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Co-Producing Employee Engagement Approaches in a Workplace Partnership: A Route to Partial Success in Public Health Workplaces

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ABSTRACT

While employee engagement might enhance staff wellbeing alongside organisational performance, delivering mutual gains can be challenging. This article assesses co-production as a route to engagement in a public health workplace, and finds that co-produced engagement strategies and mutual gains outcomes are possible where underpinned by genuinely collaborative organisational governance arrangements.

1 | Introduction

There is increasing interest in fostering employee engagement (EE) across diverse workplaces, and a growing evidence base suggests that engaging employees can be associated with enhanced employee wellbeing and performance (CIPD 2021). This matters to highly labour-intensive public health workplaces facing the combined challenges of rising demand and, in the National Health Services (NHS) in the UK nations, severe public spending constraints. Effective engagement strategies could enhance staff wellbeing with consequences for improved services, better care quality and health outcomes (Van Stolk and Hafner 2021).

However, the development of engagement strategies in public health workplaces and elsewhere can be problematic. Their aims are sometimes contested, and practice is often inconsistent (Bailey et al. 2018). EE strategies may individualise what are collective workplace experiences and hence be "routes to partial failure" (Hyman 1987, p. 30). Yet engagement strategies could also be routes to "partial success" if they improve worker experience and job quality while delivering organisational benefits (Townsend, Wilkinson, and Burgess 2013, p. 916).

Given the contested nature of EE, there are important questions about the effectiveness of engagement strategies, how employees respond and whether they improve workplace practice. This article analyses staff and stakeholders' views of iMatter, the EE strategy of NHS Scotland. Drawing on qualitative research methods engaging 103 staff and stakeholders, our research questions focus on (1) the factors driving the inception, design and delivery of iMatter, notably how workplace partnership arrangements and co-production shaped iMatter; (2) whether the iMatter approach to EE was viewed as effective by most workplace stakeholders, and (3) identifying any challenges and limitations in iMatter as an engagement strategy.

Our findings centre on how formalised workplace partnership arrangements - consensus-based joint-decision-making processes involving managers, staff and trade unions/professional associations - shaped the emergence of iMatter. Workplace partnership arrangements supported co-production that in turn delivered a well-designed engagement approach rooted in daily workplace practice and widely perceived by staff as effective. Many staff felt that iMatter facilitated action-focused discussions on improving job quality and workplace practice,

addressing a recurring criticism of engagement strategies that limited feedback or change follows engagement surveys (Kwon and Kim 2020). Yet we also found that frontline staff identified limitations of the EE strategy in addressing fundamental challenges to job quality and employee wellbeing rooted in staffing and resource shortages

Our research contributes to debates on EE, workplace partnership and co-production. It highlights the potential for workplace partnerships to shape HR and workplace practices beyond employment relations considerations. It illustrates the potential of co-produced EE approaches in delivering an effective engagement strategy rooted in day-to-day workplace practice. This is a novel way to think about the design of EE mechanisms that builds on insights from co-production by providers and users in a health service context. In addition, the findings highlight the potential complementarities across partnership and task-level engagement approaches.

Below, we present a brief review of the literatures on EE in public health services; on co-production as a potential facilitator of effective EE strategies; and on how workplace partnership might support both co-production and effective engagement approaches.

2 | Employee Engagement in Public Health Services

2.1 | Engagement Opportunities and Challenges

In part, increasing interest in EE in public health services reflects the broader enduring popularity of the concept in diverse organisational contexts (Ritz and Knies 2024). Since seminal work on EE in the 1990s (e.g., Kahn 1990) and on 'work engagement' in the 2000s (e.g., Bakker and Leiter 2010), interest in measuring, supporting and promoting engagement has grown. EE "is regarded by many organisations as one of the central planks in their HR or people strategy" (Bailey et al. 2018, p. 259). While the literature adopts multiple definitions across different contexts, we adopt the influential definition of MacLeod and Clarke, viewing EE "... as a workplace approach designed to ensure that employees are committed to their organisation's goals and values, motivated to contribute to organisational success, and are able at the same time to enhance their own sense of well-being" (2009, p. 9).

A key driver of interest in EE is the evidence base–contested but arguably reasonably consistent–that fostering engagement can deliver mutual benefits for employees and organisations (CIPD 2021). Evidence reviews, particularly on work engagement as a "positive, fulfilling, affective-motivational state of work-related wellbeing" (Bakker and Leiter 2010, p.1), point to employee benefits in reduced stress, anxiety and burnout. For organisations, fewer days lost to health-related absence and in improved in-role and extra-role performance may contribute to increased customer/client satisfaction and labour productivity (CIPD 2021).

