

10

Motivating and retaining employees

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Chapter topics

- Why motivation and retention of employees are important in healthcare
- Current evidence and thinking on the relationship between motivation and engagement, employee well-being and organisation performance
- The role that leadership, including self-leadership, plays in motivation
- The impact of uncertainty and change on motivation
- Practical recommendations on how to enhance employee motivation and retention

Introduction

The healthcare sector globally faces a sustainability crisis. Over the last 50 years, the costs of healthcare have outpaced economic growth by an average of 2 per cent (World Economic Forum 2013). Better treatment, new technologies, increased longevity, growing populations and more informed patients mean that health spending is continuing to rise while affordability has been impacted by the pressures on GDP growth since the economic crisis of 2008. At the same time, the high dependence on expert personnel and the individualised nature of the service they provide makes it difficult to keep costs below an economy's rate of inflation (Morgan 2015). Labour costs are a high proportion of the healthcare budget.

Across the globe, around 10 per cent of GDP is spent on healthcare. It is likely the amount spent on healthcare will remain at this level over the next few years (The Economist Intelligence Unit 2014; Morgan 2015; OECD 2015). The fastest growth in spending over the next ten years is likely to be in the Middle East, Africa and Asia. In many of these countries the affordability of investment will be tested by economic volatility and political uncertainty. In the OECD countries, growth will be very slow, apart from North America where growth is hard to predict because of healthcare reforms. Government spending reductions have meant that, since 2008, overall OECD healthcare spending as a share of GDP has remained stable and there is little sign of this changing. In Western Europe, in particular, heavy government debts and constraints on tax revenue limit the opportunities for further growth in spending.

The healthcare workforce differs from the wider workforce in a number of ways. The sector is very labour-intensive. In the UK, for example, around 5 per cent of the workforce is employed in healthcare. It is highly educated (48 per cent of staff

are professionally qualified in the UK) and has a higher proportion of women workers than the general population. The cost and length of time it takes to train doctors, nurses and other professional staff mean their skills can be in short supply and it is difficult to balance supply and demand (Health e-carers Blog 2015; The King's Fund n.d.).

There are political as well as social pressures for change. Questions about how much of a nation's resources should be devoted to healthcare and how the service can best be provided are complex issues which have no simple answers. The mix of public and private sector provision that characterises the sector further complicates the picture. The consequence is that the healthcare environment is often characterised by abrupt changes in strategy and direction as political leadership goes in and out of power. Periods of profound uncertainty are often the result. Politicians can easily be tempted to become over-involved in operational matters and may set unrealistic budgets and targets. Change is inevitable and essential but support for implementation is rarely steady, consistent and reliable. Discontinuity and unexpected change are more common (Dixon 2015; Morgan 2015).

Change and uncertainty on this scale bring both opportunities and threats. The impact on a highly educated, talented and generally self-motivated workforce, many of whom have entered their profession in order to help others and provide care and support rather than for purely financial reasons (Wren 2014), should not be underestimated.

In these circumstances, retention of staff can become an important issue (The King's Fund 2013; HCO News 2015). A study by Health e-Careers (2015), based in Centennial in the US, has found that nearly one-third of healthcare recruiters rank employee turnover as their top staffing concern. The costs of recruitment and getting people up to speed can be high. Furthermore, it is not always easy to find people with the right skills. Covering positions with short-term temporary contractors or agency staff can be very expensive.

Highly educated and well-trained health professionals, many of whom have skills which are in short supply, can ultimately vote with their feet if they are not happy with their work or organisation, especially when better opportunities exist elsewhere. Some healthcare professionals, such as nurses and doctors, are in demand internationally (World Health Organisation 2010). Ultimately, there is also always the possibility of well-educated staff leaving the sector to work in another industry altogether (Centre for Workforce Intelligence 2014).

On the other hand, a certain degree of turnover can be desirable. Situations may arise where roles are changing, different skills are needed and the individuals holding these roles either are not prepared to change or lack the ability to do so. The key challenge in these circumstances is to find ways of retraining and/or encouraging staff movement. There is also a trend, particularly with the millennial generation, for people to move around rather than look for a job for life (Meister 2012). While this may affect organisation stability and 'memory', it can also help with flexibility and renewal. Overall, there is a balance to be struck between too much and too little movement.

People choose to leave their jobs for a variety of reasons (Torrington et al. 2011). Competition from other employers, one of the so-called 'pull factors', can

be a very important reason, particularly when skills are in short supply and the market is growing. Salary and pay are often important as people strive to improve their standard of living. A more attractive location and/or better working conditions can be a draw. People may also decide another job provides better opportunities for personal and career development.

However, a number of studies have shown that it is dissatisfaction with work or the organisation that leads most commonly to unwanted turnover (Taylor 2002; Branham 2005). These are called 'push factors' and include job dissatisfaction, lack of career development, boredom, and poor supervision or management. They point out that very few people seem to leave jobs where they are broadly happy.

Research on turnover in healthcare, particularly with nurses where there have been shortages for some time, bears out these general points (e.g. Cooner and Barriball 2007; Li et al. 2011; Toode et al. 2011; Leineweber et al. 2016; Robson and Robson 2016). Overall, the results indicate that the workplace environment has a large impact. Flexibility of schedules, supportive leadership and improving the practice environment are critical. High workloads and insufficient resources can be a source of dissatisfaction and can reduce the 'meaning' associated with work. Nurses who feel that there is an imbalance between effort and reward are more likely to want to leave.

Motivation, engagement and performance

In these circumstances, it is hardly surprising that the subject of staff motivation and engagement has become an important topic for the health sector. Engaged employees are less likely to leave an organisation (Towers Watson 2014). They hold a more positive attitude (Rayton et al. 2012) towards their work, the organisation and its values. They tend to speak well of their organisations, and are willing to give extra discretionary effort – 'go the extra mile' – whenever necessary (Hay Group n.d.).

The mind-set of an engaged employee has been summarised as 'say, stay and strive' (Aon Hewitt 2014). Engaged employees are emotionally and intellectually committed to their work and their organisations and are willing to do what it takes to ensure a successful outcome. They make a personal choice to do more than the bare minimum. They are typically energised, involved in and passionate about their work. They tend to be proactive, persistent, helpful to others, and can be trusted. Engaged workers are generally satisfied and happy as well as fully committed.

The Macleod Report for the UK government came to the conclusion that employee engagement is the single most important factor in creating outstanding organisational performance (Macleod and Clarke 2009). It is for this reason that engagement has become a topic of huge practical importance across a range of industries.

Subsequent research was carried out by the 'Engage for Success' taskforce (2012, 2014) from a whole variety of sources in an effort to 'nail the evidence' on engagement. They brought together academic research, data compiled by research houses (such as Towers Watson, Kenexa, Hay, Aon Hewitt and Gallup)

and case studies/in-house experience from a number of leading UK organisations (including Marks and Spencer, BAE, Olympic Delivery Authority). Employee engagement was shown to impact positively on performance and productivity, absenteeism, levels of innovation, customer service, positive outcomes in public services and staff advocacy of their organisations.

How much scope is there to improve levels of engagement in the healthcare sector? On the basis of their global employee survey data, Towers Watson (2011) commented that in healthcare, 'Employee engagement is far lower than optimal, particularly in a profession which requires significant dedication and energy.' Cornerstone (2015) came to a similar conclusion for the United States, based on data obtained from asking expert respondents in senior positions. While definitions and measurement methods vary, both studies show that at least half of the workforce is not giving full discretionary effort. In the United Kingdom, a review of leadership and engagement in the NHS by the King's Fund (2012) provides further evidence for the importance of engagement in healthcare.

