape perceptions, as well as create awareness. Negative perceptions appeared most powerful when addressing gaps in knowledge. Staff were keen for these perceptions to be challenged, and felt that if communications did this, they would be more motivated to participate. In line with the subthemes around perceptions, staff felt communications could increase participation if they provided: evidence of effectiveness (or the effectiveness of prior campaigns); clear description of purpose and description of why the campaign was relevant to them.

Increasing participation: reflexive learning

Participation is a behaviour, impacted for and against by the wide-ranging factors covered in the three themes. Behavioural science aims to understand how these factors shape behaviour and has led to the development of models to guide 'behaviour change'. The 'COM-B' model provides a good fit for the themes developed in this study (table 6).[22] While some drivers are likely already areas of focus for leaders, subject to significant externalities, others appear well within their sphere of influence. The application of the model has further value in seeing the behaviour (participation) as more than just an outcome. Just as 'capability-opportunity-motivation' effect participation, participation will impact subsequent 'capability-opportunity-motivation'.

Increasing participation: addressing inequality

In LTHT, there were inequalities in participation (table 1). Those who felt undervalued, overworked, discriminated against or excluded were less likely to take part in the campaign. As a result, these groups were less likely to become engaged with the organisation and even less likely to participate in future campaigns. This creates a cycle of increasingly disproportionate engagement. Marmot's principle of 'proportionate universalism' appears relevant in guiding the solutions: 'actions must be universal, but with a scale and intensity that is proportional to the level of disadvantage'.[29] A deeper understanding of participation, as summarised in table 6, can direct where the 'scale and intensity' in required, and what it might look like for different groups.[29] The link to 'public health' terminology is not solely metaphorical. Large healthcare organisations are anchor institutions, and both staff engagement and belongingness provide means through which they can positively impact the health of individuals and communities.[25–27]

Interpreting participation: participation as a measure of engagement

Throughout this, and other, research, the link between participation and engagement has been highlighted, creating the temptation to use participation as an indicator of engagement.[24] However, we have seen that many other drivers of participation exist (table 6), meaning participation is not a proxy measure for engagement. Further, staff preferred to use different platforms to express positive and negative feedback, as was demonstrated through discussion around the NSS. To understand the level of workforce engagement, leaders cannot rely solely on a single data source (such as the NSS).

Limitations

This research involved smaller-than-intended focus groups and is unlikely to be fully representative of the diversity of the whole Trust. Non-attendance was an issue in some groups, resulting with as few as four participants per group. However, given the discussion that groups generated, this was not thought to have compromised results.[21] The research prioritised deeper exploration over generalisability, as qualitative research is suited to, hence the choices around convenience sampling (and the

Table 6 COM-B informed drivers of participation

COM-B Component	Influencing factor	Key drivers	Suggested solutions
Capability	Awareness of the campaign Ability to use required technology	Effectiveness of communications Methods of participation	Locally tailored communications Flexible means of participation
Opportunity	Capacity to take part Sufficient access to required technology	Staff capacity Information technology infrastructure Methods of participation	Protected time Flexible means of participation
Motivation	Perceived effectiveness Perceived purpose Perceived relevance	Engagement Prior experiences Belongingness Visible leadership Campaign communications	Integrate existing belongingness and management structures Visible, personal and authentic leadership Provide evidence of prior effectiveness Share campaign purpose Specify relevance to staff

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potential for self-selection bias), collecting data to the point of saturation and not collecting additional demographic information.[30] Accordingly, the results do not form a simple recipe for success but provide leaders with starting-off points to be developed further through contextual knowledge and additional evaluation.

CONCLUSION

Healthcare organisations work better with an engaged workforce, and staff-engagement campaigns offer a method to build this engagement. This research demonstrates what factors may be driving participation, and non-participation, in such campaigns. Staff need to know about the campaign; they need to be engaged with the organisation; and they need to be provided the opportunity to take part. The research has looked beyond the 'conundrum' of participation being dependent on pre-existing engagement, highlighting drivers more likely to sit within leader's sphere of influence and frameworks from the wider literature that may support them in addressing these. Accordingly, the research provides pragmatic guidance for leaders in thinking about how to use staff-engagement campaigns more effectively. Leaders could gain further value through additional evaluation of participation in subsequent campaigns, and research into the impact participation and non-participation in such campaigns have on staff engagement.

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