Yet interest in EE may also reflect a need to 'do more with less' in response to globalisation-driven intensification of competition in the private sector and cost containment in the public sector (Ritz and Knies 2024). Further, in organisations delivering person-centred services, such a "harnessing of organisation members' selves to their work roles [whereby] people employ themselves physically, cognitively and emotionally during role performance" (Kahn 1990, p. 694) is often seen as crucial. This leaves the EE movement open to critiques that it attempts to normalise work intensification, increases the demands on workers and individualises workplace problems (Kwon and Kim 2020).

However, previous surveys of NHS employees suggest a relationship between EE, employee wellbeing and performance. Moscelli, Miah and Ahmed (2020) analysis of survey data from NHS England nurses found a significant relationship between work engagement and staff retention. Quek et al.'s (2021) micro-study with NHS nurses similarly identified engagement as a predictor of retention/turnover, hypothesising that shared leadership practices provide the foundation for higher levels of EE. Mazzetti et al. (2023) meta-analysis of EE-related outcomes found evidence of an association between work engagement and reduced turnover intention among public service employees.

Crucially, studies with cohorts of health professionals have identified an association between EE, reduced errors, improved care quality and better clinical outcomes (Van Stolk and Hafner 2021; Teoh, Hassard, and Cox 2022). This logic – that EE can contribute to better care and patient outcomes – may explain why healthcare managers increasingly seek to identify specific practices that foster engagement (Ward 2019; Moscelli, Miah, and Ahmed 2020).

Nevertheless, the literature on EE in healthcare and other public services also flags distinctive challenges. It has been argued that 'red tape'–that is, regulation or administrative tasks that may seem pointless to employees–is more prevalent in public service workplaces and may feed into disengagement (Fletcher et al. 2020). Further, successive waves of new public management in the UK have increased demands on employees, impacting engagement and wellbeing with, for example, intensified performance management and staffing/resource shortages leading to burnout and disengagement (Ritz and Knies 2024).

2.2 | Co-production as a Route to Engagement

Given these distinctive challenges in designing appropriate EE strategies in public and notably health services, an approach rooted in co-production with employees may have significant potential. Interest in co-production has increased since the 1970s as public organisations grapple with so-called 'wicked problems' and seek to tap the contribution of different citizens and stakeholder groups to deliver effective collaborative solutions (Loeffler 2021). Co-production has multiple definitions across contexts and disciplines but is widely understood as an "interactive process through which the providers and users of public services apply their different resources and capabilities in the production and delivery of these services" (Ansell and Torfing 2021, p. 46).

The language of co-production in health services usually describes the empowerment of service users and patients (Vargas et al. 2022). It is rarely considered explicitly as applying

to relations between managers and staff. This may reflect a perception that the contexts of employment and service provider/user relationships differ significantly. However, employees are users of internal organisational processes such as engagement strategies designed (mostly unilaterally) by people management professionals. Arguably, then, important insights from the co-production literature resonate in the employment context, especially in relation to EE, since engagement *of employees* requires not only management or HR processes but active employee buy-in. Put simply, where managers wish to better engage employees, genuine coproduction may bring significant benefit.

Viewing engagement strategies through the lens of co-production is a conceptual innovation that better illuminates the potential and limits of engagement strategies and helps lay the foundations for mutual gains outcomes. Genuine co-production has the potential to deliver benefits: the EE approach is more likely to reflect employees' needs, to be seen as credible, be open to continuous improvement facilitated by effective feedback mechanisms and be accepted by staff whose stronger sense of ownership promotes proactive engagement and encourages participations among peers (Acar, Steen, and Verschuere 2023).

Yet co-produced engagement strategies are rare. Adapting guidance from the wider co-production literature (e.g., Lindsay et al. 2021; Osborne and Strokosch 2022; Acar, Steen, and Verschuere 2023), genuine co-production between managers and staff is likely to involve 'professionals' (HR and line managers) and 'users' (frontline employees) collaborating as equals to shape strategies based on relationships of trust; an emphasis on users' (staff) choices and preferences in shaping actions to promote engagement; a commitment to drawing on employees' assets (experience, knowledge and 'expertise in their own lives'); and an emphasis on positive action and individual empowerment. These criteria represent a high bar for co-production between managers and employees, requiring that employees have real and significant voice to shape their own interventions (Aakerblom and Ness 2021). The wider literature on co-production points consistently to the facilitating role of 'collaborative governance' (Ansell and Torfing 2021). Collaborative governance is defined as arrangements where multiple stakeholders engage in a collective decision-making process that is formal, consensus-oriented, and deliberative (Voets et al. 2021), where decision-making is inclusive, tapping the expertise of all relevant groups, and is "consensual but creative, to support and nurture a constructive management of difference" (Lindsay et al. 2021, p. 284). Workplace partnership arrangements between employers, trade unions and employees are a form of collaborative governance (Marks et al. 1998) that might effectively underpin co-produced engagement strategies that deliver worker wellbeing and organisational benefits.