Levels of staff engagement make a difference to the patient experience. West and Dawson (2012) highlighted a study by Prins and colleagues (2010) of more than 2000 Dutch doctors which showed that those who were more engaged were significantly less likely to make mistakes. Similarly, a study of more than 8000 hospital nurses by Lashinger and Leiter (2006) found higher engagement was linked to safer patient care. A more recent study by Maben (2010) on the 'feel good' factor has shown evidence for a link between staff well-being and the quality of patient care.

Engagement and well-being

An important factor affecting engagement is the very demanding nature of many healthcare jobs. An independent survey on well-being of 3700 public and voluntary sector staff in the United Kingdom, commissioned by *The Guardian*, showed that NHS staff were more likely to feel stressed because of their job than any other public sector workers (*The Guardian* 2015). Some 61 per cent of healthcare professionals who took part in the research reported feeling stressed all or most of the time. Indeed, it has even been argued that stress and burnout are 'inevitable problems for the highly committed, highly involved individuals who work in healthcare services' (McManus 2007) as they deal with the physical and emotional problems of seriously ill patients, cope with running effective teams, manage conflicting demands and follow rigorous governance processes.

A number of studies highlight the importance of staff having control over their work. West and Dawson (2012) emphasise the need for managers to give staff autonomy as well as providing support, recognition and encouragement. Mauno and colleagues (2007), in a study of Finnish health staff, showed that staff having control over how they did their jobs was the best predictor of engagement. In an earlier study, Hakanen and colleagues (2006) found job control and manageable workload had an impact on engagement.

Having control over one's workload is important in an environment where lack of resources can be a key issue. The Yerkes-Dodson law, originally proposed in 1908,

postulated that there was an optimum level of arousal for peak performance: the same principle applies to engagement and workload (Yerkes and Dodson 1908). It is impossible to be truly engaged if workload is too low (which can be boring and frustrating) or too high (which can lead to stress and burnout). Over one hundred years after the original research, the issues for modern healthcare professionals are generally associated with too much rather than too little workload (Hurst 2008; Prins et al. 2010; West et al. 2012).

Donaldson-Feilder et al. (2011) reviewed the consequences of excessive pressure on employees. As far as the individual is concerned, work-related stress can affect physical and psychological health, as well as social and relational behaviours. The psychological contract between employer and employee is affected: engagement, commitment, and morale drop, and there is a propensity to complain about unfair treatment. The organisational impact can be far-reaching and carry substantive costs. They provide evidence for stress resulting in increased sickness absence, presenteeism, accidents, and turnover.

Donaldson-Feilder and colleagues (2011) also emphasise the importance of the immediate supervisor in creating a healthy work environment. They provide tips and advice on how this can best be achieved through managers adopting a considerate and positive approach. The importance of positive leadership in the healthcare environment has been confirmed by a number of authors (Nembhard and Edmundson 2006; Alimo-Metcalf et al. 2008; Laschinger et al. 2012) while the dysfunctional consequences of abusive supervision have been explored by Tepper et al. (2008, 2009).

Managers who are stressed can impact others (McKenna 2015). They typically display a narrowing of focus, a lower 'bandwidth' of attention and less empathy. Staff who are overloaded are forced to prioritise and make difficult choices on what they should and should not do. In a highly cost-conscious environment and in the absence of clear organisation values, the provision of compassionate care to patients may suffer. For example, nursing staff in the UK Mid Staffs hospital, faced with severe resource constraints and lacking proper leadership, ended up prioritising paperwork above patient care (Francis 2013).

The drivers of engagement

Given that engagement is so important, how can an organisation best go about building it? Unfortunately, there is no single driver of engagement and there is no simple way of improving it directly. The exact drivers will differ in different organisations, at different times and in different circumstances. The factors affecting engagement in any specific situation need to be determined from a clear and deep understanding of that organisation's culture and climate (Plenty 2001; Robinson et al. 2004; Bedarka and Pandita 2014).

Measuring engagement provides the best starting point. There is no substitute for accurate diagnosis. Employee surveys can be helpful in pinpointing the issues especially when they are used as a basis for dialogue and discussion. Data from surveys can be backed up by information gained from in-depth individual discussions and focus groups (Plenty 2001).

Notwithstanding the difficulties of applying findings from general studies directly to any specific organisation, there is abundant research on general drivers of engagement available from commercial consultancies and employee survey providers who have the benefit of gathering vast amounts of data from international companies to provide food for thought. Whilst there are no universally agreed definitions, models, frameworks and standards, there is a good deal of commonality in the findings. For example, Aon Hewitt report annually on trends in global engagement (2014). Their research emphasises the importance of organisation reputation, career opportunities, recognition, pay and communication. People want a path, goals and focus, and like to be part of a winning team. Aon Hewitt (2014) also find that leadership is key and the ability of leaders to engage and connect with their staff is critical.

Towers Watson (2014) find that there are three measurable components to engagement which is sustained over a period of time. These are traditional engagement (employees' commitment to expend discretionary effort); enablement (having the tools, resources and support to do a job effectively); and energy (having a work environment which actively supports physical, emotional and interpersonal well-being). Leadership is a driver – not just of sustainable engagement overall – but also of each of the components.

Sirota and Klein (2013), using data from over 3 million results globally, have produced a three-factor model of engagement which shows that a sense of achievement in work (**A**chievement), a socially supportive environment (**C**amaraderie), and a sense of fairness (**E**quity) (**ACE**) account for much of the variance in their data. Leaders who create an 'ACE' culture and climate provide a very helpful environment for staff motivation.

We have found from our own work on leadership and consultancy work that most health and social care professionals are strongly motivated by the meaningful work they do and the contribution they make (Plenty 2015). Most have a strong sense of purpose and enjoy the opportunity of being part of a team. They enjoy 'making a difference' and caring for others. They generally work best when they are treated with respect, given the authority, responsibility and autonomy to get on with their jobs, have the flexibility to organise their own work and are given the necessary support to do their job well (equipment, technology, processes). It is also important for them to be able to understand the organisational 'big picture' and see opportunities for personal development.

The UK-based social enterprise Your Healthcare (2016) provides a very good example of this kind of environment. This organisation is a not-for-profit social enterprise whose core business is to provide high-quality, person-led health and social care services for residents in Kingston and Richmond in South-West London on behalf of the NHS. It provides a wide range of integrated services, including general and specialist community-based nursing, therapies and social care, and very specialist neuro-developmental support, children and families community-based services, as well as running a residential home, community in-patient beds and a range of infrastructure services. Your Healthcare has set out to empower and support front-line staff by giving them more freedom in how they operate by cutting bureaucracy and red tape. It has developed a manifesto for how staff are expected to work together (Your Healthcare 2015) (Box 10.1).

Box 10.1 The five freedoms of the ‘Your Healthcare’ Manifesto

Your Healthcare earned the right to become a community interest company independent of the NHS in 2010 and since then has focused on cutting bureaucracy and red tape. By 2015, it had become a £30m business with about 700 employees. It has reduced the number of senior and middle managers and focused resources and effort on supporting front-line staff, who are members of ILTs, i.e. ‘independently led teams’, and have a great deal of flexibility in how they manage and organise their work.

