agiLab

The University of Sussex and NHS HR Directors Network (SE)
Research and Best Practice in Agile Working

Understanding and reducing tensions between clinical and non-clinical staff in the NHS, in relation to agile working

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A note about agiLab

agiLab is the co-creation of academics at the University of Sussex, the NHS South-east Regional Social Partnership Forum (SPF) and the NHS HR Directors Network (SE). agiLab aims to promote and facilitate an evidence-based approach to best practice and research in agile working through academic and practitioner collaboration and knowledge exchange. A key strategic aim of the NHS is to develop more flexible and pioneering ways of meeting the diverse needs of workers, patients, and society. agiLab aims to be at the forefront of leading the agenda to support and optimise this, via the utilisation of, and contribution towards, state-of-the-art academic research. www.agilab.org.uk

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Foreword

It is with great pride that we introduce this research report on behalf of NHS Employers, trade union colleagues and senior workforce leaders from across the NHS.

To meet the ambitions of the NHS Long Term Workforce Plan we must focus on strengthening the supply and retention of our workforce, ensuring both attraction to the service and supporting and encouraging colleagues to remain. The NHS is increasingly competing in a diverse labour market where employees can explore careers with employers offering a variety of flexible benefits, agile working patterns and opportunities.

Building on the learning from the working practices developed during the Covid-19 pandemic many NHS trusts have begun to adopt an agile working approach to deliver on the 'we work flexibly' people promise. These different approaches are regularly discussed by workforce leaders within their peer networks and at our social partnership forums so that learning can be shared and implemented to ensure NHS staff feel valued and supported.

Collaborating with the University of Sussex is always a pleasure and their expertise, guidance and support throughout this journey has been invaluable. The study benefitted from the commitment of our agiLab steering committee, made up of our senior workforce leaders, trade union and NHS Employers colleagues, who have shared their time and insight during a challenging period. Each group of stakeholders recognise workforce challenges through a different lens and this is the strength of partnership working which helps us to deliver on matters of shared concern. This has also enabled a wide field of participants being recruited to be part of this significant project to further our understanding of the issue and help to identify and break down the barriers restricting the wider implementation of new ways of working.

Reading the recommendations of this report we are struck by the importance of open and honest communication about agile working arrangements, within and across different areas of the workforce. To make the NHS an employer of choice staff must feel safe, confident and supported to speak up. Having a speaking up and listening culture is critical to developing strategies to support those who are struggling.

We are hopeful that by highlighting the presence of indifference as a 'red flag' for burnout and exhaustion we can ensure those workers most at risk will receive compassion, empathy and support from their colleagues and leaders. The findings of this report will enhance existing work across a wide range of workforce priorities including retention, career pathways, psychological safety, compassionate leadership and the development of a just and learning culture.

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23rd October, 2023

1. Executive Summary

To meet the people promise that 'we work flexibly', the NHS has been active in rolling out agile working arrangements to help staff change how, when and where they work, to fit in with individual circumstances and changing organisational needs. Agile working arrangements work best when they are customised at a team or individual level, but this can give rise to resentment amongst staff, especially if workers view some groups as benefitting from more advantageous agile 'deals'. Since the more widespread application of agile working, following the Covid-19 lockdowns, the NHS has reported that tensions have been emerging between clinical and non-clinical workers in respect of their different agile working arrangements. Concerned to understand what is causing this tension, and what can be done to assuage this, this research programme was co-developed between academic researchers at the University of Sussex's agiLab, and practitioners and trade-union representatives within the NHS. The research programme aimed to: ***identify, understand and address how and why interpersonal tensions arise amongst clinical and non-clinical staff in the NHS, in relation to their agile working arrangements***.

To address this, we undertook an online 'vignette' based experiment with N=296 workers (118 in clinical roles and 178 in non-clinical roles). Two vignettes described an agile working arrangement, typical for either clinical or non-clinical workers. Each scenario was presented from the perspective of the worker, and reflected one of three different 'types' of emotional expression about their agile working arrangement: 'non-emotions', 'negative' emotions, and 'indifference'. One vignette about a worker's emotional expression from the 'other' group (clinical or non-clinical) was presented to each participant. Participants were then asked to comment on how this presentation made them feel, think and act in relation to the worker and the group that the worker represented.

We found that both clinical and non-clinical workers felt the most empathy towards clinical workers, in respect of their agile working arrangements, indicating that both groups see clinical worker deals as less advantageous. Across both groups, we also found that when a worker expressed indifference (compared with no emotion or negative emotions) about their agile working arrangements, this evoked more hostile and less empathic reactions from workers in the 'other' group. The other group then demonstrated less positive attitudes towards the worker and the group they represent, were less inclined to help them, and considered them to have a better deal than workers in their own group.

Returning to the academic literature to interpret these findings, we noted that 'indifference' is a dysfunctional emotional reaction that can be a late-stage indicator of burnout, and a sign that workers are struggling or shutting down. Being indifferent about one's agile working arrangement suggests that the arrangement is no longer working for them and needs to change. Rather than responding with hostility to indifference, research suggests that colleagues and managers would do well to see indifference as a 'red flag' – a signal that the arrangement has become stressful and that the colleague requires compassion and support. By also identifying that expressions of negative emotions were more likely to evoke empathy, our research highlights how encouraging workers to share dissatisfaction and frustration could allow managers to step in, make changes and offer support. Altering flexible plans before they become problematic should help to stave off the occurrence of indifference, and potentially burnout.

We make a number of recommendations that the NHS might like to consider, to raise awareness of indifference and to understand what this might signal in terms of how people are coping with their agile working arrangements. Sharing perspectives on the positive and negative implications of different agile working arrangements can allow colleagues to offer each other support and compassion. Encouraging ongoing conversations about how agile working arrangements are working out also means that stressful patterns can be altered before they become problematic. Truly 'agile' working involves regularly assessing and adapting working patterns to meet both worker and organisational needs. Our research provides further evidence that 'we work flexibly' will work best when this incorporates ongoing communication and adaptations to meet changing needs.

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2. Introduction

2.1 The rise of agile working in the NHS

Increasing the level of flexibility offered to employees at work has become a key priority for organisations in recent years, prompted by a desire to: (a) improve employee work-life balance and reduce incidence of stress-related absenteeism, turnover and illness; (b) be more competitive within the labour market; (c) respond to new legislation about rights to request accommodations and adjustments for workers in protected groups; and, (d) increase productivity by fostering a more autonomous, happy workforce who now demand better work conditions (Kelliher & Anderson, 2010; Kossek et al., 2018). However, the implementation of flexible working has not always been successful, with organisations often failing to put appropriate infrastructure in place to support this (Hassard & Morris, 2022). Further, workers have found that more 'freedom' to work where, when and how they want can also go hand-in-hand with increased monitoring, feeling tethered to work through electronic devices and being ever-more controlled by organisations to whom they feel they should be grateful (Hassard & Morris, 2022; Mazmanian et al., 2013). Flexible working therefore requires careful handling and evaluation to ensure that it works both for the employee and the employer.

Within the NHS, since the launch of the NHS People Plan (2020) and accompanying people promise **'we work flexibly'**, offering flexible working by default has been an important objective. The extent to which people agree with the statement 'we work flexibly' is measured in the annual NHS staff survey. For true flexibility to be enjoyed, academics argue that the worker needs to feel like they have control and choice over their working arrangements (Hyman & Summers, 2004; Igbaria & Guimaraes, 1999). However, this also needs to be accompanied by employer-led adjustments when potentially negative repercussions emerge that workers may not be aware of (e.g. the increased isolation that remote working can afford: Cooper & Kurland, 2002). In recent years, there has been some concern that offering increased flexibility at work tends to be unequally distributed, with workers who have greater status, voice and social capital benefitting most (Kossek & Kelliher, 2023). This can lead to resentment and conflict between staff if perceptions abound that some workers are enjoying better flexible deals than others. There is also some concern that flexible options are offered as a one-off, rather than regularly revisited and adapted as needs change (Schmidtner et al., 2021).

Agile working is an expression of flexible working that involves a more responsive, adaptive and pre-emptive approach to offering flexible working options that meet both worker needs and emerging demands at a market, service or societal level (Russell & Grant, 2020). Historic approaches to flexible working offer workers a static set of options that are usually worked into a formal employee contract, but which can quickly become obsolete when worker or organisational demands change. Agile working differs from this static, formal approach to flexibility. In our definition:

> Agile working encompasses both formal and informal flexible work arrangements to support organisational and worker needs regarding when, where and how people work. It involves adapting work patterns and use of digital tools as needs change. Agile working therefore offers genuinely innovative, customised and responsive options to liberate workers and organisations from rigid, traditional constraints relating to working time, places and tasks.