2.3 | Workplace Partnership, Co-production and Employee Engagement

A growing body of research on workplace partnerships over recent decades has pointed to their potential to support a shift from distributive to integrative bargaining and to move from adversarial to more cooperative management-union relations (Johnstone and Wilkinson 2013). At least in theory, workplace partnerships are premised on their potential to deliver mutual gains to employees and employers, with performance and/or productivity improvement aligned to stronger employee voice in organisational decision-making alongside material benefit. Drawing on Budd (2004), Johnstone and Wilkinson note that the "... quest for labour-management partnership is potentially a form of governance which can regulate the various tensions between efficiency, equity and voice" (2013, p. 744).

While there is no single agreed definition, Johnstone (2015) describes workplace partnership as an overarching employment relations style and philosophy and a particular bundle of HR policies, process and outcomes, centring on employee voice (often representative through trade unions), consultative decision-making, early consultation and the opportunity for staff to genuinely affect decisions.

Whether workplace partnerships deliver mutual gains, particularly for workers, remains contested. Some studies evidence a range of benefits to employees and unions, while others point to negative outcomes such as work intensification (Wilkinson et al. 2014). This is perhaps unsurprising given that partnership arrangements are embedded in specific regulatory, economic and organisational contexts and shaped by discrete business models, management and union strategies and priorities, and human resource policies and practices. Key contextual factors–such as strong public policy commitment to partnership and recognition of the legitimate voices of multiple stakeholders–are more strongly associated with mutual gains outcomes (Kochan and Rubinstein 2000). Yet despite this variability in outcomes, there is an a priori and evidence-based rationale for seeing genuinely mutual and collaborative workplace arrangements as a source of employee engagement, organisational effectiveness and job quality (Boxall 2013), including engagement in innovation and change (Marks et al. 1998; Findlay, Stewart, and Lindsay 2019).

Building on the three literatures above, we address our research questions through analysis of NHS Scotland, identifying the factors driving the inception, design and delivery of their engagement strategy, including the role of workplace partnership arrangements and co-production, the efficacy of the EE strategy and any challenges and limitations. We outline below our research methods and the organisational and policy context for the research. We then present findings that contribute to understanding how co-production and workplace partnership can support effective, action-focused approaches to EE.

3 | Research Methods

Our research was designed to identify the efficacy and benefits of NHS Scotland's EE strategies, and especially the iMatter approach, as well as any limitations and challenges. We adopted a purposive approach used elsewhere in healthcare research to extract in-depth data from expert groups while minimising saturation risks (Campbell et al. 2020). We deployed a range of qualitative methods. First, we collaborated with Scottish Government and NHS Scotland stakeholders to select six NHS

Board case studies, varied across the focus of provision, number of employees and geography (spanning urban, peri-urban and rural locations alongside two special Boards delivering nationwide frontline services). We conducted interviews, mainly by telephone, with senior management and staff-side stakeholders (HR Directors and Employee Directors) and Operational Leads responsible for supporting iMatter delivery. In each Board we conducted one focus group with frontline staff and line managers. Focus group numbers ranged from four to ten. Where attendance was challenging due to shift patterns, focus group numbers were supplemented by a small number of individual staff interviews. Sixty-nine individuals participated in focus groups and interviews.

We also collected data from senior national-level stakeholders involved in co-producing, developing and funding iMatter. We issued an e-survey eliciting views from five Health Board Chief Executives. We conducted one telephone interview with a senior Scottish Government official familiar with the development of iMatter and three staff (union)-side stakeholders involved in higher level partnership bodies. We interviewed representatives of the IT company who supported and managed the iMatter survey tool. This purposive sample frame was co-produced with managers and trade union representatives at Board and national level in line with the principles of stakeholder-informed qualitative research (Hudon et al. 2021). Overall, we engaged with 108 staff at all levels, managers and external stakeholders (Table 1).

Our research instruments covered multiple themes: the governance and co-production processes that gave rise to iMatter; the perceived efficacy of iMatter tools and the broader approach to EE and staff experience; the benefits and limitations of action planning and associated team-level actions; and comparison with prior EE strategies. All interviews and focus groups were transcribed and content analysed to generate key themes, then within-theme codes were identified and refined for systematic data categorisation.

The research predated the Covid-19 pandemic and so does not reflect any changes and challenges encountered by NHS stakeholders during that crisis and since. However, the workplace partnership, staff governance and EE arrangements survived the Covid-19 crisis and remain in place.