A ‘Manifesto’ (2015) has been put in place which articulates ‘five freedoms’ for ILTs:

- 1 Freedom to change things for the better.
- 2 Freedom to ask questions.
- 3 Freedom to tell ‘our great stories’ to help retain and grow the business.
- 4 Freedom to innovate.
- 5 Freedom to talk to partners about aligning services for greater gain for the community and best value for our commissioners.

The organisation has been successfully trading for six years and the feedback received shows services are seen to be of high quality. Staff survey results confirm staff are generally and genuinely motivated. Further innovation in integrating health and social care is planned for the future.

Motivation in times of change

Healthcare organisations around the world, particularly those in mature markets, are currently going through substantive change and restructuring. Since 2008, many have imposed ‘top-down’ changes to cut costs. This has usually been carried out through strong directive leadership, more centralised control, top-down restructuring, tight performance management and opening up parts of the organisation to increasing competition and market forces through outsourcing (The King’s Fund, 2012).

The challenges of introducing top-down strategic change in the healthcare sector are considerable and make strong demands on leadership. If insufficient attention is given to the people dimension, morale can drop, performance will suffer and absenteeism and sickness increase. An adversarial climate can develop, resulting in alienation, a poor industrial relations climate, and high turnover. This may be seen as a necessary price to pay by those responsible for driving the change but can translate into real problems with attracting and retaining staff as well as strong resistance – and even resentment – to introducing the changes desired. The Junior Hospital Doctors dispute in the UK NHS illustrates well the complexities and issues associated with top-down efforts to reform the sector (BBC News 2016).

Directive change of this nature is sometimes seen as essential as it can be done quickly and bring immediate results, particularly where there is pressure to balance the books. The consequences have generally been a combination of restricting service provision, rationing of services, cutting staff, giving below inflation pay increases and – occasionally – more efficient ways of delivering the service (The King’s Fund 2012). From an employee’s point of view, change of this nature is rarely motivational, at least in the initial stages. People have little control over what is happening to them, workloads increase as resources become more constrained and the cost-cutting mentality begins to bite and there is often a difficult transition period where new models of working are not yet established. Resentment can set in. In many cases people feel uncertain about their personal situation and job security. Social relationships and support structures are likely to change. Development opportunities are limited (Bridges 2009).

Our experience from working with organisations in these circumstances is that the level of motivation typically drops in the initial stages and then either recovers or continues to decline depending on the quality of leadership (Morrissey and Plenty 2013; Plenty 2001) (Figure 10.1).

This framework also fits with leadership lessons from the Antarctic explorer Shackleton (Morrell and Capparell 2002). For motivation to recover, people must trust their leaders and have a clear idea of where the organisation is going. Communication is of the essence: people need to understand and believe in the strategic direction their organisation is taking and feel there are still opportunities for development. Provided top leaders are able to really connect with their staff, and if adequate support (training, equipment, systems and processes) is put into place to enable people to do their jobs well, it is likely that motivation will

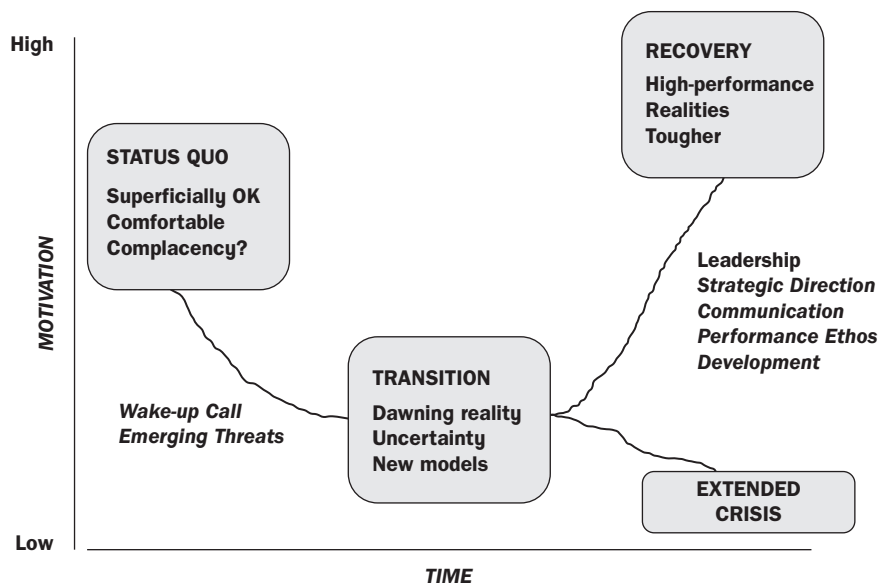


Figure 10.1 The dynamics of top-down change

Source: Morrissey and Plenty (2013).

recover and improve beyond the initial starting point as roles are clarified and the expectations of what is required become clearer.

The risk of a top-down approach, from a healthcare perspective, is that without skilled leadership – and particularly when the pressures to change are as intense as they can be in healthcare – a preoccupation with narrow financial targets and a lack of concern for patient care can be the result. Some healthcare organisations, for example, in the NHS in the UK, have developed top-down, highly target-driven cultures which have at times led to a bullying and less than compassionate culture (The King's Fund 2012; British Psychological Society 2014).

In the healthcare environment, it is important to keep 'compassionate care' as a principal objective (Ballat and Campling 2011; Berwick 2013). Leadership behaviours which facilitate a more considerate – and effective – approach for the NHS have been described by Storey and Holti (2013). This can also be helped by providing staff with structured organisation-wide reflective spaces to manage the psychological challenges posed by the healthcare context, for example, by the use of Schwartz Centre Rounds or by promoting other forms of reflective practice (The Point of Care Foundation 2014; Wren 2014).

In the long run, a top-down approach to change is rarely sufficient. The scope to cut costs by reducing headcount is limited for safety and governance reasons. Simple structural solutions rarely last in the complex world of healthcare provision where regulations, governance and associated organisations are in a state of constant flux (Morgan 2015). High workloads, an uncertain environment and the pressures and responsibilities associated with working with unwell people in a highly regulated system can all make for a very challenging and demanding workplace.

Long-term sustainability requires transformational change if levels of service are to be maintained, let alone improved (The King's Fund 2012). Innovative technology, a focus on prevention, new business models, simplified processes, improved cooperation and collaboration between health and social care, and 'co-production' – where more responsibility for one's own health is taken by individuals – are all likely to be required (Batalden et al. 2015). These changes must be achieved in an environment which is heavily regulated and controlled and where the prevailing ethos of the service providers is social as well as economic.

The way that change is managed and people are led can make a real difference to the enthusiasm that people have for the changes required. The healthcare workforce is well educated and talented. Given the right organisation culture and leadership, there is an opportunity to transform the way that healthcare is delivered by involving people with experience on the front line in streamlining work practices and coming up with innovative approaches to care. This can be an engaging, motivational experience with opportunities for real personal development (Dixon, 2015).

This approach is inherently more engaging than an imposed top-down approach, as it is based on the power of intrinsic motivation which typically increases as people take on more responsibility for themselves (Deci and Ryan 1985, 2000; Ryan and Deci 2000). However, putting into place the culture of trust, transparency, openness, experimentation, freedom and accountability required can be quite a leadership challenge.

