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Exploring the relationship between patients' experiences of care and the influence of staff motivation, affect and wellbeing

Executive Summary

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Key Messages

- There is a relationship between staff wellbeing and various dimensions of (a) staff-reported patient care performance and (b) patient-reported patient experience.

- Individual staff wellbeing is best seen as an antecedent rather than as a consequence of patient care performance; seeking systematically to enhance staff wellbeing is not only important in its own right but also for the quality of patient experiences.

- Patient experiences are generally better when staff feel they have:
  - a good local (team)/work-group climate
  - co-worker support
  - job satisfaction
  - a positive organisational climate
  - organisational support
  - low emotional exhaustion
  - supervisor support.

- Yet working environments associated with high levels of emotional exhaustion (e.g. end-of-life care) or high job demands (e.g. accident and emergency) take their toll on staff even if staff are performing well.

- Our research suggests local climate is critical for staff wellbeing and high quality patient care delivery. Ward/team leaders have a critical role in setting expectations of values, behaviours and attitudes to support the delivery of patient centred care and thus it is important for NHS organisations to:
  - systematically measure and monitor levels of quantitative job demands; invest in unit level leadership and supervisor support and invest more in creating well functioning teams.

- If NHS organisations regularly monitor patient experience (e.g. complaints, real-time feedback) and staff wellbeing (e.g. high sickness absence, reports of bullying or disciplinary issues) this can help them to: (a) target resources to areas that are known to be problematic and (b) disseminate learning and good practice from local teams/work groups that are known to be doing well.

Executive Summary

Background

It appears self-evident that patients' experiences and the quality of health care they receive are influenced by the experiences and wellbeing of the staff providing that care. Associations have been described between job satisfaction and performance and absenteeism of health workers, as well as nurses' job satisfaction and patient satisfaction, nurse stress and patient satisfaction (and in acute care, medication errors and falls). However, much of the evidence comes from North America and methodological weaknesses have been identified. The links between staff wellbeing, affect, motivation and patient care are likely to be multi-faceted. Such links are shaped by the societal and organisational contexts within which interpersonal relationships of care - between staff and patients as well as between staff – occur. They are also influenced by the broader, shifting, and sometimes discordant debates over what constitutes 'satisfying work' and 'quality care' that circulate within different staff groups and amongst individual practitioners and patients. There is limited UK research that explores factors that link staff motivation and wellbeing to patient experiences. The clinical and emotional care needs of patients and their anticipated or actual prognosis have been shown to have an impact on the work motivations and psychological work reactions of staff. Although research to date has shed light on how experiences differ between staff groups, there has been no consideration of how these relate to patient experiences of care.

Aims

In this three-year mixed methods study we explored links between (a) patients' experiences of health care, and (b) staff motivation, affect and wellbeing. Our specific study objectives were to:

1. Identify and analyse attitudes and behaviours of staff described by patients as shaping their experiences that may connect with, and be influenced by, staff wellbeing.
2. Determine which particular staff attitudes, affect and behaviours impact on patients' experiences of care.
3. Explore how staff experience work and how this influences their affect, motivation and capacity to deliver high quality care.
4. Identify how context, including different types of organisational arrangements, culture or climate contribute to staff wellbeing and patient care.
5. Explore with staff the issues of emotions at work, emotional labour and customer orientated care.

6. Identify ways to enhance the experience of patients and the wellbeing of the healthcare workforce.

Methods

We undertook a two phase research process linked to the stated objectives of the study. In Phase I we held two patient focus groups and negotiated access to four - purposively selected - NHS trusts; two in the acute and two in the community sector. We interviewed 55 senior managers from these four trusts to understand their views of staff wellbeing and patient experience and determine any interventions underway in their organisations seeking to improve either or both. In Phase II we selected two clinical microsystems in each of the four case study organisations to reflect different types of care relationships and settings and high and low performing microsystems as determined by senior managers. In each microsystem we undertook a staff and patient survey, staff and patient interviews and non–participant observation of routine day-to-day interactions and of team and care processes. To protect the identity of the trusts we have created pseudonyms for each of the four NHS trusts. The eight microsystems (anonymised) were:

- Emergency Admissions Unit and a Maternity service in 'Oakfield' (acute trust 1)
- Medicine for the Elderly Department and a Haemato-Oncology service in 'Elmwick' (acute trust 2)
- Adult Community Nursing Service (1) and a Community Matron Service in 'Ashcroft' (community organisation 1)
- Adult Community Nursing Service (2) and a Rapid Response Team in 'Larchmere' (community organisation 2)

In total, 498 patient experience surveys and 106 patient interviews were conducted. 301 staff wellbeing surveys were completed at time 1 (and 126 at time 2) and 86 staff interviews and 206 hours of observation were undertaken. We present findings from four of these microsystems in the main body of the report – to highlight the high and low performing case studies in acute and community.