3.1 | Policy and Organisational Context

Partnership working lies at the heart of how NHS Scotland functions across fourteen regional and nine special NHS Boards that fund and plan health services alongside Health and Social Care Partnerships (HSCPs) responsible for social care. Post-devolution in 1999, the Scottish Government eschewed market-focussed processes and practices increasingly adopted in NHS England, including purchaser-provider splits, GP-led commissioning, internal competition and growing use of private sector contracting. Instead, they followed "... a different route, based on ideas of mutuality, collaboration and partnership-working that reflected a belief in collectivist ideas to achieve improvements in quality combined with social justice" (Thompson 2020, p. 52).

Successive Scottish governments have committed explicitly to workplace partnership arrangements that "... give staff and their trade unions a bigger say in the design and management of the NHS" (Scottish Executive 1999, p. 1). Formally constituted partnership fora at national, regional and local levels deliver a highly developed system of collaborative employment relations (Findlay, Stewart, and Lindsay 2019; Bacon and Samuel 2017). Partnership working has generated multiple benefits, including better workforce planning strategies (Anderson et al. 2021) and an absence of industrial action alongside improved pay and benefits (Findlay, Stewart, and Lindsay 2019). As outlined below, partnership working also provided fertile ground for the co-production of EE strategy.

At national level, a Scottish Partnership Forum (SPF) and Scottish Workforce and Staff Governance Committee (SWAG) are tripartite and co-chaired, with membership from employers, trade unions (including Unison, the BMA, the RCN, Unite and other specialist health unions) and government. While the SPF is responsible for strategic direction, SWAG provides a specialised national forum to address workforce issues and

TABLE 1 | Respondents by board and stakeholder group.

	HR director	Employee director (staff)	Operational lead	Board member	Staff	Line managers	Other stakeholders
1 (Regional)	1	1	1	1	4	4	
2 (Regional)	1	1	1	1	4	4	
3 (Regional)	1	1	1	_	4	6	
4 (Regional)	1	1	1	1	7	4	
5 (Special)	1	1	1	_	9	8	
6 (Special)	1	1	1	1	10	5	
CEOs/Chief Officers							6
IT company							2
National policy and staff-side							4

supports the development and implementation of employment policy, including approaches to employee engagement. Negotiation is undertaken separately through a national Terms and Conditions Committee.

At health board level, Staff Governance Committees oversee workplace standards, evaluate people management strategies and implementation plans, and maintain local partnership working. These committees must include an Employee Director and at least two 'staff-side' representatives from trade unions and professional organisations. Employee Directors sit on NHS Boards, providing a staff perspective on strategy development and service delivery and reflecting the views of local partnership fora. Distinctively among UK NHS organisations, NHS Scotland's staff governance regime is rooted in collaboration and multi-stakeholder co-operation.

Alongside a partnership approach to governance, co-production and EE are core policy aspirations in NHS Scotland. Scotland's then Chief Medical Officer describes co-production as 'active dialogue and engagement'; 'putting users and providers on the same level'; 'treating individuals as people with unique needs, assets and aspirations'; providing 'support tailored to their needs' and services that 'learn to work with people and not do things to them' (Burns 2013, p. 31). The potential for EE to impact care quality and clinical outcomes is also referenced explicitly by NHS Scotland's engagement strategy: "Staff who feel engaged, involved and valued provide for a strong workforce and a strong workforce is essential to achieve continuous improvement in delivering healthcare services" (NHS Scotland 2020, p. 1).

4 | Findings

4.1 | Inception, Design and Delivery of iMatter

Effective EE mechanisms were identified as a priority in the Scottish Government (2016, p. 4) Health and Social Care Delivery Plan, which seeks that "people who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide". Improving EE has been prioritised by successive workforce strategies (e.g., NHS Scotland 2017) and Staff Governance Standards agreed through NHS Scotland partnership arrangements.

Until 2015 NHS Scotland's engagement strategy comprised a national staff survey, but response rates sometimes proved disappointing (typically averaging 28%–35%) and the process (in common with EE strategies in many large organisations) was perceived as an expedient top-down exercise, with limited practical relevance to, or actions arising for, the work of frontline teams (Findlay, Stewart, and Lindsay 2019). The limitations of the staff survey stimulated the SPF to explore alternative ways to engage staff. From 2017 iMatter was developed by NHS Scotland's workplace partners. Rather than imposing a model from the top-down, the iMatter process sought to "combine and strengthen different kinds of knowledge and experience, and... work with people rather than processing them" (Hashagan et al. 2011, p. 2).