In recent years, many NHS trusts have begun to adopt an agile working approach to deliver on the 'we work flexibly' people promise. This was especially made salient when the Covid-19 pandemic emerged in 2020, drastically affecting the NHS, its staff, and the needs of the patient population. In real-time, the NHS needed to respond, changing people's working patterns to meet governmental lockdown demands, a health crisis, and the need to keep staff safe yet working. Working arrangements were in constant flux and adaptations were made as new demands developed. For

the first time, agile, flexible working was being operationalised across the whole organisation. In the next section we outline how the Covid lockdowns led to the emergence of more agile forms of work in the NHS, and then move on to discuss the lasting impact of this for workers today.

2.1.1 How Covid lockdowns expedited the move to agile working in the NHS

In March 2020, as the UK went into national lockdown, services across the NHS were asked to begin instigating agile working models. NHS reports found that this was across a wide range of job types, with both clinical and non-clinical workers responding to changing service, societal and worker needs.

In relation to **when** people work (agile time), the increased pressure that the Covid-pandemic placed on NHS resources meant that clinical and non-clinical staff often changed their working hours to accommodate workers' home demands and/or patient restrictions. Some NHS clinical workers, for example, moved to 'bank' working incentivised by, amongst other things, the ability to fit their working time around the needs of the family (Sahai, 2022).

In relation to **where** people work (agile places) for non-clinical NHS professional services, almost 100% of the workforce moved immediately to a remote working model (NHS Shared Business Services Report, 2020). Therapeutic clinical workers also moved to working remotely (e.g. physiotherapy and clinical psychology services: agiLab, 2021). Other services saw a rise in hybrid working – with some workers based at home, some within NHS estate settings and others moving between the two (NHS Employers, 2021).

Finally, in relation to **how** people work (agile roles), the NHS reported that 19% of NHS staff were redeployed to different roles to help address the Covid pandemic in 2021 (NHS Staff Survey Results, 2021). For example, physiotherapists assisted ICU patients on Covid-wards, or specialist nurses were deployed to offer vaccinations at community centres. There was also an increase in the use of digital tools to meet new working demands, such as the use of video conferencing for holding meetings and consultations (Mehta et al., 2020).

2.1.2 Agile working in the NHS since lockdown

Much of the 'agile working' that was rolled out during the pandemic was implemented by necessity or even enforcement (e.g. re UK government lockdown requirements) and therefore did not necessarily offer staff the vital element of choice that should characterise agile working (Liberati et al., 2021; Shirmohammadi et al., 2023). However, the pandemic enabled many agile working policies to be practically tested and, for the first time, workers and organisations, could envision the benefits that flexibility could bring, when properly supported. Since the pandemic, many changes to digital infrastructure and work practices have been retained by the NHS.

In the latest NHS Staff Survey (2022), agreement with the statement 'we work flexibly' had increased in all types of trusts since 2021, with 46% of staff agreeing with this, and 53% of staff agreeing they enjoyed good work-life balance. Across all trusts and occupational roles (except medical and dental categories) 69% of staff also reported that they could approach their manager with flexible working requests – again, up from the previous year. Whilst this suggests that the NHS is moving in the right direction to sustainably offer flexible options post-pandemic, it also reveals that large quantities of staff are still not getting the level of flexibility they want from their work. Such disparity is concerning, as in another area of the NHS Staff Survey (2022), it is revealed that at least 35% of clinical staff across all categories agree that they are burnt out, compared to just a quarter of administrative and clinical workers; with the latter enjoying the second highest likelihood of their manager listening to their agile working requests. In this new post-lockdown era of agile working, for work to be truly agile (and flexible) it needs to be responsive to worker *and* organisational needs.

2.2 Conflict amongst clinical and non-clinical groups in relation to agile work

Across the academic research literature that examines flexibility at work, the concept of offering idiosyncratic and informal 'deals' with individual workers has been pitched as a useful way of customising flexibility to meet individual needs and circumstances (Hornung et al., 2008; Kossek & Kelliher, 2023; Rousseau, 2005). However, despite the laudable intentions of such policies, research is emerging to suggest that when deals are customised to particular workers' needs, this lack of uniformity in conditions, can also give rise to perceptions of unfairness. Indeed, workers with more status, voice and social capital are most likely to be advantaged by these idiosyncratic flexible deals, whilst other workers are overlooked (Kossek & Kelliher, 2023; D'Mello et al., 2022). Where unfairness is perceived and/or granted, inter-group conflict can heighten (Tajfel et al., 1979).

Indeed, in agiLab meetings over the past 3 years, anecdotal reports suggest that perceived inequity is most salient for clinical workers comparing themselves with non-clinical workers, and that this then creates conflict and hostility between groups. Those who feel they are getting a relatively poor deal when it comes to agile work may be looking on in envy as other groups enjoy greater benefits, and this is reported to be fuelling resentments.

For example, **clinical staff** in front-line roles may consider that non-clinical staff are able to work from home more and enjoy benefits such as opportunities for more flexible childcare, flexible hours, and protections from health risks. **Non-clinical staff** however may feel envious of clinical staff who are adding significant value on the frontline, whilst working in supportive teams in a climate of being 'all in it together'.

Whilst reports of these concerns are largely anecdotal, there is also some research evidence from emerging agiLab reports that highlights, and provides examples of, these burgeoning tensions.

> *"I spoke to the director of the care group and because there was, there's the nastiness around people working from home… basically saying people working from home were shirkers. I got very upset about that. The interpretation for me, and what was clearly coming across from some members of that care group management team, was that people working from home had their feet up, and were enjoying a period of relaxation, and you know not, not working very hard. And it was the exact opposite. We were, we were absolutely flat-out and that stung. To think that people I'd worked with for all that time felt that way."* (Participant 1 in 'Leading an Agile Workforce', Russell et al., 2022)

> *"We've got clinical people, especially those working in mental health, where they look at working from home as a real negative and a negative impact because there's no differentiation between that work and home. So, if you're having quite challenging conversations with patients around mental ill health in your home place... Whereas before, you could leave, leave all of that work stuff in the workplace and drive home. Now it's in your home."* (Participant 2 in 'Leading an Agile Workforce', Russell et al., 2022)

> *"We do have quite a different role to those that are frontline providing nursing care, for example …, so there's always something when you're in a clinical role that makes it a lot harder…. I had this terrible guilt that I wasn't doing anything to help."* (Participant 3 in 'Leading an Agile Workforce', Russell et al., 2022)

As such, the NHS is concerned to more fully understand whether and why such tensions exist between clinical and non-clinical staff, in relation to their agile working arrangements. Identifying developing conflict between occupational groups and using a research-led approach to tackling this should allow the NHS to address the issues before they become problematic. Using evidence-based guidance from an applied research study can help the NHS work on building better interpersonal relations amongst staff, before clinical-non-clinical conflict negatively affects longer-term team harmony, productivity and service provision. In this report, we therefore aim ***to identify, understand and address how and why interpersonal tensions arise amongst clinical and non-clinical staff in the NHS, in relation to their agile working arrangements***.

2.3 Research framework

A plethora of research examines the role of empathy and perspective-taking in conflicts and conflict resolution. Empathy is "the capacity to understand and enter into another person's feelings and emotions or to experience something from the other person's point of view" (Colman, 2009, p.248). Empathy has been shown to improve attitudes and helping behaviours towards other groups (Dovidio et al., 2010; Stürmer et al., 2006). People experiencing empathy also show greater willingness to reduce hardship or suffering experienced by other groups (Chernyak-Hai & Halabi, 2018; Rosler et al., 2017). Empathy is therefore an emotion-based state that can reduce intergroup conflict and promote compassion amongst different groups (Klimecki, 2019).

However, when people perceive themselves to be suffering more, or believe they are being unfairly treated in comparison to other groups, their empathy for their counterpart is reduced. This is especially salient in the phenomenon of 'competitive victimhood' (Noor et al., 2012). Competitive victimhood involves a person occupying the moral or social high ground in competitive contexts, whereby they view themselves as having it worse, or suffering more. This is particularly found when experiencing 'hardship' is seen to provide moral or social standing (Shnabel et al., 2013).

In the case of the NHS, it is possible that clinical and non-clinical personnel are inadvertently pitting themselves against each other and subconsciously competing in terms of who has the worst working conditions (and therefore, who is sacrificing more in an effort to meet the needs of NHS service users: a moral victory). A potential lack of empathy – relating to the experience of competitive victimhood - could be the fuel that is powering this.

The importance of emotional expressions in inducing empathy has been documented in the academic literature (Hawk et al., 2011). For example, when people perceive that other people are having a difficult time (i.e. experiencing negative emotions), they are more likely to feel empathy towards the expressing individual (Batson et al., 1987). However, this is usually biased towards people who are perceived to be of a similar group to them (Cikara et al., 2014). We therefore aim to examine whether emotional expressions revealed by clinical and non-clinical workers, in relation to their agile work experiences, will evoke an 'other' group member's empathy, sense of competitive victimhood, and/or desire to help the 'other'. This will help us to unpick the mechanisms that may be responsible for conflict and disharmony that appears to be emerging in relation to perceptions of others groups' agile working arrangements in the NHS.