In practice, the implementation of change is rarely straightforward (Plenty and Morrissey 2013). The case study in Box 10.2 is based on the authors' personal experience as Directors of a Women and Children's Refuge (Aoibhneas 2016) facing substantive cuts in budget but also needing to change the way it operated. There was extensive consultation between staff, union, board and management throughout the whole process and there was a motivation throughout to improve service user experience by improving operational standards and increasing service efficiency. This client-centred focus helped to unite all stakeholders around a common shared agenda.

Box 10.2 Aoibhneas Women and Children's Refuge

The Aoibhneas Refuge in Dublin, Ireland (Aoibhneas 2016) provides support for women and children suffering from domestic violence. It was established in August 1988. The organisation operated successfully for many years but following the economic crisis in Ireland, the organisation was informed in late 2012 of substantial budget cuts to come that could impact the viability of the refuge.

The Board decided an urgent 'top-down' approach to change was needed initially. The vision was for a high-performance culture with world-class operations – 'One Family One Team'. Features were to be a flat structure, an open communication process, high engagement, and value for money. The change resulted in the removal of a layer of management, new rosters, and adjustments to working practices. All this involved a process of consultation in a complex industrial relations environment.

A new manager of the refuge was selected and appointed and her appointment allowed a more 'transformational' approach to be taken for the next phase of change. Coaching, training and development were enhanced. A new case management system was introduced and a more sophisticated process for supervision. Governance systems were revamped. More transparent processes and improved communications have provided the opportunity for staff to become more involved.

The changes have so far been successful. The process remains ongoing and there are still issues to be resolved, but the organisation is now on a far more sustainable footing and is considered as a good practice example within the refuge community.

Cost savings of over 20 per cent were achieved and some of the surplus reinvested in visible infrastructure improvements. Staff are now proud of the way their organisation works. The quality of care has been increased and throughput increased. Motivation dropped initially but recovered as the process continued. There have been substantive staff changes as better educated and higher qualified staff have gradually replaced the original workforce, the vast majority of whom have chosen to retire or leave voluntarily. The issue the Board now faces is how to retain this high-calibre workforce in an increasingly competitive market, and how to ensure adequate cover at all times.

Leadership style in a volatile and uncertain environment

What kind of leadership approach is the most appropriate to achieve results in the health sector and to keep people on board? The evidence increasingly shows that as the world becomes more complex – the so-called VUCA world characterised by Volatility, Uncertainty, Complexity, and Ambiguity (Bennett and Lemoine 2014) – traditional ‘command and control’ approaches in healthcare need to be replaced by a more collective team-based leadership style (British Psychological Society 2014).

A fascinating article by Snowden and Boone (2007) in the *Harvard Business Review*, ‘A Leadership Guide to Decision Making: The Cynefin Framework’, provides an insight into the kind of leadership style most likely to be successful in different situations. It builds on complexity theory to explain how the issues facing leaders can be categorised into a number of domains and contexts:

- *Simple contexts* are characterised by stability and clear cause-and-effect relationships. ‘Command and control’ leadership works well in this domain.
- *Chaotic contexts* where relationships between cause and effect are impossible to determine. Here only turbulence exists and leaders first need to act to establish order.
- *Complicated contexts* show a clear relationship between cause and effect, but not everyone can see it. This is the realm of experts.
- *Complex contexts* are characterised by unpredictably, flux, changes in boundary conditions, external shocks and surprises and interactions which are difficult to predict.

In reality, the balance between all these domains is constantly shifting. Leaders need to be able to identify which style is needed and then be flexible enough to move between styles. Nevertheless, the nature of change in healthcare has moved the overall balance from ‘simple’ and ‘complicated’ towards the ‘complex’ domain.

In the complex domain, an emergent trial and error approach is generally the most effective, where leaders learn from experience and ‘safe to fail’ experimentation. Directive leadership styles are less helpful; indeed, leaders who try to impose order in a complex context will more than likely fail. Those who set the stage, step back a bit, allow patterns to emerge, and determine which ones are desirable are more likely to succeed. Relationships are key. This kind of leadership works best with a good deal of interactive communication: dialogue, discussion and staff involvement.

This is certainly not a traditional ‘command and control’ style and generally does not come naturally to people with a history of working in traditional hierarchical systems. An understanding of the drivers of human social behaviour is useful when seeking insight into how individuals are likely to respond in this context. The SCARF framework (Rock 2008) is based on neuro-psychological research and articulates five domains of human social experience:

- **Status**, which is about relative importance to others.
- **Certainty**, which relates to concerns about being able to predict the future.
- **Autonomy**, which provides a sense of control over events.

- **Relatedness** is a sense of safety with others, of friend rather than foe.
- **Fairness**, which is a perception of fair exchanges between people.

These domains activate either the 'primary reward' or 'primary threat' circuitry (and associated networks) of the brain. For example, a perceived threat to one's status activates similar brain networks to a threat to one's life, while a perceived increase in fairness activates the same reward circuitry as receiving a monetary reward.

During periods of uncertainty and change, every one of these emotional buttons can be pushed and this can make change feel highly threatening. A key part of the leadership role in a complex environment is thus to find ways of interpreting and communicating difficult situations in a positive way. In an uncertain environment, the SCARF framework implies it may be more sensible to focus on and communicate principles, process and timelines, rather than speculate on the possible outcomes. This gives more people more certainty, more sense of autonomy and control and helps demonstrate fair process.

A collective approach to leadership is helpful. The King's Fund (2012) has written extensively about the need to rethink the way that power and responsibility are shared within teams and organisations and across the healthcare system so that staff, patients and boards can build the relationships necessary to drive up the quality and future sustainability of high-quality care, increase innovation and improve productivity.

Collective leadership provides the opportunity for bottom-up improvement and greater involvement of staff. Organisations which encourage transformation and innovation generally allow staff a good deal of freedom and authority but in exchange require them to accept more accountability. Leadership is distributed more widely and layers of management are removed, reducing costs and improving productivity (Laloux 2014).

Laloux (2014) describes how this approach has worked with impressive results in the Dutch healthcare company Buurtzorg. Nurses work in small teams of 10–12 with each self-managed team serving around 50 patients in a small well-defined neighbourhood. There is no boss, no middle management and very little corporate support. Management tasks are carried out by the self-governing, self-organising teams. In 2009, the organisation required on average 40 per cent fewer hours per client than other nursing organisations and patients stayed on care only half as long. Absenteeism and turnover were far lower than comparable conventional organisations.

It is important that leadership is considered the responsibility of all employees and not just those at the top (Wheatley 2006). The authors have developed the Shamrock model of leadership (Plenty and Morrissey 2013) to show the leadership competencies required at all levels to enable the achievement of sustainable performance in a complex, changing and uncertain world (Figure 10.2). It is as important to manage and lead oneself, maintain positive relationships and understand the bigger picture (and how one fits in) as it is to direct and control the activities of others.