Co-production was central to the emergence of iMatter. Before rollout, Scottish Government and NHS Scotland workforce specialists facilitated extensive engagement with frontline NHS staff across grades and levels to coproduce EE tools and a modus operandi for action-focused engagement activities. An iterative series of discussions with staff eventually produced a 29-item mainly online survey that mapped onto Staff Governance Standards. Survey questions focused on job resources (such as role clarity, opportunities for voice and feeling treated with dignity and respect), relationships with line managers, and broader views of and relationships across respondents' NHS organisation (see Table 2). The iMatter survey was validated, demonstrating satisfactory internal reliability (Snowden and MacArthur 2014).

iMatter is, however, more than a survey. It delivers an integrated set of engagement practices and tools including the online survey and data analysis tool; coaching and team-based problem-solving materials designed to support line managers and teams to identify challenges and codesign improvements in workplace practices; online resources, learning and development for staff and managers; and extensive benchmarking to allow stakeholders to track progress and/or identify challenges. iMatter followed the evidence in recognising the importance of group-, leader-, and organisation-level factors in shaping the job resources available to health professionals that can shape their engagement (Lesener, Jochmann, and Wolter 2020).

Co-production of iMatter also relied upon staff and management participation and buy-in. Line managers at team-level

TABLE 2 | iMatter survey themes and example statements.

Theme	Example statements
Job resources	I am clear about my duties and responsibilities.
	I am confident my ideas and suggestions are acted upon.
	I am treated with dignity and respect as an individual.
Manager/team	I am confident my performance is managed well in my team.
	I have trust and confidence in my direct line manager.
	I feel involved in decisions relating to my team.
Organisation	I get the help and support I need from other teams, and so forth. ...
	I feel my organisation cares for my health and wellbeing.
	I feel involved in decisions relating to my organisation.

were charged with supporting employees to engage with the iMatter process and leading action-focused discussions based on data analysis from the survey. Analytical reports were prepared by a central iMatter team, which also strongly encouraged and supported line managers to maximise response rates, setting a 60 per cent response target for most teams. Each line manager was required to work with their team to coproduce and upload an Action Plan based on their iMatter analysis within twelve weeks of receiving results. NHS employers appointed 'Operational Leads'–dedicated staff roles responsible for supporting managers to engage with iMatter, providing data analysis, and informing team-based activities to improve staff experience and workplace practice. Operational Leads also organised and delivered staff training and provided ongoing training/guidance for managers; linked with the IT contractor that managed the online survey; collated and reported iMatter output data to managers; reported to Board/National Partnership Fora; and monitored Action Plans. iMatter was gradually rolled out across the 140,000 staff in the nation's regional Health Boards (delivering frontline healthcare services) and special NHS Boards (providing specialist and national services).

4.2 | Efficacy and Impact of EE Strategies

This research aimed to capture multiple stakeholders' views on the efficacy of iMatter (Authors, 2019). There was strong support (with some exceptions) for iMatter's co-produced and proactive approach, particularly when compared with previous EE strategies. Operational Leads and HR Directors pointed to the improved 'reach' and take-up of iMatter, with response rates generally significantly higher than in preceding staff surveys. Nationally, the iMatter response rate during our fieldwork was 62 per cent, eclipsing a 38% response rate in the final year of the previous staff survey. Response rates were higher amongst staff in senior roles and where workforces were 'frontline', larger and 'static' (i.e. primary care settings). Notwithstanding significant variation (from 53% to 68% in territorial Boards), most staff completed the process in all Boards. Response rates were lower where staff were geographically dispersed or had limited Internet access, and among those in part-time/temporary roles. Accordingly, iMatter did not entirely overcome the variability in take-up and reach that has proved problematic for EE elsewhere (Segalla 2021).

The research found consistently that employees valued iMatter's capacity for informing discussions and actions on areas of workplace practice including strengthening team collaboration (how tools were designed to function at team-level was commented on positively by staff and line managers); improving peer-to-peer feedback, communication and mutual support; and (in most cases) improving line manager engagement.

Specifically, staff in focus groups spoke of the benefits of Action Planning workshops with their team based on analyses of iMatter data. Managers assessed the training provided for them as effective in supporting them to facilitate action-focused discussions. Staff at different levels valued the opportunity to engage with their team and line manager and valued the action-oriented nature of the process that delivered practical benefits. For example, many respondents noted that enhancing their own and colleagues' access to training and development was a central theme for Action Planning.

> *As a team, we chose, well, the three areas, main areas to work on, and then we discussed all things that we could do. The team building, we were so glad that we got the opportunity to say that we wanted to do... I was really glad to be part of it. My manager didn't just sit down and be like, "Right. These are the three areas. This is what we are going to do." We all had a say. We all spoke about it.*
>
> *Staff Focus Group Participant, NHS Board 4*

The benefit of bringing teams together with a sense of focus and purpose to spend 'quality time' together was a recurring theme in our data across staff, Operational Leads and managers.