2.4 Our study

By understanding what people feel about the agile working arrangements of other groups, and how this affects their thoughts, feelings and behaviours towards others, we can begin to identify and understand whether, why and how clinical and non-clinical workers are experiencing conflict with each other. We can then begin to outline action plans for dealing with and resolving such conflict.

In this study, we therefore asked the following questions:

1. Do clinical and non-clinical workers perceive the other group's agile arrangements as worse than their own?
2. If so, does the emotion expressed in relation to the work, by the 'other' worker, affect:
    a. How the clinical or non-clinical worker **feels** about the 'other' worker and their group (how empathic or hostile do they feel about them)?
    b. How the clinical or non-clinical worker **thinks** about the 'other' worker and their group (do they have a positive attitude towards them, and do they feel a sense of competitive victimhood)?
    c. How the clinical or non-clinical worker **behave** towards the 'other' worker and their group (do they want to help and support them)?
3. What actions can be put in place, to help reduce conflict and hostility and ensure fair, supported agile arrangements for all?

To answer these questions, we designed an online experiment with clinical and non-clinical workers. Using an experimental methodology means that we can identify differences between these groups and specifically **isolate the factors** that we think are involved (e.g. emotional expressions, empathic responses, competitive victimhood) in creating conflict. We can also causally examine how/whether these factors have a **knock-on-effect on each other**. By running experiments with workers who are actually operating in clinical and non-clinical roles (predominantly in the NHS) we can ensure that any findings are **relevant and relatable to the real-world** issues being faced in modern, agile work in the NHS.

3. Methodology

3.1 Research design

Working with NHS agiLab steering committee members, including Unison union reps, we co-created descriptions of realistic and typical agile working scenarios for (i) a clinical worker, and, (ii) a non-clinical worker. These scenarios were matched to control for desirability, length of description and relevance to the NHS. Because of the role emotions can play in conflict situations (Halperin, 2015), the scenario was then altered to reveal one of three emotional expression conditions for each 'type' of worker – a non-emotional expression (i.e. no emotions were expressed), a negative emotional expression (i.e. emotions related to low well-being were expressed), and an indifferent emotional expression (i.e. anti-emotions were expressed relating to not caring or being indifferent to their circumstances). We wanted to present one of these three scenarios to a participant representing the 'other' group. For example, a clinical participant might read the scenario about an indifferent non-clinical worker; a non-clinical worker might read the scenario about a clinical worker expressing negative emotions, and so on.

Having read the scenario, we then wanted to ask the other group member to report on how they felt, what they thought, and what they would do about the scenario. This provides a carefully controlled experimental design with three different emotional expression conditions for either clinical or non-clinical workers (i.e. 6 scenarios were created in total).

The scenarios were sense-checked with 3 clinical reviewers and 4 non-clinical reviewers from the NHS, prior to the study proper. Amends were made as appropriate. Please see Table 1 for the final set of 6 scenarios used in this study. The study was pre-registered with the Center for Open Science (https://osf.io/p4avn/?view_only=bb943ec620fa4daf8514c3048d9f4cdd).

3.2 Participants, ethics, and sampling

Most participants to this study were recruited by members of the agiLab steering committee and their networks (85%). Prospective participants captured in this way were sent a study advert by the contact and asked to click on a link if they wanted to sign up and take part. Participation was entirely voluntary and reflects a purposeful opportunity sampling approach (Collingridge & Gantt, 2008). The remaining 15% of participants signed up via the Prolific academic crowdsourcing platform and we screened recruitment for health-related workers only.

A total of 296 participants provided data for this study; 118 were clinical workers and 178 were non-clinical workers. Each group was asked to respond to one of the scenarios about a member of the other group. 95% of participants were NHS workers (5% were health-related workers not employed by the NHS). In terms of current pay band (NHS or equivalent), 25% were levels 2-4, 47% were levels 5-7, 20% were level 8 (a-c), and 7% were levels 9 and above (16 people did not provide this data). Ages ranged from 22 to 70 (average age = 47, with 95% of people between ages 24 and 69). In terms of gender, 21% were male, 77% female, 0.3% were non-binary, 0.7% were 'other' and there was 1% missing data.

Prior to data collection, ethical approval was granted by the University of Sussex Research Ethics Committee. The committee approved the research in March, 2023 (ER/ER336/9).

3.3 Data collection procedure

The study took place between April and June, 2023. Participants first filled out demographic measures and information about their work (arrangements, working hours). Next, participants were asked to read a short text about an 'other' group member's experience at work. The text was adapted according to one of three emotional expression conditions (see section 3.1) to which participants were randomly assigned. In these conditions, the other group member worker expressed indifference (N = 93) no emotions (N = 101), and negative emotions (N = 102) about their agile

working experience. All text, including the differences across group and condition, are presented in Table 1. After reading the text, participants then completed measures relating to their thoughts/attitudes, feelings/emotions and behavioural intentions about the 'other' group member's experience.

Table 1: Matched scenarios across conditions and worker type

Clinical	Non-Emotional	Negative Emotions	Indifference
	Jordan, a **physiotherapist** working for the NHS, is sharing their personal experience of work: "Every day I come in to work and find myself being so busy that I often don't have time to eat. I am constantly moving between patients, colleagues, admin tasks and other responsibilities, going from place to place and from task to task. People pop in to ask me things, give me updates or additional tasks that aren't really part of my remit, so focusing on (and completing) tasks in a planned sequence is unusual. In addition to my workload, I come into contact with a lot of people. Because of the infection risk (especially as a result of the pandemic) I have to be very careful about hygiene as I have a family at home."	Jordan, a **physiotherapist** working for the NHS, is sharing their personal experience of work: "Every day I come in to work and find myself being so busy, stressed, and harassed that I often don't have time to eat, leading to low mood. I am constantly moving between patients, colleagues, admin tasks and other responsibilities, going from place to place and from task to task People pop in to ask me things, give me updates or additional tasks that aren't really part of my remit, so focusing on (and completing) tasks in a planned sequence is difficult, and this makes me feel distracted and frustrated. In addition to my workload, I come into contact with a lot of people, which leads to worry and anxiety because of the infection risk (especially as a result of the pandemic) to myself and my family at home. "	Jordan, a **physiotherapist** working for the NHS, is sharing their personal experience of work: "Every day I come in to work and find myself being so busy that I often don't have time to eat. I am constantly moving between patients, colleagues, admin tasks and other responsibilities, going from place to place and from task to task, but I figure it's just a job, so I'm not bothered about the situation. People pop in to ask me things, give me updates or additional tasks that aren't really part of my remit, so focusing on (and completing) tasks in a planned sequence is unusual, but I don't care really. In addition to my workload, I come into contact with a lot of people. Because of the infection risk (especially as a result of the pandemic) I have to be very careful about hygiene as I have a family at home but, whatever. All in all, I'm generally indifferent about the whole thing."
Non-Clinical	Jordan, an **administrator** working for the NHS, is sharing their personal experience of work: "Every day I work from home, in front of my computer screen for most of the working day. I sit alone at the kitchen table and often lose track of time. I have little human interaction with my colleagues but often have members of my family coming in and out and asking me for things. Focusing on (and completing) work tasks requires a lot of self-discipline and concentration. I receive very little feedback or advice	Jordan, an **administrator** working for the NHS, is sharing their personal experience of work: "Every day I work from home, bored in front of my computer screen for most of the working day. I sit all alone at the kitchen table and often lose track of time. I have little human interaction with colleagues but often have members of my family coming in and out, which makes me feel incompetent and frustrated. Focusing on (and completing) work tasks requires a lot of self-discipline and concentration, and I often worry about my performance. I	Jordan, an **administrator** working for the NHS, is sharing their personal experience of work: "Every day I work from home, in front of my computer screen for most of the working day. I sit alone at the kitchen table and often lose track of time. I have little human interaction with my colleagues but often have members of my family coming in and out and asking me for things, but I figure it's just a job, so I'm not bothered about the situation. Focusing on (and completing) work tasks requires a lot of self-

	about how to do my work. If I need to know or do something new, I have to look it up myself, as experienced colleagues are not often available for me to ask. I work hard and am careful but there is always a risk that I will do the wrong thing."	receive very little feedback or advice, which is difficult. If I need to know or do something new, I have to look it up myself, as my manager is not often available for me to ask. I work hard and am careful but there is always a risk that I will do the wrong thing, and I experience anxiety and dejection about this."	discipline and concentration. I receive very little feedback or advice about how to do my work, but I don't care really. If I need to know or do something new, I have to look it up myself, as my manager is not often available for me to ask. I work hard and am careful but there is always a risk that I will do the wrong thing, but, whatever. All in all, I'm generally indifferent about the whole thing."