Successful self-management requires people to take initiative and be proactive. To be able to take charge, it is essential that people feel the 'locus of control' is

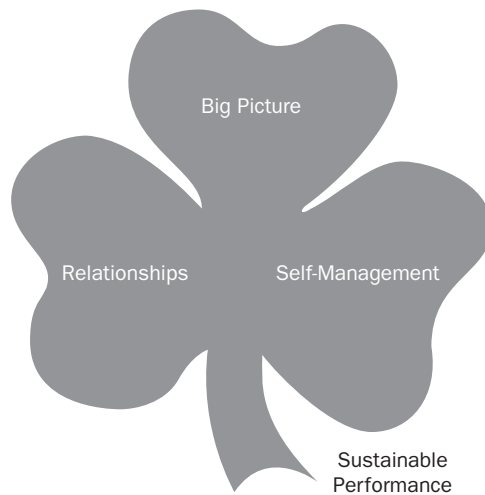


Figure 10.2 The Shamrock Model of Leadership
Source: Plenty and Morrissey (2013).

within themselves rather than outside of themselves. It is important that people are self-confident and feel in charge of their own destiny even in stressful, uncertain and difficult circumstances. Understanding one's own attitudes towards risk, uncertainty and ambiguity through psychometrics such as the PCL 'Risk-Type Compass' (n.d.) can be useful for healthcare professionals whose training is primarily technical and geared to minimising risk.

Developing resilience and mental toughness can also be extremely helpful in the healthcare sector. Mental toughness is about how effectively individuals deal with stress, pressure and challenge. Strycharczyk and Clough (2015) describe how mental toughness can be measured and developed through training and coaching.

In a high-performance culture, people need to understand that they and the organisation share mutual responsibility for motivation. Developing self-awareness of one's style, personality and impact on others through 360-degree feedback, for example, the NHS Leadership Academy 360 Degree Feedback Model (n.d.) can be very helpful. This provides a structured method for comparing self-perceptions of one's own style with the views of peers, subordinates and managers.

Practical recommendations for motivation and retention

The starting point for any organisation when addressing retention and motivation of staff should be to ensure that pay and conditions are competitive (Torrington 2011) though this may be difficult to achieve in those healthcare contexts where salaries are set by government or other external bodies. Where review is possible, it can be done through the use of salary surveys and informal 'soundings' of competitors.

Nevertheless, the research cited in this chapter implies that pay and conditions are rarely the key to improving the motivation and retention of professional healthcare employees. Instead, a strong focus on developing an organisation

culture which supports intrinsic reward – the sense of achievement through a job well done and the satisfaction gained through a contribution to patient welfare – makes sense (Self Determination Theory n.d.). The most important thing leaders can do is to focus on creating a motivating, challenging, developmental and sustainable high-performance work environment where staff are treated with respect.

Strategic retention is primarily a responsibility of senior leaders and HR Directors (Morrissey and Plenty 2013). We outline a few practical steps below:

- *Start by attracting and recruiting the best quality staff.* Make sure you develop an ‘employer brand’ which reflects your organisation’s ‘DNA’ – its vision and values. Recruit for personal and leadership skills as well as technical ones. Values-based recruitment – looking for qualities such as integrity, empathy and resilience – has been found to be helpful in ensuring the right kind of person joins the profession (Patterson et al. 2008; Prideaux et al. 2011; Cleland et al. 2012; Work Psychology Group and NHS Health Education England 2014).
- *Communicate and explain the big picture.* Share vision, values and strategic objectives, make sure what is said is grounded in reality and listen to what people have to say. Ensure all stakeholders are kept on board. Be BOLD, share the vision widely and continuously and listen to feedback. Keep people up to date with what is going on (Elvin 2005; Senge 2006; Kotter 2012; Plenty and Morrissey 2012).
- *Build a high-performance ethos.* The case studies and examples quoted in this chapter illustrate how people are motivated by being in a successful organisation. These organisations ensure that compassionate care remains the focus but that at the same time economic realities are clearly articulated. They do not remove the economic pressures for change but encourage their staff to find new and innovative ways of working. They also expect high standards – including the quality of people management – and do not settle for poor performance. Wherever possible, they reduce unnecessary layers of management and bureaucracy as this helps increase motivation and reduces costs.
- *Involve people.* Consult and involve people on the changes to be introduced. Give personal development opportunities to people. Encourage people to take responsibility for decision-making and – within clear boundaries – give them challenging assignments and projects, including work on business improvement (Higgs and Rowland 2010). Look at what can be done to support staff’s well-being and health through facilities, in-house medical support, training and counselling (Plenty 2015).
- *Help people to do their jobs better.* Focus attention at the level of the job as people are motivated by achieving results in their day-to-day work. Encourage innovation and experimentation at a local level. Remove the key barriers to high performance by ensuring the right tools, resources and equipment and training are in place – for soft skills as well as technical ones. Make sure that the work design and work flow have been thought through so that they reflect the most efficient and effective ways of achieving the required outputs (Clegg et al. 2014).
- *Listen to staff.* It is important that nurses and health professionals, who are the ‘human capital’ of contemporary health services, are given opportunities to speak out and have the courage to do so. Ensure there are regular processes in

place for dialogue and developing a clear understanding of what is important to people, particularly in terms of organisation issues, flexible working practices, staff well-being and personal development (Plenty and Morrissey 2014; Plenty 2015).

Conclusion

In summary, creating an engaging, challenging and developmental high-performance work environment is critical in motivating and retaining healthcare professionals. Involve people, consult them, trust them, give them real accountability and responsibility and reduce red tape and bureaucracy. They will enjoy their work, feel motivated to contribute to the success of their organisation – and won't want to leave.

Key concepts discussed

- Healthcare around the world faces a sustainability crisis as demand for services is increasing faster than the financial resources available. There is pressure to contain costs and transform, reorganise and restructure services. Change and uncertainty on this scale are having an impact on the motivation and retention of the highly educated and skilled staff who represent a high proportion of this labour-intensive sector.
- Motivated and engaged employees are less likely to leave their jobs and more likely to give additional discretionary effort to their work. They are also more likely to provide safer patient care. Unfortunately, engagement levels in healthcare are lower than optimal largely due to the demanding nature of many healthcare jobs.
- Engagement can be improved through more positive leadership and supervision, creating a better immediate working environment and by giving people more autonomy and control over their work. Treating people with respect is essential. A sense of achievement, social and emotional support – and being treated fairly – are critical components of an engaging workplace and support intrinsic motivation.
- Directed top-down change, driven by the need to balance the books, has been a feature of the sector but this seldom keeps people on board and can sometimes lead to a bullying culture rather than one focused on compassionate patient care. Furthermore, it rarely results in the service transformation that is needed.
- A more collective and distributed approach to leadership, involving front-line staff, encouraging dialogue and discussion with stakeholders and being prepared to try things out at a local level, provides opportunities for innovation and is more suited to the fast-changing professional healthcare environment. Staff are given more freedom in exchange for accepting greater accountability and responsibility.
- Organisations can help by communicating the big picture, fostering a high-performance ethos, streamlining work processes and providing people with the necessary support for them to do their jobs properly. This can result in improvements in staff motivation, patient care and organisational performance.

Key readings

McKenna, E. (2015) *Business Psychology and Organizational Behaviour*, 5th edn. Hove: Psychology Press.

Torrington, D., Hall, L., Taylor, S. and Atkinson, C. (2011) *Human Resource Management*, 8th edn. Harlow: Pearson Education.

These two are useful general text books. They provide a good starting point for developing a deeper understanding of the area from the different but complementary perspectives of human resources professionals and business psychologists.

Branham, L. (2005) *The 7 Reasons Employees Leave: How to Recognize the Subtle Signs and Act Before It's Too Late*. New York: Amacom.

This provides an 'easy-to-read' summary of the reasons why people leave their jobs.