> *Actually, there is something about getting quality time in a room with people that do similar jobs, if not the same job, and actually just having the chance to sit and talk, to think of ideas.*
>
> *Operational Lead Interviewee, NHS Board 2*
>
> *I think, you know, sometimes again the team tend to forget about each other quite easily and are very focused on the clients. Every now and again it is nice to just be like, "Let's bring the team in". Our manager tends to see that, that we do need the time to come together... so that's been good.*
>
> *Staff Focus Group Participant, NHS Board 2*

While the research sample is not statistically representative of the NHS Scotland workforce, staff insights were delivered at every level and across job roles, HSCPs and Boards, and were broadly supportive of iMatter. While there were more mixed views in some groups and among more sceptical managers/staff, the most striking research finding was that most staff held strongly positive views of iMatter.

Minutes for SWAG and discussions with staff-side representatives reveal some scepticism about the initial adoption and development of iMatter (Findlay, Stewart, and Lindsay 2019). Yet the interviews revealed a shift among staff-side representatives (union officers and lay stewards) from initial scepticism towards more positive views about the new approach. For them, the fact that the iMatter process and measures were co-produced with staff and reflected staff-side consultation from the outset delivered important benefits, including an approach to EE that was credible with frontline staff; higher response rates that provided amplified employee voice based on a more representative sample; clear alignment with nationally-agreed NHS Staff Governance Standards; and perhaps most importantly a robust data source for engaging with and challenging management.

Managers, employees and staff-side representatives also compared iMatter positively with the preceding national staff survey that had come to be seen by some as bureaucratic and unresponsive to employees' needs (reflected in relatively low response rates). As one line manager noted:

> *Compared to the national survey, this is much more focused on the team. The feedback is more pertinent. It's about a local focus, a team focus, not a big national picture that doesn't tell us anything.*
>
> *Line Manager Interviewee, NHS Board 3*

Staff and line managers in focus groups and interviews similarly reported a change from previous 'tick box' survey exercises with 'long reporting cycles' (with annual engagement reports typically published just before the next survey launch) that did not focus on identifying actions to drive change, and which managers were aware had limited uptake among staff.

> *The [National Staff Survey] response level dropped off... because after the first one, it didn't really seem there was any change, regardless of what the report came back. Nothing seemed to make a difference, so a lot of people thought, "What's the point?"....*
>
> *Line Manager Focus Group Participant, NHS Board 5*

Notwithstanding the limitations identified below, for the staff and managers who participated in the research, iMatter seems to have avoided many of the downfalls associated with less effective EE strategies. The critical literature highlights how EE strategies are too often seen as 'all talk, no action' (CIPD 2021), whereas iMatter provided a strong emphasis on identifying feasible actions at team-level, maintaining the buy-in of staff and delivering practical benefits in learning, communication and collaboration. Prior research has advocated for engagement strategies that focus on personal development and career progression (Van Stolk and Hafner 2021), themes that often emerged in Action Plans and were valued by frontline staff. So, in providing a staff engagement model located at team-level, that supported teams to coproduce ideas for improvement, and that required the former to evidence how teams had taken forward practical actions, iMatter appears to have been effective in delivering on its objectives.

4.3 | Limitations and Challenges for EE Strategies

There were, however, important limits to the positive impacts of iMatter, with managers and staff pointing to the dislocation between the EE model and an acknowledged need to address specific examples of bullying, as well as fundamental problems of work intensification. Further, there was some criticism of iMatter's partial focus on senior management practice and decision-making, which staff felt disconnected from. The iMatter tool (and therefore some team-level problem-solving discussions) was most effective in informing collaborative working on team building, practice sharing and line manager communication. But staff were often frustrated that concerns raised over senior management's apparent reluctance to reinvest in staffing and resourcing were not addressed in the iMatter process, notwithstanding that these issues were the subject of extensive discussions at national and Board partnership level.

> *A lot of the problems that were highlighted, there's nothing we could do at [team] level. It's all well above our pay grade.*
>
> *Staff Focus Group Participant, NHS Board 5*

Linked to this, perhaps the most consistent criticism of the iMatter process reflected its inability to address fundamental stressors faced by staff, especially related to under-staffing, impacts of high levels of sickness absence, work intensification and limited time for learning or even rest.