3.4 Measures

3.4.1 Feelings/Emotions

We examined emotions towards both the expressing individual in the text and the group to which the individual belongs. This was to establish any spillover effects of emotions elicited towards a representative of the other group to the other group as a whole.

We measured *empathic emotions*, by asking participants to what extent from 1 (not at all) to 6 (absolutely) they were experiencing Compassion, Empathy, Sympathy and Concern towards the expressing individual in the text (α = .89[1]) and towards the 'other' group represented by the individual (α = .91).

We measured *hostile emotions*, by asking participants to what extent from 1 (not at all) to 6 (absolutely) they were experiencing Anger, Frustration, Irritation and Contempt towards the expressing individual in the text (α = .85) and towards the 'other' group represented by the individual (α = .92).

3.4.2 Thoughts/attitudes

In order to measure *competitive victimhood* (α = .91) we asked participants to what extent they perceived their worker group as victims compared to the 'other' group. Items were: [own group] staff do not suffer in their work as much as ['other' group] staff; In their work, people employed as [own group] staff suffer more than ['other' group]; [own group] staff need more support in their work than ['other' group]; [own group] staff need more protection in their work than ['other' group]; In general, working arrangements are more severe for [own group] staff than for ['other' group]. Answers were provided on a scale from 1 (not at all) to 6 (absolutely).

We measured *positive attitudes* (α = .92) towards the 'other' group using a 10-item measure. Participants indicated their attitudes on a scale of 1 (not at all willing) to 7 (completely willing). Items were: Rely on the work-related judgements of ['other' group] staff, Rely on the task-related skills and abilities of ['other' group] staff, Depend on ['other' group[staff to handle an important issue on your behalf, Rely on ['other' group] staff to represent your work accurately to others, Depend on ['other' group] staff to back you up in difficult situations, Share your personal feelings with ['other' group] staff, Discuss how you honestly feel about your work, even negative feelings and frustration, with ['other' group] staff, Discuss work-related problems or difficulties that could potentially be used to disadvantage you, with ['other' group] staff, Confide in ['other' group] staff about personal issues that are affecting your work, and Share your personal beliefs with ['other' group] staff.

[1] 'α' statistic needs to be over 0.7 to be confident that the measure is reliable.

3.4.3 Behavioural intentions

Lastly, we measured *prosocial behaviour intentions* (α = .78) towards the 'other' group using a 6-item scale. Participants indicated on a scale of 1 (not at all) to 6 (absolutely) to what extent they would engage in the following actions for the 'other' group: Write a positive reference letter, Stay after hours to help a new ['other' group] staff member with their work, Pass on a message / note / package, Offer a 'shoulder to cry on' to a ['other' group] staff member when they need to offload, and Review a ['other' group] staff member's work for them.

4. Findings

We undertook statistical analyses on our data, to help us to answer the questions set out in section 2.4. Our analyses involved testing whether differences in the emotional expression of 'other' group members' agile work affected how their opposite counterpart felt, thought and would behave towards them. This helped us to understand any potential sources of conflict or hostility. Statistically significant differences indicate that we can be reasonably confident that our findings can be relied upon and would be replicated if we were to repeat the study again.

A full report of our findings, with the statistical information, can be found in the Appendix. A summary of these findings is outlined below.

4.1 Statistically significant findings

Question 1 asked, *do clinical and non-clinical workers perceive the other group's agile arrangements as worse than their own?* Generally, non-clinical workers felt more empathy towards clinical workers' agile working arrangements than vice versa. This means that non-clinical workers do not feel worse off compared to clinical workers and may well see clinical workers as having a 'worse' deal. Further, clinical workers appear to feel that they suffer more than non-clinical workers in their agile arrangements and may well see non-clinical workers as having a 'better' deal than them.

4.1.1 Differences in how workers <u>feel</u> about others' agile working arrangements

Question 2a asked, *how does the clinical or non-clinical worker feel about the 'other' worker and their group (how empathic or hostile do they feel about them)?* Across both groups, participants reading about the negative emotion expression scenario and the non-emotional expression scenario felt significantly more empathy towards the expressing individual, compared to those reading about the indifference expression scenario. This means that when people express indifference (compared to negative or non-emotions) about their agile working arrangement, they receive the least amount of **empathy** from members of 'other' groups.

Additionally, participants reading about the non-emotional expression scenario felt significantly less hostility towards the expressing individual, compared to those in the indifference expression scenario. There was no effect for the negative emotional expression scenario. This means that when people express indifference (compared to non-emotions) about their agile working arrangement, members of 'other' groups experience higher levels of **hostility** in response.

This set of findings indicates that when people express indifference about their agile working arrangement (I don't care, it doesn't matter to me), others will feel more hostility and less empathy towards them.

4.1.2 Differences in how workers <u>think</u> about others' agile working arrangements

Question 2b asked, *how does the clinical or non-clinical worker think about the 'other' worker and their group (do they have a positive attitude towards them, and do they feel a sense of competitive victimhood)?* Clinical workers were significantly more likely than non-clinical workers to perceive themselves as 'victims' after reading about an 'other' group member's agile working arrangement, regardless of what was expressed. This could mean that both groups see **clinical workers as having a worse deal** (i.e. suffering more), or it could mean that non-clinical staff generally don't consider that they suffer as much in relation to their agile working arrangements, compared with clinical staff. This reflects what we found in relation to question 1.

Further, when people feel more empathy and less hostility towards an 'other' individual's agile working arrangement they subsequently think of themselves as suffering less (lower competitive

victimhood), and they have more positive attitudes (see them as more trustworthy and reliable) towards the 'other' group.

4.1.3 Differences in workers' behavioural intentions towards other group members

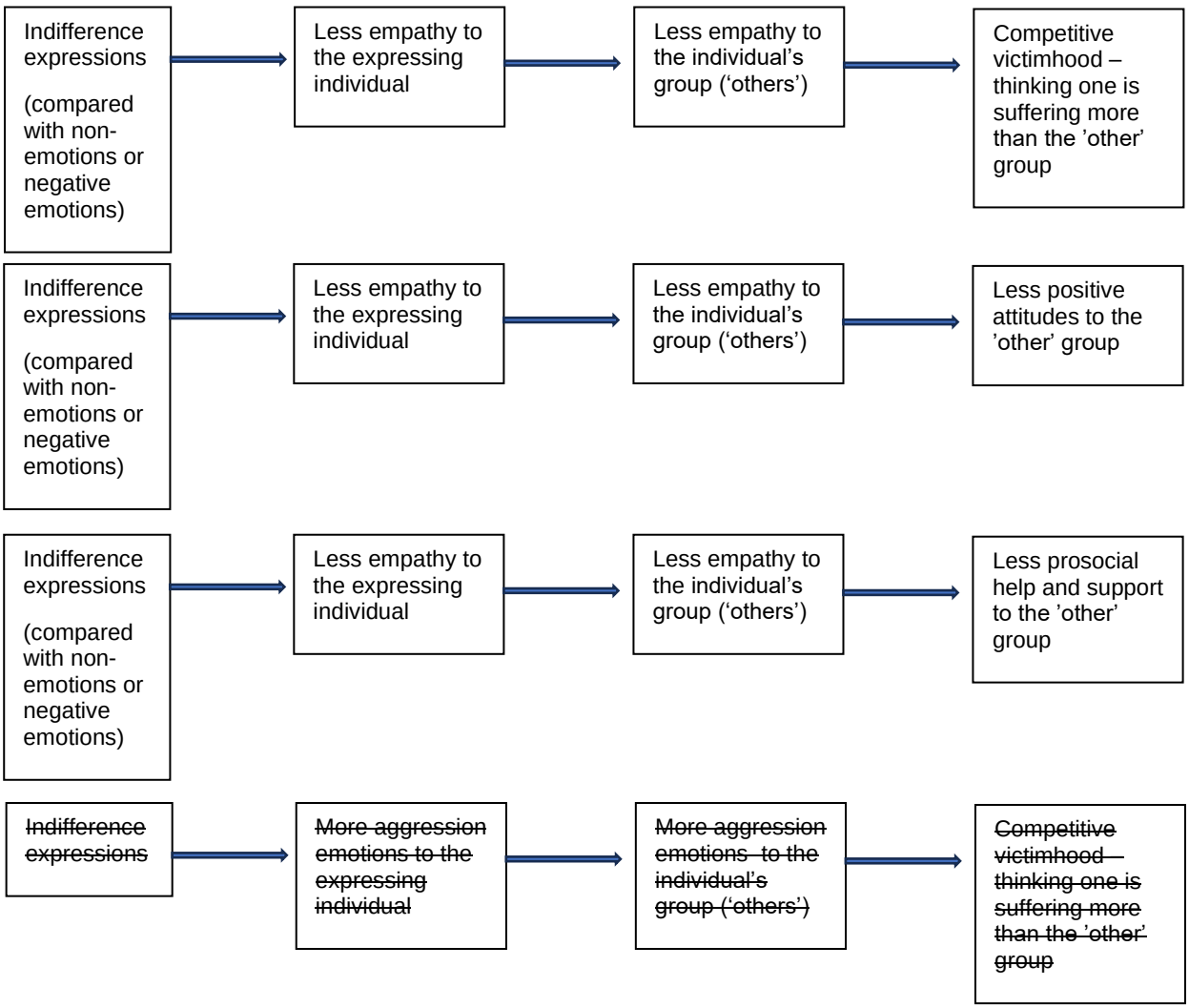
Question 2c asked, *how do clinical or non-clinical workers behave towards the 'other' worker and their group (do they want to help and support them)?* After reading about an 'other' group member's agile working arrangements, those who felt more empathy and less hostility had more positive 'prosocial' intentions towards the 'other' group (e.g. they wanted to help and support them).