Locke, E.A. (1997) The motivation to work: what we know, in M.L. Maehr and P.R. Pintrick (eds) *Advances in Motivation and Achievement*. Greenwich, CT: JAI Press.

This provides a summary of the early work on motivation.

The website www.selfdeterminationtheory.org/theory (accessed 2 May 2016) provides a good account of a theory which has become an important influence on work in this area.

MacLeod, D. and Clarke, N. (2009) *The MacLeod Review – Engaging for Success: Enhancing Performance through Employee Engagement*. London: Department for Business Innovation and Skills.

This makes the case forcefully for employee engagement.

Examples of studies

Major human resources consultancies and research houses such as Aon Hewitt, Towers Watson and the Hay Group have the benefit of being able to access vast quantities of international employee survey data and conduct regular reviews of engagement, including the health sector.

- Aon Hewitt (2014) *Trends in Employee Global Engagement*. Available at: www.aon.com/attachments/human-capital-consulting/2014-trends-in-global-employee-engagement-report.pdf (accessed 29 November 2015).
- British Psychological Society: Occupational Psychology in Public Policy Working Group (2014) *Implementing Cultural Change within the NHS: Contributions from Occupational Psychology*. Available at: www.bps.org.uk/system/files/user-files/Division%20of%20Occupational%20Psychology/public/17689_cat-1658.pdf (accessed 29 November 2015). The British Psychological Society has produced an excellent summary of recent research on cultural change in the NHS.
- Engage for Success Task Group THE EVIDENCE 2012. Available at <http://engageforsuccess.org/wp-content/uploads/2015/09/The-Evidence.pdf> (accessed 1 May 2016). This summary of the evidence for engagement carried out by a workgroup including Rayton et al. brings together a range of evidence linking engagement to business performance.
- The King's Fund (2012) *Leadership and Engagement for Improvement in the NHS: Together We Can*. London: The King's Fund. In the UK, the King's Fund regularly publishes high-quality reviews of leadership and people matters in the NHS.
- Towers Watson (2011) *Employee Engagement and the Transformation of the Health Care Industry*. Available at: www.towerswatson.com/en/Insights/IC-Types/Ad-hoc-Point-of-View/Perspectives/2011/Employee-Engagement-and-the-Transformation-of-the-Health-Care-Industry (accessed 29 November 2015).
- Recent research papers specifically targeted at motivation and retention in healthcare can be found in the specialist publications, such as the *International Journal of Nursing Studies*. A couple of examples are quoted below but there are many others.

- Leineweber, C., Chungkham, H.S., Lindqvist, R. et al. (2016) Nurses' practice environment and satisfaction with schedule flexibility is related to intention to leave due to dissatisfaction: a multi-country, multilevel study. *International Journal of Nursing Studies*, 58: 47–58.
- Li, J., Galatsch, M., Siegrist, J. et al. (2011) Reward frustration at work and intention to leave the nursing profession: prospective results from the European longitudinal NEXT study, for Occupational Safety and Health, Berlin, Germany. *International Journal of Nursing Studies*, 48(5): 628–35.

Useful websites

- Aoibhneas case study: www.aoibhneas.org
- Authors' website: www.thisis.eu
- British Psychological Society website: www.bps.org.uk
- Buurtzorg example: www.nieuworganiseren.nu/cases/buurtzorg-nederland
- Evidence for Engagement: www.engageforsuccess.org
- The King's Fund: Excellent resource for healthcare ideas, particularly in the UK: www.kingsfund.org.uk
- Leadership Academy: Useful materials and resources: www.leadershipacademy.nhs.uk/resources
- Your Healthcare case study: www.yourhealthcare.org

References

- Alimo-Metcalfe, B., Alban-Metcalfe, J., Bradley, M. et al. (2008) The impact of engaging leadership on performance, attitudes to work and well-being at work: a longitudinal study, *Journal of Health Organization & Management*, 22(6): 586–98.
- Aoibhneas (2016) Organisation Website, Available at: www.aoibhneas.org (accessed 7 May 2016).
- Aon Hewitt (2014) *Trends in Employee Global Engagement*. Available at: www.aon.com/attachments/human-capital-consulting/2014-trends-in-global-employee-engagement-report.pdf (accessed 29 November 2015).
- Ballat, J. and Campling, P. (2011) *Intelligent Kindness: Reforming the Culture of Healthcare*. London: Royal College of Psychiatrists.
- Batalden, M., Baltaalden, P., Margolos, P. et al. (2015) Coproduction of healthcare service. *BMJ Quality and Safety*. Available at: <http://qualitysafety.bmj.com/content/early/2015/09/16/bmjqs-2015-004315.full> (accessed 9 May 2016).
- BBC News (2016) Junior doctors' strike: second all-out stoppage hits NHS. Available at: www.bbc.com/news/health-36145686 (accessed 1 May 2016).
- Bedarka, M. and Pandita, D. (2014) A study on the drivers of employee engagement impacting employee performance. *Procedia Social and Behavioral Sciences*, 133: 106–15.
- Bennett, N. and Lemoine, G. (2014) What VUCA really means for you. *Harvard Business Review*, 92(1/2).
- Berwick, D. (2013) A promise to learn, a commitment to act: the Berwick Review into patient safety. National Advisory Group on the Safety of Patients in England. London: Department of Health. Available at: www.gov.uk/government/uploads/system/uploads/attachment_data/file/226703/Berwick_Report.pdf (accessed 2 May 2016).
- Branham, L. (2005) *The 7 Reasons Employees Leave: How to Recognize the Subtle Signs and Act Before It's Too Late*. New York: Amacom.
- Bridges, W. (2009) *Managing Transitions: Making the Most of Change*, 3rd edn. New York: Da Capo Lifelong Books.