> *We get enough information [about training opportunities] but not enough time. You need to create time offline and there is just not enough.*
>
> *Staff Focus Group Participant, NHS Board 4*
>
> *People are now out there disillusioned going, "I'm struggling to get my rest period. I'm struggling to get finished in time." It's impacting. It's the job, job, job, job.*
>
> *Staff Focus Group Participant, NHS Board 5*

While work intensity undoubtedly affected the ability to participate in iMatter action planning and outcomes, iMatter as a process was specifically designed to focus at workgroup level, with collaborative partnership structures providing for strategic oversight and consideration of systemic issues (such as work intensity). While there are no formal evaluation data regarding how iMatter may have systematically influenced national policy and strategies, priorities raised consistently by staff during successive iMatter processes have since been subject to action at regional and national board level. For example, clear national guidance for managers on 'Flexible Work Pattern Policy' has been provided (NHS Scotland 2023), with Scotland's largest health board, NHS Greater Glasgow and Clyde, explicitly citing "feedback our staff provided through iMatter" as informing the four pillars of its workforce strategy (NHS Greater Glasgow and Clyde 2021, p. 3).

Interviews and focus groups also highlighted challenges associated with team-based Action Planning, including sometimes substantial changes to team membership because of staff turnover (as well as limited time due to work demands). Other limitations identified by stakeholders related to variable response rates across teams and Boards, perhaps reflecting variable managerial buy-in and commitment to EE strategies; and concerns that geographically dispersed teams or those with limited Internet access (because of geography or work patterns) might be excluded. These testimonies across all stakeholder groups highlighted some of the fundamental job quality challenges in health and care that team-level EE tools are unable to address.

4.4 | Partnership and Co-production as a Foundation for Effective Engagement

We have suggested above that co-production–a key principle of engagement with patients and service users in health services–was central to the development process for iMatter and the broader EE strategy in this case. Indeed, it is possible that experience of co-production with service users helps predispose towards coproduction with staff. iMatter co-produced a set of engagement practices/tools supporting line managers and teams to identify challenges and codesign improvements in workplace practices. Coproduction with frontline staff was central to the process and underpinned iMatter's credibility and efficacy. Staff-side representatives and Employee Directors argued that co-production embedded staff insights into Matter's content and approach, while trade union voice ensured alignment with national Staff Governance Standards–ensuring the relevance and credibility of iMatter and in turn incentivising higher survey response rates. Co-production was also a defining feature of the iMatter Action Planning process. Staff described a sense of ownership over discussions and actions–that is, Action Planning was seen by staff as something they owned and were driving forward together rather than something 'being done to them'.

Stakeholders were clear that collaborative staff governance arrangements facilitated co-production and enhanced engagement. Employee Directors and staff-side representatives, but also senior managers, argued that national and local/Board-level partnership arrangements provided a crucial foundation for effective EE. NHS Scotland's workplace partnership and collaborative staff governance arrangements have been evaluated consistently as playing an important role in enhancing employee voice and participation in decision-making and promoting co-operative approaches to improving staff experience (Bacon and Samuel 2017; Findlay, Stewart, and Lindsay 2019; Lindsay et al. 2019). Our data reiterated that the input of Employee Directors and national and local staff-side representatives was central to informing the governance, content and delivery model for iMatter. We have also noted that iMatter was well-resourced, with substantial investment in IT for data gathering and analysis, central support for training in EE activities and Action Planning and dedicated time for Operational Leads at Board-level to support and promote actions. Such resourcing was advocated for, secured and signed off in collaborative national fora. More broadly, workplace partnership and its extensive, formalised fora for collaboration and joint-decision-making provided the context for a genuinely co-produced approach to EE and allowed for iMatter to be seen as part of broader employee voice mechanisms, contributing to greater trust and commitment among staff.

5 | Discussion and Conclusions

Employee engagement is highly sought in public health services and beyond due to its links to improved employee wellbeing and performance. Yet engagement strategies can be contentious, and context matters.

Our first research question focussed on identifying what facilitated the effective inception, design and delivery of iMatter, focusing on the role of workplace partnership and co-production. Studies of effective frontline co-production have highlighted the facilitating role of collaborative governance by multiple stakeholders in deliberative, consensus-oriented fora in allowing for multiple voices in decision-making and in the constructive management of difference (Ansell and Torfing 2021). NHS Scotland's formalised and multi-level workplace partnership arrangements have framed how staff and trade union voice and collaborative decision-making shapes workplace practice through nationally agreed Staff Governance Standards. Both SPF and SWAG have proved effective mechanisms for joint decision-making. Board-level staff governance committees, including Employee Directors, have ensured a prominent role for employee voice, lending credibility to jointly agreed strategies, including on EE, and adding to evidence on the power of partnership and on co-production of innovative EE strategies.