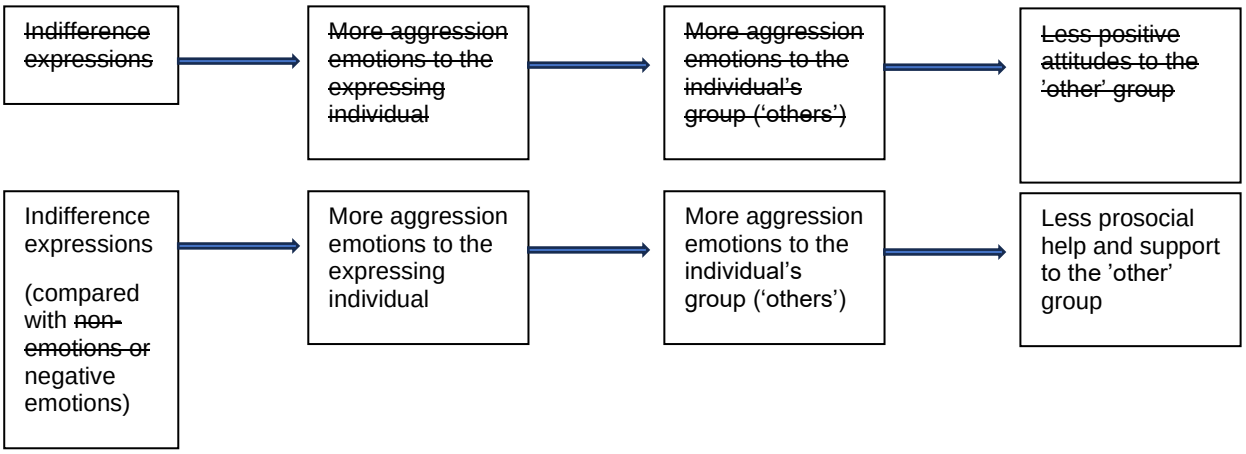
4.1.4 Note

These findings were found across the groups and empathy was always more strongly connected to positive thoughts and behavioural intentions, compared to hostility.

4.2 Investigating the role of indifference

Because indifference expressions appeared to provoke the most hostility and least empathy in 'other' groups, we wanted to examine the role of indifference further. Indifference is a "low arousal response to an emotionally eliciting situation or person" (Cohen-Chen et al., 2022, p.1337). We tested the following relationships to see whether indifference expressions directly caused a knock-on effect of other group members' feeling hostile towards them, having negative thoughts about them, and not wanting to help them. We have crossed out any relationships that were not statistically significant after having tested them.





4.3 Summary of findings

These findings offer important insights into some of the causes of conflict between clinical and non-clinical workers, related to agile working, in the NHS.

We found that both clinical and non-clinical workers experienced more empathy in relation to clinical workers' agile arrangements. This indicates that both groups of workers consider that **clinical workers may be suffering more** and need more compassion. We also found that empathy for 'other' groups is lower, and hostility is higher, when the other group expresses indifference about their agile working experience. This expression of **indifference evokes a range of negative reactions**. The 'other' worker feels negatively towards the worker in the scenario, which then means they feel more negatively towards the group that they represent (e.g. clinical or non-clinical workers) as a whole. In turn, this means that they will be less likely to want to help and support workers in the 'other' group.

The study reveals the important role of indifference in potentiating 'conflict' between groups in relation to agile working arrangements. What this means and how this can be addressed, will be considered in the next section. This will be important to address our final study question 3: *What actions can be put in place, to help reduce conflict and hostility and ensure fair, supported agile arrangements for all?*

5. Conclusion and Recommendations

5.1. What do our findings mean for the NHS?

Indifference expressions are non-emotional, or anti-emotional, responses to events or people that should be emotionally evocative, implying a lack, or deficit, of emotion (Cohen-Chen et al., 2022). Indifference can be expressed through the face, body and voice and can suggest that the person or event is irrelevant or not consequential enough to elicit an emotional reaction (Cohen-Chen et al., 2022). This may be why, when workers read about a colleague expressing indifference about their agile working experience, this evoked lower levels of empathy and compassion both for the colleague and the group that they represented. Our study found that when indifference was expressed, workers were less likely to view the 'other' group as suffering (compared to their own group), had fewer positive attitudes about the group (seeing them as less reliable, trustworthy, etc.) and were less likely to want to help or support that group, even when they were having a hard time. Workers didn't feel this way when other group colleagues expressed negative or no emotions about their agile working experiences.

5.1.1 Indifference in health and care settings

So, why does the expression of indifference rile NHS colleagues so much? In our research, colleagues still cared about and were more empathic towards colleagues from other groups when they expressed negative emotions about their agile working arrangement. This is potentially because they could see that their colleague was suffering, having a hard time, and was frustrated and upset about this. This fits with academic literature that shows how negative emotions can signify weakness in others and elicit concessions from observers (Sinaceur et al., 2015; van Kleef et al., 2006). However, if a colleague seems not to care about their work and seems to be unaffected by it (as with indifference), research suggests that workers may see this as **contemptuous** and potentially **undermining** (Cohen-Chen et al., 2022; Fischer & Giner-Sorolla, 2016; Melwani & Barsade, 2011).

Indifference could be especially negatively viewed in the NHS because many people choose to work in health-related sectors as part of a vocational will to help and care for people and to make a difference (Eldh et al., 2016). When faced with a colleague who does not seem to share that sense of vocation, this could be seen as a betrayal, and so people may be less forgiving, withdrawing their compassion accordingly. Indeed, in a recent research study of midwives who expressed indifference, the midwives were harshly judged by the research paper authors, who said that "they should be reminded that compassionate midwifery care for women is a basic human right" (Ergin et al., 2020, p. 887). Such attitudes are concerning, especially as, in the midwifery research example above, indifference was higher when midwives had experienced a greater number of traumatic births. This indicates that:

Indifference is a dysfunctional emotional expression that can be a signifier of struggle (Wang et al., 2022). Akin to disengagement in work settings[2], indifference can be observed after workers have experienced chronic periods of high stress and are at risk of burnout (Bakker et al., 2004). In a state of emotional exhaustion, workers can become cynical and may shut off their emotions as a way of **protecting the self** (Taris et al., 2005; Wang et al., 2022).

Expressing negative emotions is resource-intensive, and if workers have few resources available to them because they are so exhausted, indifference may kick in because there is nothing left to give. The indifferent actor is, in effect, presenting a 'cry for help'. They are potentially demonstrating that

[2] "Disengagement refers to distancing oneself from one's work, work objects (e.g., computers, recipients), or work content (e.g., software programming, providing services). It represents an extensive and intensive reaction in terms of an emotional, cognitive, and behavioral rejection of the job and it delineates an occupational disillusionment (cf. Freudenberger, 1974)." (Bakker et al., 2004, p. 84)

they have reached the limit of what they can cope with and so are shutting down. At this point what they most need is intervention – to address the stressful work demands that have pushed them to this point, and to receive support and care. Our research shows that those expressing anxiety, frustration or distress (negative emotions) appear to evoke a compassionate and supportive response. But those who have gone beyond this are at much greater risk of having support withdrawn and, as our data shows, may even encounter feelings of hostility from their colleagues.

For the NHS, **when people are expressing indifference about their agile work arrangements, this should act as a 'red flag' or late-stage indicator that, 'here is someone at significant, immediate risk of burnout'**[3]. Implications of burnout for organisations are well documented; workers can become less productive, prone to errors, more likely to be sick, absent and late, and more likely to quit the organisation (Brotheridge & Grandey, 2002; Lee & Ashforth, 1996). Risks of burnout to the worker are that they can suffer from health-related problems such as insomnia and sleep disturbance, relationship problems and physical illness (Brotheridge & Grandey, 2002).