- British Psychological Society Occupational Psychology in Public Policy Working Group (2014) *Implementing Cultural Change within the NHS: Contributions from Occupational Psychology*. Available at: www.bps.org.uk/system/files/user-files/Division%20of%20Occupational%20Psychology/public/17689_cat-1658.pdf (accessed 29 November 2015).
- Centre for Workforce Intelligence (2014) *In Depth Review of the General Practitioner Workforce Final Report*. Available at: www.cfwi.org.uk/publications/in-depth-review-of-the-gp-workforce/@@publication-detail (accessed 7 May 2016).
- Clegg, C., Bolton, L., Offutt, R. and Davis, M. (2014) Work design for compassionate care and patient safety, in *Implementing Cultural Change within the NHS: Contributions from Occupational Psychology*. Available at: www.bps.org.uk/system/files/user-files/Division%20of%20Occupational%20Psychology/public/17689_cat-1658.pdf (accessed 29 November 2015).
- Cleland, J., Dowell, J., McLachlan, J. et al. (2012) Research report: Identifying best practice in the selection of medical students (literature review and interview survey). Available at: www.gmc-uk.org/Identifying_best_practice_in_the_selection_of_medical_students.pdf_51119804.pdf.
- Cooner, B. and Barriball, L.K (2007) Impact of job satisfaction components on intent to leave and turnover for hospital-based nurses: a review of the research literature. *International Journal of Nursing Studies*, 44(2): 297–314.
- Cornerstone (2015) *The Challenging State of Employee Engagement in Healthcare Today – and Strategies to Improve It*. Available at: www.cornerstoneondemand.com/sites/default/files/whitepaper/csod-wp-healthcare-employee-engagement-012015.pdf (accessed 29 November 2015).
- Deci, E.L. and Ryan, R.M. (1985) *Intrinsic Motivation and Self-Determination in Human Behaviour*. New York: Plenum.
- Deci, E.L. and Ryan, R.M. (2000) The ‘what’ and ‘why’ of goal pursuits: human needs and the self-determination of behaviour. *Psychological Inquiry*, 11: 227–68.
- Dixon, J. (2015) The NHS has social objectives as well as economic ones. Can we reconcile them? *The Guardian*. Available at: www.theguardian.com/commentisfree/2015/nov/08/national-health-service-deficit-junior-doctors (accessed 1 May 2016).
- Donaldson-Feilder, E., Yanker, E. and Lewis, R. (2011) *Preventing Stress in Organisations: How to Develop Positive Managers*. Chichester: Wiley-Blackwell.
- Elvin, W.J.L. (2005) The role of communication in organisational change. *Corporate Communications: An International Journal*, 10(2): 129–38.
- Engage for Success Task Group (2012) THE EVIDENCE 2012. ‘Nailing the Evidence’ workgroup. Available at: <http://engageforsuccess.org/wp-content/uploads/2015/09/The-Evidence.pdf> (accessed 1 May 2016).
- Engage for Success Task Group (2014) THE EVIDENCE 2014. ‘Wellbeing and Employee Engagement’ workgroup. Available at: <http://engageforsuccess.org/wp-content/uploads/2015/09/wellbeing-and-engagement-04June2014-Final.pdf> (accessed 1 May 2016).
- Francis, R. (2013) *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry: Executive Summary*. Available at: webarchive.nationalarchives.gov.uk/20150407084003/http://www.midstaffpublicinquiry.com/sites/default/files/report/executive%20summary.pdf (accessed 29 November 2015).
- Hakanen, J.J., Bakker, A.B. and Schaufeli, W.B. (2006) Burnout and work engagement among teachers. *Journal of School Psychology*, 43: 495–513.
- Hay Group (n.d.) Definition of engagement. Available at: www.haygroup.com/us/services/index.aspx?id=1742 (accessed 29 November 2015).
- Health e-carers Blog (2015) Staff turnover top concern for healthcare recruiters. Available at: news.healthcareers.com/2015/03/staff-turnover/?type=pr (accessed 29 November 2015).
- HCO News (2015) Employee retention a concern for healthcare industry. Available at: www.hconews.com/articles/2015/04/15/employee-retention-concern-health-care-industry (accessed 29 November 2015).

- Higgs, M. and Rowland, D. (2010) Emperors with clothes on: the role of self-awareness in developing effective change leadership. *Journal of Change Management*, 10(4): 369–85.
- Hurst, K. (2008) UK ward design: patient dependency, nursing workload, staffing and quality – an observational study. *International Journal of Nursing Studies*, 45: 370–81.
- Kotter, J.P. (2012) *Leading Change*. Cambridge, MA: Harvard Business Review Press.
- Laloux, F. (2014) *Reinventing Organizations*. New York: Nelson Parker.
- Laschinger, H.K.S. and Leiter, M.P. (2006) The impact of nursing work environments on patient safety outcomes: the mediating role of burnout/engagement. *Journal of Nursing Administration*, 5: 259–67.
- Laschinger, H.K.S., Leiter, M.P., Day, A. et al. (2012) Building empowering work environments that foster civility and organizational trust: testing an intervention. *Nursing Research*, 61(5): 316–25.
- Leineweber, C., Chungkham, H.S., Lindqvist, R. et al. (2016) Nurses' practice environment and satisfaction with schedule flexibility is related to intention to leave due to dissatisfaction: a multi-country, multilevel study. *International Journal of Nursing Studies*, 58: 47–58.
- Li, J., Galatsch, M., Siegrist, J. et al. (2011) Reward frustration at work and intention to leave the nursing profession: prospective results from the European longitudinal NEXT study. *International Journal of Nursing Studies*, 48(5): 628–35.
- Locke, E.A. (1997) The motivation to work: what we know, in M.L. Maehr and P.R. Pintrick (eds) *Advances in Motivation and Achievement*. Greenwich, CT: JAI Press.
- Maben, J. (2010) The feel good factor: evidence for a link between staff wellbeing and the quality of patient care. *Nursing Standard*, 24(30): 70–71.
- MacLeod, D. and Clarke, N. (2009) *The MacLeod Review: Engaging for Success: Enhancing Performance through Employee Engagement*. London: Department for Business Innovation and Skills.
- Mauno, S., Kinnunen, U. and Ruokolainen, M. (2007) Job demands and resources as antecedents of work engagement: a longitudinal study. *Journal of Vocational Behaviour*, 70: 149–71.
- McKenna, E. (2015) *Business Psychology and Organizational Behaviour*, 5th edn. Hove: Psychology Press.
- McManus, C. (2007) Stress in health professionals, in *Cambridge Handbook of Psychology, Health and Medicine*. Cambridge: Cambridge University Press.
- Meister, J. (2012) Job hopping is the 'new normal' for millennials: three ways to prevent a human resource nightmare. *Forbes Leadership*. Available at: www.forbes.com (accessed 1 May 2016).
- Morgan, P.A., (2015) *Sustainable Development for the Healthcare Industry: Reprogramming the Healthcare Value Chain*. New York: Springer.
- Morrell, M. and Capparrell, S. (2002) *Shackleton's Way: Leadership Lessons of the Great Antarctic Explorer*. New York: Deckle Edge.
- Morrissey, T. and Plenty, R. (2013) Navigating leadership in difficult times: lessons from industry: leadership and motivation matters in times of strategic change. Available at: www.thisis.eu/uploads/Dublin2013Sept12FinalVersion.pdf (accessed 2 May 2016).
- Nembhard, I. and Edmondson, A.C. (2006) Making it safe: the effects of leader inclusiveness and professional status on psychological safety and improvement efforts in health care teams. *Journal of Organizational Behaviour*, 27: 941–66.
- NHS Leadership Academy (n.d.) Healthcare Leadership Model 360 degree feedback tool. Available at: www.leadershipacademy.nhs.uk/resources/healthcare-leadership-model/supporting-tools-resources/healthcare-leadership-model-360-degree-feedback-tool/ (accessed 5 May 2016).
- OECD (2015) *Focus on Health Spending: OECD Health Statistics 2015*. Available at: www.oecd.org/health (accessed 29 November 2015).
- Patterson, F., Ferguson, E. and Thomas, S. (2008) Using job analysis to identify core and specific competencies: implications for selection and recruitment. *Medical Education*, 42: 1195–204.