Results

Phase I

Patient recollections of their own - and others' - experiences are vivid, and focus largely on the relational aspects of their care. In our focus groups patients were able to discriminate between 'good' and 'bad' individual staff working within services, on wards or shifts. This discrimination rested on the nature of relational care received and patients distinguished between staff perceptions of their work as a job or as a vocation (and insisted on the importance of the latter). At the same time some patients recognised the influence of the workplace on staff behaviours towards patients: notably, work in 'heavy' or dangerous service areas, a poor built environment and

poorly managed wards. Our data also highlighted patients' and relatives' limited capacity to directly question staff about poor care and poor caring behaviours.

The interviews with senior managers in our four NHS organisations revealed different organisational contexts in which a range of initiatives to improve staff wellbeing and/or patient experience were being implemented. They showed that staff wellbeing was understood in two very different ways: either as a factor that supported organisational objectives and reputation (a corporate view) or the result of patient care work satisfaction, that was frustrated or undermined by organisational initiatives and demands (a vocational view). In either case it was clear that managers appropriated the theme of 'staff wellbeing' to justify and promote longer established views on the purpose and motives for health care work.

Phase II

Our results show there is a relationship between staff wellbeing and various dimensions of (a) staff-reported patient care performance and (b) patient-reported patient experience. This relationship is complex. For example, although our staff survey panel data suggested wellbeing does not appear to have a very strong or clear direct effect on how staff rated their own patient care performance, it does show that staff wellbeing is an important antecedent of patient care performance. It also suggests that wellbeing is affected by employee experiences at work and by individual skills and work orientations. The descriptive statistics from our staff and patient experience surveys indicate seven staff variables ('wellbeing bundles') which correlate positively with patient-reported patient experience. These are:

- local (team)/work-group climate
- co-worker support
- job satisfaction
- organisational climate
- perceived organisational support
- low emotional exhaustion, and
- supervisor support.

Our in-depth qualitative field work across the eight microsystems offers greater insights into these variables. It highlights the adverse impact of high levels of job demand on staff wellbeing, through higher levels of emotional exhaustion and reduced job satisfaction, which impact on patient care. Any positive effects of job satisfaction and positive affect on performance are nullified by high levels of exhaustion. In microsystems where patients rated their experiences as being relatively low we consistently found poor relational care with staff largely failing to 'connect' with individual patients. However, our findings also suggest a win-win situation whereby high levels of patient care performance need not necessarily be achieved at the expense of employee wellbeing.

High levels of job control - as well as key personal resources such as high levels of job skills, competence and work dedication – can significantly help to cushion the negative effects of high job demands on wellbeing. Such personal resources can also moderate the adverse effects of high demands

and exhaustion. Additionally, high levels of social support from supervisors, co-workers and the organisation has a positive effect on wellbeing in that it helps to reduce exhaustion, while also enhancing satisfaction and relative positive affect at work.

Our findings also show that the effect of staff wellbeing on performance depends, at least in part, on the climate for patient care. In particular, our results indicate that a strong climate for patient care particularly at the local (team) level can help to reinforce some of the positive effects of individual wellbeing on patient care performance. Critically, local climate can also act as a substitute for individual wellbeing; 'making up' for the absence of high levels of wellbeing. Seeking systematically to enhance staff wellbeing is, therefore, not only important in its own right but also for the quality of patient experiences.

Implications for practice

NHS organisations should consider how best to:

- Target their limited internal resource in areas that are known to be problematic either in terms of low patient experience (complaints, real-time feedback) and/or poor staff wellbeing (indicated by, for example, high sickness absence, reports of bullying or disciplinary issues).
- Disseminate the learning from those areas that have good patient experience and high staff wellbeing and are known to be places where staff want to work (by, for example, linking specific wards through buddying of ward mangers to help challenge and transfer learning from one to the other).
- Enable team leaders to invest time and energy in team building activities to benefit patient care delivery.