Ironically, our research has shown that just at the point when workers may be at the most significant **risk of burnout**, their expression of indifference may mean that **colleagues become less compassionate, empathic, helpful and supportive** towards them. Colleagues from other groups, who may lack experience of the agile work patterns of the indifferent colleague, may especially lack the ability to empathise, as they do not have a shared experience to draw on.

5.1.2 Indifferent expressions in agile working

If indifference is seen to be a late-stage indicator of burnout, in an agile working context, this strongly suggests that the agile work arrangement is not working for them. It may be that an initial flexible arrangement (perhaps initiated during the lockdown era) has now become a mandatory or expected mode of working and the worker no longer feels they have control or choice over what they are doing (Liberati et al., 2021; Shirmohammadi et al., 2023). In terms of their **place** of work, perhaps the agile worker is now regularly working from home, even though this means they have become isolated, or lack the appropriate support and infrastructure to do their work effectively (Cooper & Kurland, 2002). In terms of the worker's **role and tasks**, perhaps the agile worker is still working outside of their normal job roles and responsibilities and is taking on too much, or being required to learn too many new processes and systems and is feeling overwhelmed (Lloyd & Payne, 2021). In terms of **time** of work, perhaps the agile worker is still being expected to work outside normal office hours to cope with patient demands, even though they have evening caring responsibilities that they need to meet (Von Bergen & Bressler, 2019; Leary, 2023).

As the NHS struggles to return to a state of 'normality' and is dealing with unprecedented pressures post-lockdown (BMA, 2023), it may well be that the highly agile response of workers to the pandemic has now become a static constraint, with workers no longer able to respond flexibly and with choice, even though times have changed. Experiencing a lack of true flexibility, choice and autonomy means that a previously agile arrangement is now a rigid and inappropriate working pattern that is creating high levels of strain (Schmidtner et al., 2021). If indifference is identified in a 'so-called' agile worker, this could be an important indicator that the 'agile' working pattern urgently needs to change before burnout is experienced.

5.1.3 A note on the experience versus expression of indifference

It is important to acknowledge here that *expressions* of indifference can be used as a device or a powerplay, when a worker is trying to achieve a desired outcome (Cohen-Chen et al., 2022). In other words, a person may not feel indifferent (i.e. they aren't experiencing this anti-emotion, they are only

[3] Recent research in the clinical literature shows how indifference expressions develop as a coping mechanism to protect the self following childhood trauma (Wang et al., 2022). Extending this process to the work domain indicates that a sustained period of stressor exposure could also lead to indifference expressions as a coping device.

expressing it), but are purposefully choosing to show indifference in order to give the impression that they don't care. This is a move often used in negotiation scenarios, e.g. as a person tries to show a 'poker-face' (Thompson et al., 2001). In such cases the indifference is not authentically experienced but demonstrates a conscious strategy to 'suppress' real and felt emotions, as a means to an end.

Managers therefore need to be mindful that in this report we are talking about authentically expressed and experienced indifference – and how this is always a red flag for an inappropriate response pattern associated with struggle or problematic mental states (Wang et al., 2022). Workers who are strategically expressing indifference (to hide their genuine feelings) may require a different set of responses and support from management, to better understand why this strategy has been applied and what their genuine feelings about their agile working arrangements are. This may be particularly relevant in 'resilience' cultures, where workers are expressly taught how to suppress or overcome negative emotions. Emotional suppression is a form of emotional labour that can have negative effects on people (Abraham, 1998; Morris & Feldman, 1997). If taken too far, this could result in indifference expressions, which, our study reveals, could then provoke more hostility and conflict from colleagues.

5.2. What can the NHS do?

These findings suggest a clear path of action that the NHS can now follow to help address the anecdotally reported conflict that may be emerging between clinical and non-clinical workers in relation to each others' agile working arrangements. Whilst the natural reaction of the observer might be to feel impatient, annoyed and hostile towards a colleague expressing indifference, the indifference expression offers a clear sign of struggle and signifies a need for support. These are the workers at high risk of burnout (Bakker et al., 2004; Taris et al., 2005), whose agile working patterns are unlikely to be working for them any more. These are also the workers who therefore most need change, more control over their agile working, and compassion. Increasing awareness of this is a fundamental first priority.

Further, when workers express negative emotions about their agile work, this seems to evoke compassion and support. This suggests that the NHS could now encourage colleagues to share their emotions about their agile work; this could help inform a need for change to ensure working patterns are truly agile and meeting workers' needs. Encouraging the sharing of emotion does not need to be perceived as moaning or complaining; in fact, expressing negative emotions about work can offer an important outlet for offloading and obtaining help, to address the stress-inducing work arrangement before it becomes a significant problem.

Our advice is to put in place systems so that colleagues can regularly share and care for each other. Staff should be encouraged to express their negative emotions about their agile work, and when colleagues note indifference in others, this will be a clear sign that more urgent support and change is needed. Managers should instigate conversations around flexibility at this stage and encourage workers to think about alternative agile arrangements that need to be put in place. Agile working is, by definition, a way of working that allows people and organisations to have their needs met by altering how, when and where people work as circumstances change. If an arrangement is no longer working, it needs to be changed. Helping colleagues and managers learn how to overcome a natural tendency to be hostile towards colleagues who show indifference is paramount to ensure that such change is initiated.

We therefore suggest a three-pronged approach (addressing research question 3 from section 2.4):

1. **Encourage staff to talk** about the aspects of their work arrangements that are making them feel negative, especially to other staff and colleagues. Have strategies in place to support colleagues who are struggling. Discuss what improvements can be made to ensure working arrangements are truly agile and meeting workers' evolving needs.

Instating/reinstating wobble rooms for staff to offload feelings about their work, and provide appropriate support to those who need care, support or counselling. Ensure forums are available to all workers (both online and physical).

Engage in team level discussions about the aspects of the agile work that people are struggling with, to encourage support, empathy and solutions from colleagues across the team.

Encourage team level discussions about agile working arrangements that work well, so that beneficial and effective options can be understood and rolled out, and problematic patterns of work can be changed.

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Figure 1: Interventions for sharing negative emotions

2. **Increase awareness for staff and managers to recognise the signs of indifference.** These signs include appearing not to care, a disengagement with the job, the patients, colleagues and their work. Alert staff and managers to the fact that they may experience instinctive hostile reactions to indifferent expressions, but that it is important to avoid withdrawing support at these times. Encourage conversations with the indifferent expressing individuals, to assess what support is needed, and how their work arrangements can be changed to meet their agile needs. Offer counselling if necessary, especially if indifference has emerged from an acute (e.g. traumatic) experience (Wang et al., 2022), or prolonged exposure to an arrangement that is exhausting them. In such cases, indifference may be serving to protect the self and needs to be carefully addressed so that alternative coping strategies can be adopted without exposing the individual to a vulnerable state.

Red flag indifference training to spot the signs of indifference in colleagues and probe what aspect of agile work is making people 'feel' this way. Does **when, where** or **how** people work need to change?

Teach staff to check if they are experiencing hostile reactions when faced with a colleague expressing indifference. Encourage the staff member to consider offering support or compassion at such times.

Offer counselling and support to target the causes of the indifference, rather than the indifference expression itself.

Figure 2: Tackling awareness and causes of indifference

3. **Discourage excessive emphasis on building 'resilience'**. Whilst it is important to help colleagues learn to cope with difficult periods, resilience cultures could potentially result in the suppression of emotions. Putting in place a static but so-called flexible arrangement and then leaving staff to get on with this indefinitely is not effective from an agile working perspective. Suppressing how one feels about one's work is emotionally laborious and in prolonged periods characterised by chronic stressors, the suppression of emotions – under the guise of being resilient – could promote damaging feelings of indifference and disengagement.

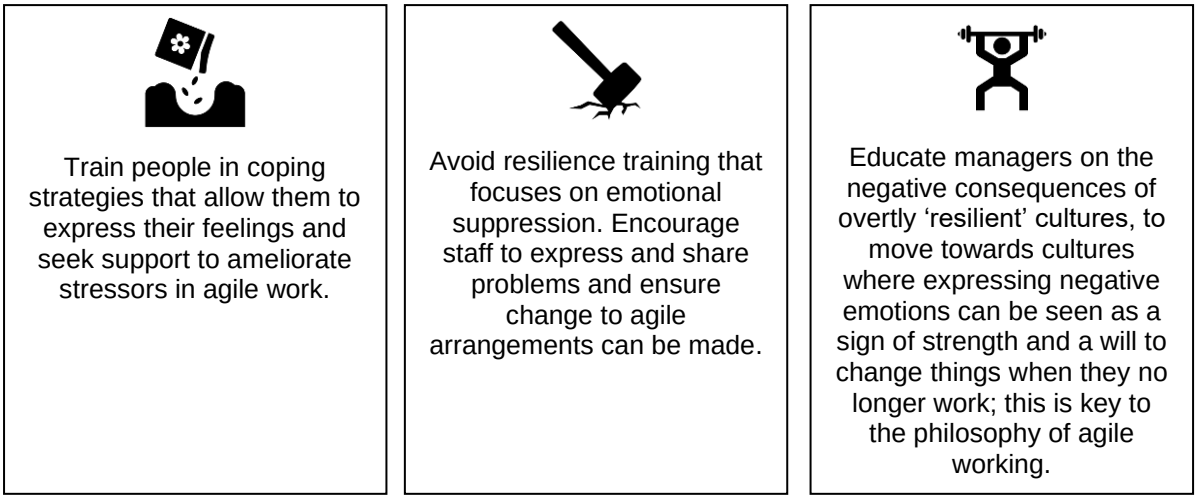

Figure 3: Reducing resilience cultures

5.3. A future research and care agenda

The findings of this research study are novel and raise a number of important issues for the NHS about how people are encouraged or discouraged to share emotions about their agile work, and the extent to which this evokes change, compassion and support versus hostility and neglect. Because of the novelty of our findings, our research raises a number of questions that now need further attention. We outline these below.