- PCL Risk Type Compass Psychometric (n.d.) Available at: www.psychological-consultancy.com/products/risk-type-compass (accessed 2 May 2016).
- Plenty, R. (2001) Unpublished: personal experience from co-ordinating the Shell People Survey across the Shell Group.
- Plenty, R. (2015) Unpublished: personal experience from facilitating 3 'Future Forum' workshops for staff in Your Healthcare, June, September and December 2015.
- Plenty, R. and Morrissey, T. (2012) Future thinking – how do airport operators best accommodate changes in leadership, organisation thinking and corporate culture? *Airport World*, June–July: 48–51.
- Plenty, R. and Morrissey, T. (2013) More than just results. *Airport World*, June–July: 62–64.
- Plenty, R. and Morrissey, T. (2014) Courageous leadership: lessons from Nelson Mandela. *Airport World*, June–July: 53.
- Prideaux, D., Roberts, C., Eva, K. et al. (2011) Assessment for selection for the health care professions and specialty training: consensus statement and recommendations from the Ottawa 2010 Conference, *Medical Teacher*, 33(3): 215–23.
- Prins, J.T., Hockstra-Weebers, J.E., Gazendam-Donofrio, S.M. et al. (2010) Burnout and engagement among resident doctors in the Netherlands: a national study, *Medical Education*, 44(3): 236–47.
- Rayton, B., Dodge, T. and D'Analeze, G. (2012) The Evidence: Employee Engagement Task Force 'Nailing the evidence' workgroup. Available at: opus.bath.ac.uk/35611/1/The_Evidence.pdf (accessed 6 February 2017).
- Robinson, D., Perryman, S. and Hayday, S. (2004) *The Drivers of Employee Engagement*. Available at: www.employment-studies.co.uk/system/files/resources/files/408.pdf (accessed 1 May 2016).
- Robson, A. and Robson, F. (2016) Investigation of nurses' intention to leave: a study of a sample of UK nurses. *Journal of Health Organization and Management*, 30(1): 154–73.
- Rock, D. (2008) SCARF: a brain based model for collaborating and influencing others. *NeuroLeadership Journal*, 1: 1–9.
- Ryan, R.M. and Deci, E.L. (2000) Self-determination theory and the facilitation of intrinsic motivation, social development, and well-being. *American Psychologist*, 55: 68–78.
- Self Determination Theory. Available at: www.selfdeterminationtheory.org/theory/ (accessed 2 May 2016).
- Senge, P.M. (2006) *The Fifth Discipline: The Art and Practice of the Learning Organization*, 2nd revised edn. New York: Random House Business.
- Sirota, D. and Klein, D. (2013) *The Enthusiastic Employee: How Companies Can Profit by Giving Workers What They Want*, 2nd edn. Harlow: Pearson FT Press.
- Snowden, D.J. and Boone, M.E. (2007) A leader's framework for decision making. *Harvard Business Review*, November 1–10.
- Strycharczyk, D. and Clough, P. (2015) *Developing Mental Toughness: Coaching Strategies to Improve Performance, Resilience and Well-Being*, 2nd edn. London: Kogan Page.
- Storey, J. and Holti, R. (2013) *Towards a New Model of Leadership for the NHS*. Leeds: NHS Leadership Academy.
- Taylor, S. (2002) *Employee Retention Handbook (Developing Practice)*. London: CIPD.
- Tepper, B.J., Carr, J.C., Breaux, D.M. et al. (2009) Abusive supervision, intentions to quit, and employees' workplace deviance: a power/dependence analysis. *Organizational Behavior and Human Decision Processes*, 109(2): 156–67.
- Tepper, B.J., Henle, C.A., Lambert, L.S. et al. (2008) Abusive supervision and subordinates' organization deviance. *Journal of Applied Psychology*, 93(4): 721–32.
- The Economist Intelligence Unit (2014) *Global Outlook: Healthcare*. Available at: www.pages.eiu.com/rs/eiu2/images/GlobalOutlook_Healthcare.pdf (accessed 29 November 2015).
- The Guardian* (2015) NHS staff most stressed public sector survey finds. Available at: www.theguardian.com/healthcare-network/2015/jun/12/nhs-staff-most-stressed-public-sector-workers-survey-finds (accessed 29 November 2015).

- The King's Fund (2012) *Leadership and Engagement for Improvement in the NHS: Together We Can*. London: The King's Fund.
- The King's Fund (2013) You can't get the staff these days: the shifting NHS workforce. Available at: <http://www.kingsfund.org.uk/blog/2013/09/you-cant-get-staff-these-days-shifting-nhs-workforce> (accessed 9 May 2016).
- The King's Fund (n.d.) *Overview of the Health and Social Care Workforce*. Available at: www.kingsfund.org.uk/time-to-think-differently/trends/professional-attitudes-and-workforce/overview (accessed 29 November 2015).
- The Point of Care Foundation (2014) *Home*. Available at: www.pointofcarefoundation.org.uk (accessed 9 May 2016).
- Toode, K., Routasalo, P. and Suominen, T. (2011) Work motivation of nurses: a literature review. *International Journal of Nursing Studies*, 48(20): 246–57.
- Torrington, D., Hall, L., Taylor, S. and Atkinson, C. (2011) *Human Resource Management*, 8th edn. Harlow: Pearson Education.
- Towers Watson (2011) *Employee Engagement and the Transformation of the Health Care Industry*. Available at: www.towerswatson.com/en/Insights/IC-Types/Ad-hoc-Point-of-View/Perspectives/2011/Employee-Engagement-and-the-Transformation-of-the-Health-Care-Industry (accessed 29 November 2015).
- Towers Watson (2014) *Global Workforce Study: At a Glance*. Available at: www.towerswatson.com/assets/jls/2014_global_workforce_study_at_a_glance_emea.pdf (accessed 29 November 2015).
- West, M. and Dawson, J. (2012) Employee engagement and NHS performance. Available at: www.kingsfund.org.uk/sites/files/kf/employee-engagement-nhs-performance-west-dawsonleadership-review2012-paper.pdf.
- West, M., Dawson, J., Adamasachow, L. and Topakas, A. (2012) *NHS Staff Management and Health Service Quality: Results from the NHS Staff Survey and Related Data*. Lancaster: Lancaster University and the Work Foundation.
- Wheatley, M.J. (2006) *Leadership and the New Science: Discovering Order in a Chaotic World*. New York: Simon & Schuster.
- Work Psychology Group and NHS Health Education England (2014) *Evaluation of Values Based Recruitment (VBR) in the NHS*. Available at: www.hee.nhs.uk/wp-content/uploads/sites/321/2013/11/Literature-Review-Full-Report.pdf (accessed 1 May 2016).
- World Economic Forum (2013) *Sustainable Health Systems: Visions, Strategies, Critical Uncertainties and Scenarios. A Report from the World Economic Forum in Collaboration with McKinsey & Company*. Available at: www3.weforum.org/docs/WEF_SustainableHealthSystems_Report_2013.pdf (accessed 5 May 2016).
- World Economic Forum (2015) How precision medicine will make healthcare cheaper. Available at: agenda.weforum.org/2015/09/how-precision-medicine-is-making-healthcare-cheaper/ (accessed 29 November 2015).
- World Health Organisation (2010) *International Migration of Health Workers*. Available at: http://www.who.int/hrh/resources/oecd-who_policy_brief_en.pdf (accessed 1 May 2016).
- Wren, B. (2014) Managing staff experience to improve organisation culture, in *Implementing Cultural Change within the NHS: Contributions from Occupational Psychology*. Available at: www.bps.org.uk/system/files/user-files/Division%20of%20Occupational%20Psychology/public/17689_cat-1658.pdf (accessed 29 November 2015).
- Yerkes, R.M. and Dodson, J.D. (1908) The relation of strength of stimulus to rapidity of habit formation. *Journal of Comparative Neurology and Psychology*, 18: 459–82.
- Your Healthcare (2015) *Our Manifesto*. Available at: www.yourhealthcare.org/ourmanifesto (accessed 6 May 2016).