Our second research question concerned stakeholder perceptions of the effectiveness of iMatter, and what underpinned its effective design and delivery. Reflecting on these questions, and 'what might work' in EE, NHS Scotland's approach seems to have made some progress in addressing a recurring 'all talk, no action' criticism of engagement strategies (Kwon and Kim 2020). Drawing on the voice and priorities of frontline workers, NHS partners were able to coproduce an action-focused approach to EE, with centrally funded analytical support providing quick access to team-level data for managers and staff, and line managers charged with the responsibility of facilitating evidence-informed Action Planning workshops. As noted above, while frontline employees were sometimes sceptical about the capacity of such activities to address some fundamental workplace challenges, they nonetheless welcomed the opportunity to engage with their teams and were able to recount practical actions (often focused on learning and/or team building) flowing from these activities. The enhanced usability and credibility of the iMatter approach was also reflected in substantially improved engagement survey response rates. Therefore, in assessing what might work for EE strategies in the public sphere, there are lessons to be learned in terms of involving employees at all levels from the outset as co-producers of EE tools; and recalibrating these tools and linked collaborative activities to focus on generating actionable insights.

The iMatter approach also points to importance of properly resourced engagement strategies. Investments in Operational Leads to encourage, support and train line managers and teams to use engagement and Action Planning tools, and in a user-friendly online data gathering tool linked to analytical capacity that provided quick analysis and feedback at team-level, were crucial. A key lesson, especially for large-scale, complex organisations, is that EE cannot be promoted 'on the cheap' – senior leadership teams need to commit to and provide resources for credible and practical engagement tools (Knight, Patterson, and Dawson 2019).

Our third research question explored the challenges and limitations associated with NHS Scotland's approach to EE. While offering a generally positive assessment of recent changes to staff engagement, we also note limitations. Staff, their

representatives, managers and stakeholders acknowledged that while iMatter facilitated effective collaborative action around learning and development and teambuilding, fundamental challenges of staff resourcing and work intensification remained problematic. It is important to note, however, that these limitations of the engagement strategy are perhaps less concerning given that staffing and workload issues are addressed in national and local partnership structures. This highlights the synergy between strategic partnership arrangements and a workgroup-focussed engagement strategy.

Even supporters of the new approach to EE acknowledged that there remained work to do – for example, while response rates increased significantly under iMatter (especially commendable given the expansion of NHS Scotland EE strategies to take in the social care workforce), more than one-third of targeted staff did not participate, and there were concerns that those in dispersed teams and/or with limited access to online tools might be disadvantaged. Yet despite these limitations, iMatter is widely seen as a success, even if partial, by a range of stakeholders, including workers.

We acknowledge an inevitable risk of sample bias in our research, which engaged with participants who volunteered into the data gathering process. There are also limitations to the transferability of lessons from this apparently positive experience located in a large public organisation with substantial resources to invest in testing and supporting new approaches to EE. We concur with previous research that adequate resourcing matter if credible and effective EE strategies are to emerge. Nevertheless, we conclude that there is scope for public health organisations to arrive at approaches to EE that are action-focused and credible with staff - if they are co-produced with frontline employees and their representatives and aligned with agreed workplace governance.

This article makes distinctive contributions to the literatures on EE, workplace partnership and co-production. In examining how workplace partnership can facilitate the design and operation of engagement strategies, the research offers an innovative contribution to the conceptual literature–as well as new empirical insights – on partnership and employee engagement, by locating engagement strategies (their design, enactment and oversight) within the wider context of organisational governance. In assessing the potential of co-produced engagement strategies to explore factors shaping their efficacy, this research adds to the evidence base on 'what might work' in EE strategies in public health and other organisations.

The research also offers new theoretical insights on the transferability of the concept of co-production to the development, deployment and evaluation of EE strategies rooted in everyday working practices, expanding the concept of co-production to encompass collaboration between management and employees. This is a novel approach which sees workers as users of internal HR processes requiring their participation and buy in, and hence suitable for co-production. To the extent that iMatter represented an effective approach to EE, co-production between senior HR managers, line managers, unions, employees and other employee relations stakeholders was crucial. Co-production in the delivery of health services is about acknowledging the 'assets' and insights of the service user/patient as an equal voice in the design and delivery of care (Thompson 2020). NHS Scotland stakeholders sought to transfer these principles into the codesign of EE strategies, with some success in delivering some of the positive outcomes predicted by the extant co-production literature: better informed service content; and credibility with and buy-in from staff who felt that they had voice and agency in the co-production process (Loeffler 2021).

The role of workplace partnership in shaping the approach to co-produced EE gave credibility to iMatter's action-focused approach and key partnership stakeholders became its vocal advocates. So we offer a challenge to healthcare and other public managers and stakeholders: first, to consider how the principles of co-production can support the design and implementation of EE and broader people strategies, and second, to develop forms of collaborative governance such as workplace partnerships that can provide fertile ground for the emergence of innovative approaches to EE.

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Conflicts of Interest

The authors declare no conflicts of interest.

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