5.3.1 Should staff share the 'negatives' about different agile working arrangements?

In this research study, we presented participants with emotional expressions about people's agile working arrangements. We found that hostility about other groups' arrangements could stem from those groups expressing indifference. It is important to note here that it was the expression of indifference that created hostile reactions, and not the agile working arrangement per se (expressing no emotion about the arrangement did not result in hostile reactions from others). This suggests that whilst anecdotal evidence indicates that different agile arrangements can create hostility, it is how people express emotions about their arrangements that matters. Although both clinical and non-clinical workers viewed clinical workers as suffering more in general, encouraging all workers to express their emotions about their agile working arrangements can be helpful. It can provide a better perspective about what does and doesn't work in agile working, and can help those who are struggling with isolation, interruptions, multi-tasking, lack of feedback, busy-ness, etc. to receive compassion and support from colleagues, whomever they are. It is also an indicator of a need for change. When an agile working arrangement is no longer working for someone then it needs to be altered. This is the very nature of being agile. In considering how agile working can most effectively be implemented across the NHS, sharing people's stories about the good and bad aspects of this – and being upfront about where adjustments are needed - will be helpful both for managers in delivering good, flexible work, but also to staff members in learning how to support and appreciate each other.

5.3.2 Does 'not caring' matter more in the caring professions?

The finding that indifference creates hostility and support withdrawal may be especially salient in our study because we are researching how people feel about their work in a setting that is characterised by care. People are often attracted to caring professions because they enjoy building compassionate relationships with others and helping people (Eldh et al., 2016). Yet these roles are notoriously more emotionally demanding (Bakker et al., 2004; Brotheridge & Grandey, 2002). To express that one is indifferent to one's work in these settings is likely to be viewed even more negatively, and judged to

be a basic failure of the person's character (Ergin et al., 2020). It will be interesting to understand if indifference is viewed more negatively in the NHS than in other organisations, and also to understand if indifference creates more hostility when the expressor is working in a highly vocational or traditionally more caring role. There could potentially be a gender bias here too that would be worth exploring further – e.g. do women who express indifference experience more hostility than men, given that care work is more often considered to be a feminine characteristic (R. Russell, 2001)? Such questions are important to understand, to ensure that support is provided to all workers expressing indifference and to challenge stereotypes about how indifference may be differently interpreted, depending on a person's demographics and job role.

5.3.3 Is indifference judged even more harshly by people in the same occupational group?

In our research, we asked people in the other group to say what they would do, think or feel when a clinical or non-clinical worker expressed indifference about their agile work. However, we did not look at how a worker might feel if a member of *their own* occupational group were to express indifference, negative emotions or no emotions. Would there be more or less empathy? We can see that this could go either way. For example, if a person can connect with the worker's experience of indifference in relation to their agile work (because this is a shared experience) they might be more sympathetic. Alternatively, if the person is themselves highly engaged in their work, and hears another close colleague saying that they don't care about it, this could be seen as a greater betrayal – potentially undermining the gratitude or pleasure they take from their own (similar) agile arrangement. In which case, they may be more hostile. It will be interesting in future research to understand how those in the same occupational group perceive emotional expressions from close colleagues; especially as these colleagues may be the 'first responders' to any expressions of indifference and therefore key to flagging potential struggle.

5.3.4 Can indifference be changed?

Academic knowledge about indifference at work is scant. We know that indifference found in clinical populations indicates psychological dysfunction (Drago et al., 2010; Heilman et al., 1978; Opbroek et al., 2002; Sansone & Sansone, 2010; Wang et al., 2022). In clinical settings, if the psychological dysfunction is treated then indifference may reduce (Wang et al., 2022). However, we know little about authentic expressions of indifference at work. The closest research we have relates to the literature on disengagement at work. Disengagement at work can best be rectified by employee assistance programmes, rather than employee engagement programmes (Afrahi et al., 2022). This suggests that tackling the cause of the disengagement, rather than the expression of disengagement (e.g. through resilience training), works best. Generalising such findings to indifference expressions suggests that promoting awareness in indifference is important in order to identify colleagues who may be struggling. However, next steps should then be to work with these colleagues to help remove/reduce the stressors in their work environment and help them to learn more effective coping mechanisms. This means changing agile arrangements so that these accommodate personal needs and circumstances, and regularly reviewing whether such changes are working. We recommend a number of interventions in section 5.2 and advise careful monitoring of these from the outset, so that we can identify the interventions that work most effectively.

5.4 Final thoughts

In this research study, our key aim was ***to identify, understand and address how and why interpersonal tensions arise amongst clinical and non-clinical staff in the NHS, in relation to their agile working arrangements***. We used a framework of emotional expressions, and an experimental approach with nearly 300 workers, to examine how expressed emotions about agile working arrangements might evoke different reactions from workers representing different groups.

Our data consistently showed that when a worker expresses indifference about their agile working arrangements, this was more likely to evoke a hostile (less empathic, more aggressive) response from other colleagues, which then led to less positive attitudes and lower likelihood of helping and supportive behaviour. Because indifference is a dysfunctional emotional expression it can signify that an individual has reached the end of what they can effectively cope with and has entered a self-protection mode as a late-stage precursor to burning out. This is a strong signifier that the worker's agile working arrangement needs to change, to ensure that *how, when* and *where* they work, is working for them.

We highlight a number of actions that the NHS may now like to put in place. For example, we suggest the need to increase awareness of indifference, to help staff and managers see this as a red flag for burnout and ineffectual working arrangements that need to be addressed. We suggest that managers encourage staff to share negative emotions about their agile working at a team, and even cross-team level, to increase compassion and reduce conflict about other groups having a 'better' deal. Sharing problems can be a way of building bridges and finding solutions, by taking on different perspectives about the realities of different working arrangements. It can also help to potentially prevent the build-up of stressors that could eventually lead to a response to quash emotions (a potentially precursor to indifference, not tested here). To balance this, it may also be important to share what aspects of agile working are good for people, so that colleagues can build awareness of different working patterns that they might like to request, when theirs no longer work. Finally, we suggest that managers avoid putting too much emphasis on the importance of 'resilience' cultures, which could lead to people trying to ignore or suppress negative emotions and feeling discouraged from sharing these. Our research suggests that sharing negative emotions can actually help to reduce conflict, and the academic literature reports on how emotional expression can be helpful in reducing stress reactions.

Having made a number of suggestions for addressing potential sources of conflict between clinical and non-clinical workers, we suggest that the NHS now needs to pay attention to several areas. First, the causes of indifference emotions will need to be identified and removed/reduced. Second, the success of indifference awareness interventions needs to be monitored, to identify if this both reduces indifference expressions and hostility/conflict between groups in relation to agile work. Third, the NHS might like to evaluate whether hostility in response to indifference is heightened in different groups. For example, is indifference appraised more harshly, or leniently by people in the same occupational group? When indifference is expressed by those in caring roles, and/or when indifference is expressed by women, are hostile reactions stronger?

The world of work is changing, and workers are not always able to respond to this in an effective and functional way. This report shows the importance of identifying indifference as a potential red flag that agile workers are not coping and need extra help and support. It challenges the view that 'resilience' is the key to promoting a healthy and effective culture, and alerts managers in the NHS to the importance of identifying problematic emotional responses to work. Encouraging agile workers to share negative experiences and show compassion to all colleagues – even when this is instinctively difficult - is a first step towards promoting greater empathy and less conflict at work. This research is also a reminder that – in agile working – we can only be truly agile when arrangements are regularly adapted to ensure that this continues to work well for both the organisation *and* the worker.

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Appendix

Statistical Analysis

Note that the term 'outgroup' is used to refer to the group that the 'other' colleague represents (e.g. the group would be clinical workers when a non-clinical participant is reading the scenario or 'vignette').

Group-Based Differences.