In order to enhance staff wellbeing NHS organisations can:

- Systematically monitor levels of quantitative job demands associated with different care environments and where possible limit these as a key way of minimising levels of exhaustion amongst employees.
- Invest in unit level leadership and supervisor support (i.e. ward sister level in acute and team leaders in community) that promotes good team working and supportive peer relations.
- Build teams and teamwork by, for example, encouraging ward managers and team leaders to consider:
    - active team building
    - facilitating greater staff empowerment and ownership of their work through, for example, Schwartz Rounds as one way to create space to talk about the emotional aspects of care work in the multi-disciplinary team
    - developing a local care climate that is supportive for staff but which also sets clear expectations, goals and direction for patient care performance.
- Support ward managers and team leaders to recruit and performance manage staff around the following areas:

- high levels of job skills and competence amongst front-line employees
- recruit to organisations' core values to include high levels of work dedication
- examining attitudes and beliefs in staff and champion continuing and systematic training, development and up-skilling.

In order to improve patient experience NHS organisations can:

- Support staff to deliver relational care: organisations need to enhance staff's ability to engage with patients on a meaningful personal level; this is long term work (and amounts to much more than offering staff a 'script' for patient encounters).
- Invest in staff work environments to ensure quality patient care:
  - optimise patient and carer experience feedback by triangulating from different sources
  - build in opportunities for staff to ask patients and their relatives what staff are doing well and what they could do better
  - invest in unit level leadership and supervisor support to create well functioning teams and to understand the links between ward climate, staff wellbeing and patient experience
  - use tools of acuity and dependency to argue for sufficient staff in relation to the level of need of the patient population.

Our study has also identified wellbeing 'bundles' which would enable organisations to support their staff to deliver high quality care (see 'results' section above).

Implications for policy

The Boorman Review was heralded as a watershed in wellbeing at work for the NHS, yet despite critique from Steve Boorman of Occupational Health (OH) departments, they remain the key mechanism for delivery of much of the staff wellbeing agenda. The characteristics of a new-look OH service have been outlined, including the need for it to contribute to improved organisational productivity. Staff wellbeing as conceptualised and described in our study is about much more than physical wellbeing, healthy lifestyles and individual staff stress, important though these are. It is observed that:

- A broader framing of OH enables staff wellbeing data to be sensitively used by organisational development (OD) departments to enable individuals to proactively support and manage their relationships with other staff and patients.
- OH departments that are adequately resourced and linked to OD departments in trusts mean that issues such as high sickness absence are not tackled in a reactive and punitive way but are seen as a barometer of wellbeing issues that affect care quality.
- OH departments which align much more closely to Trust Boards, are better able to ensure delivery of the clinical vision.
- Reports of high sickness absence are indicative of the context of the local ward/team climate: individual (stress; injury etc); team (lack of support; bullying); organisational and wider contextual issues.

- When such issues are highlighted at board level and measures taken through OD to manage them; our study suggests such a strategic approach to improving staff wellbeing is likely to have a positive impact upon patient care experience.
- An agreed minimum dataset for NHS staff and wellbeing services and the appointment of a board executive champion for staff health and wellbeing could be one way on ensuring staff wellbeing gains greater prominence in NHS trusts.
- Senior leaders have a vital role in enabling line managers to support staff and tackle their wellbeing issues. The mechanism for delivery of this could be local work wellbeing champions that have patient-centred care as their core mission together with high support for staff wellbeing at work.

Conclusions

Our study has found that - with the exception of one of our eight microsystems - where patient experience is good, staff wellbeing is good, and vice versa. Interactions between both organisational and team climates for patient care and individual staff and patients shape the relationship between staff wellbeing and patient experience. Our results suggest that individual staff wellbeing is best seen as an antecedent rather than as a consequence of patient care performance. Thus it is important to invest in and support individual staff wellbeing at work in order to enable staff to better deliver high quality patient care.

Our study has highlighted the importance of the local work climate for staff wellbeing and patient care performance. The importance of the team, and the team leader role in supporting and nurturing staff, in building a strong climate for patient care was evident; local leaders have a critical role in setting expectations of values, behaviours and attitudes to support the delivery of patient-centred care.

Our results have clear implications not only for job design within healthcare organisations but also for the nature and quality of team climates that could be developed and the nature of supportive local leadership and supervision that could be put in place.