We conducted a series of independent samples t-tests to examine differences between the clinical and non-clinical staff. In terms of competitive victimhood, a significant difference was found (t = 9.90, p < .001). Clinical staff scored higher (M = 3.14, SD = 1.37) than non-clinical staff (M = 1.74, SD = .84). In terms of empathic emotions towards the outgroup, non-clinical staff felt significantly higher levels of empathic emotions towards clinical staff (regardless of what condition was presented) compared to the other way around $t(294) = 7.05$, p <.001.

Experimental Effects

Next, we tested the effects of our experimental manipulation on research variables using a series of one-way ANOVAs. In terms of empathic emotions towards the individual, we found a significant difference between experimental conditions $F(2,293) = 6.44$, p = .002. Tukey post hoc analysis showed that participants in the negative emotion expressions (M = 4.84, SD = 1.13) and non-emotional expressions (M = 4.82, SD = 1.05) felt significantly more empathy towards the expressing individual compared to the indifference expression (M = 4.32, SD = 1.25; Mean Differences > .50, ps < .01). No difference was found between negative and non-emotional expressions (Mean Difference = .02, p = .99).

We found a significant difference between experimental conditions in terms of hostile emotions towards the individual $F(2, 293) = 3.90$, p = .021. Tukey post hoc analysis showed that participants in the non-emotional expressions condition (1.79, SD = .92) felt significantly less hostile emotions towards the expressing individual compared to the indifference expression (M = 2.20, SD = 1.07; Mean Difference = .41, p = .015). No difference was found between negative emotion expressions condition (M = 1.98, M = 1.08) and the other conditions.

We examined correlations between study variables, presented in Table 1.

Table 1: Zero-Order correlations between study measures

	Mean (SD)	1	2	3	4	5	6
1.Empathy Emotions towards Individual	4.67 (1.16)	--					
2.Empathy Emotions towards outgroup	4.69 (1.19)	.56**					
3.Hostile Emotions towards Individual	1.99 (1.04)	-.12*	-.13*				
4.Hostile Emotions towards outgroup	1.72 (1.02)	-.06	-.20**	.61**			
5.Competitive Victimhood (ingroup vs outgroup)	2.29 (1.28)	-.18**	-.47**	.28**	.26**		
6.Positive Attitudes towards outgroup	4.08 (1.38)	.28**	.38**	-.21**	-.21**	-.27**	
7.Pro Social Behaviour Intentions towards outgroup	5.06 (.94)	.15*	.26**	-.20**	-.28**	-.28**	.44**

Note: * denotes p < .01, ** denotes p < .05; outgroup refers to the group that the expressing individual represents, that is different to the participant.

Results showed that empathic emotions for the individual described in the vignette were negatively associated with competitive victimhood, (r = -.18, p = .002) but positively associated with positive attitudes towards the outgroup (r = .27, p > .001) as well as prosocial behavioural intentions (r = .15, p = .01). On the other hand, hostile emotions toward the person described in the vignette were positively associated with competitive victimhood (r = .28, p < .001) and predicted less positive attitudes towards the outgroup (r = -.21, p < .001) and prosocial behavioural intentions (r = -.20, p <

.001). Empathic emotions and hostile emotions were negatively associated with one another (*r* = -.12, *p* = .03).

We used a stepwise regression analysis for each of our three dependent variables.

Step 1 included our control variables of age, work demands, work hours, and current pay band. These accounted for 8% of the variance in predicting *competitive victimhood* (Adjusted R^2 = .084). When adding empathic emotions and hostile emotions towards the individual expresser, as well as empathic emotions and hostile emotions towards the outgroup (step 2), this explained 29% of the variance (Adjusted R^2 = .288; R^2 Change = .203). (Lower) empathic emotions towards the outgroup was the most proximal predictor (β = -.45, *p* < .001). Other significant predictors (in addition to group empathy) were hostile emotions towards the individual (β = .17, p < .001), work demands (β = .18, p < .001), and (lower) pay band (β = -.23, p < .001).

Step 1 included our control variables, which accounted for 3% of the variance in predicting *positive outgroup attitudes* (Adjusted R^2 = .026). When adding empathic emotions and hostile emotions towards the individual expresser, as well as empathic emotions and hostile emotions towards the outgroup (step 2), this explained 18% of the variance (Adjusted R^2 = .183; R^2 Change = .158). Empathic emotions towards the group was the most proximal predictor (β = .39, *p* < .001). Other significant predictors were (in addition to group empathy) hostile emotions towards the individual (β = -.18, p < .001), and (lower) age (β = -.20, *p* < .001).

Step 1 included our control variables, which accounted for 3% of the variance in predicting *prosocial behavioural intentions towards the outgroup* (Adjusted R^2 = .025). When adding empathic emotions and hostile emotions towards the individual expresser, as well as empathic emotions and hostile emotions towards the outgroup (step 2), this explained 10% of the variance (Adjusted R^2 = .096; R^2 Change = .074). Empathic emotions towards the group was the most proximal predictor (β = .27, *p* < .001). Other significant predictors were (in addition to group empathy) (lower) hostile emotions towards the group (β = -.20, p < .001), and pay band (β = .14, *p* = .024).

Overall, empathic emotions towards the group was the most proximal and consistent predictor of intergroup attitudes and behavioural tendencies. No interaction effects of the manipulation X group membership were found.

Mediations.

In light of these results we examined a number of mediation models (PROCESS for SPSS). Because the independent variable was non-linear, we used PROCESS indicator coding, which creates two dummy variables. The two paths compared the indifference expression condition to unemotional negative expression (coded X1) and negative emotional expression (coded X2).

We conducted a parallel serial mediation model (Model 82) comparing both the positive (manipulation → empathic emotions towards the individual → empathic emotions towards the outgroup → DV) and negative (manipulation → hostile emotions towards the individual → hostile emotions towards the outgroup → DV) paths on each of our dependent variables.

Results showed that in terms of competitive victimhood, indifference expressions (compared to both X1 negative and X2 non-emotional expressions) led participants to experience less empathic emotions towards the expresser, which reduced empathic emotions towards the outgroup and subsequently increased competitive victimhood (X1a*b = -.18, 95% Confidence Interval (CI) [-.309, -.060]; X2a*b = -.18, 95% Confidence Interval (CI) [-.327, -.067]). Hostile emotions did not have a significant effect.

In terms of positive intergroup attitudes, indifference expressions (compared to both X1 negative and X2 non-emotional expressions) led participants to experience less empathic emotions towards the expresser, which reduced empathic emotions towards the outgroup and subsequently decreased positive attitudes towards the outgroup (X1a*b = .10, 95% Confidence Interval (CI) [.031, .189];

X2a*b = .11, 95% Confidence Interval (CI) [.034, .199]). Hostile emotions did not have a significant effect.

In terms of prosocial intentions, indifference expressions (compared to both X1 negative and X2 non-emotional expressions) led participants to experience less empathic emotions towards the expresser, which reduced empathic emotions towards the outgroup and subsequently decreased prosocial behavioural intentions towards the outgroup (X1a*b = .05, 95% Confidence Interval (CI) [.007, .114]; X2a*b = .06, 95% Confidence Interval (CI) [.008, .121]). In terms of hostile emotions, indifference expressions (compared to X1 negative emotional expressions) led participants to experience more hostile emotions towards the expresser, which led to more hostile emotions towards the outgroup, subsequently reducing prosocial intentions (X1a*b = .05, 95% Confidence Interval (CI) [.008, .112]). However, the path comparing indifference to non-emotional expressions was non-significant.

Associated Resources suggested by NHS Employers

Teamworking, psychological safety and compassionate leadership

Michael West, senior fellow at The King's Fund, reflects on psychological safety, compassionate leadership and inclusivity in teams.

Top tips for supporting the psychological safety of staff

Find out how to create a psychologically safe workplace that improves staff experience and wellbeing.

On day two of EQW2023, we hosted a webinar on supporting the psychological safety of staff in the NHS.

Beating burnout in the NHS

Burnout in the NHS is more prevalent than ever. NHS trusts must address this to ensure staff wellbeing and high-quality patient care is sustainable.

NHS staff wellbeing needs poster

This resource is inspired by Maslow's hierarchy of needs and highlights the importance of basic needs to help ensure our NHS people feel healthy at work.

Embedding a healthy speaking up culture

Top tips on how to create a workplace speaking up culture which supports health and wellbeing.

Conscious retention – creating a more secure workforce

A blog exploring how freedom to speak up guardians can play a key role in the 'conscious' retention of staff.

Freedom to speak up - employer actions

This page outlines key considerations, resources and case studies useful when reviewing and developing local arrangements for speaking up.

Freedom to speak up - guidance for managers

Read our range of guidance and resources for managers who are supporting staff to speak up.

Wellbeing guardians: guidance and support

Information and guidance for wellbeing guardians in your organisation.