



ORGANISATIONAL INTERVENTIONS TO SUPPORT STAFF WELLBEING

Case studies and learnings
from the NHS

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TABLE OF CONTENTS

Foreword	2
Executive Summary	3
Project Background	5
Our Approach	9
Findings	13
Implications	21
The Case Studies	26

FOREWORD

Workplace health is a key national policy objective in the UK as inactivity due to ill-health is higher than other OECD countries. The 2023 Budget's focus on this area, specifically investing in occupational health, is welcome.

Why is this particularly important in healthcare? As the NHS adjusts to new challenges and ways of working following the COVID-19 pandemic, it is important that we recognise the contribution of the NHS workforce and do what we can to support and retain them. Staff experience and patient outcomes are interlinked. The recruitment and retention challenges of health and care professionals due to ill-health are well documented at a time when it has never been more important.

Key drivers to improve staff health and wellbeing that the report highlights are that it is not only autonomy that makes people happy, but also leadership, organisational culture, and good team relationships. These exist at different levels within an organisation and need to be backed up by evidence-based interventions as stated in this report.

I am pleased this report has been written, as often examples of good practice are not shared. These examples will hopefully inspire others to lead their own interventions. An important message is that a change for the better is possible. Here, the six principles for organisational interventions provide an evidence-based way to approach future interventions to improve staff wellbeing.

I suggest a key difference between health and wellness is that health is your state of being, or a goal

to achieve, and wellness is the active process of achieving it through growth and change. It is worth noting that Occupational Health has a strong body of research evidence. Although wellness has the laudable aim to reach our fullest potential of health and wellbeing, the evidence base is poor. However, these real-life case studies help understand and promote workplace health, demonstrating that we need an integrative approach that draws on the expertise of different stakeholders.

The report will be of particular use to Occupational Health, Organisational Development, Staff Wellbeing, and HR leads involved in the Growing Occupational Health and Wellbeing initiativeⁱ and to Integrated Care Boards who wish to put this in place. It is also of relevance to those working on supporting workforce strategies and plans across the devolved nations.

I congratulate the authors, who are leading health academics with considerable national and international experience across the health and non-health sectors, in producing this very useful report. It furthers our understanding and insight into this area.

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ⁱ <https://www.england.nhs.uk/publication/growing-occupational-health-and-wellbeing-together-strategy/>

EXECUTIVE SUMMARY

This report contributes to the call for more comprehensive and systematic interventions to support staff wellbeing in the National Health Service (NHS). Such interventions, also known as organisational interventions, aim to support staff wellbeing by trying to improve how work is designed, organised, and managed. A growing literature¹⁻³ evidences that organisational interventions are typically more effective, with more sustained effects, than interventions that solely focus on the individual healthcare worker.

We draw on two theoretical models to help structure organisational interventions. First, using the Job Demands-Resources Model⁴, interventions should focus on identifying what the demands are in a particular workplace, and how these could be reduced or removed. Next, the focus on identifying the resources in this context that can be enhanced or improved to help staff with their work, meet their psychological needs, or mitigate the effects of demands. The second model we draw on is IGLOO⁵, which provides a useful framework to view demands and resources at the level of the individual, group, leader, organisation, and overarching context. This model helps by providing a more systematic approach to understanding interventions, as well as recognising that antecedents to staff wellbeing, and the actions needed to intervene, exist across different levels.

Despite calls for more, and better, organisational interventions to improve staff wellbeing in the healthcare sector, there has been very little exploration of such interventions within the NHS. Alt-

hough the principle of reducing demands and increasing resources appears straightforward, one might ask: what does this look like in practice? Crucially, given the challenges in running organisational interventions, what contextual factors facilitate, or hinder, such interventions?

Aims

These questions are the starting premise of this report, which aims to:

- Identify examples of organisational interventions to improve NHS staff wellbeing;
- Map out how these interventions attempt to reduce demands and increase resources at the level of the individual, group, leader, organisation, and overarching context;
- Identify the barriers and facilitators of success for organisational interventions;
- Summarise key recommendations to encourage more, and better, organisational interventions to support staff wellbeing.

Method

We interviewed 17 intervention leads and reviewed published material related to 13 interventions. We identified demands and resources that these interventions aimed to address and mapped the activities comprising these efforts at the level of the individual, group, leader, organisation, and overarching context. Ten case studies were also written up to provide more detail about an inter-

vention's process, activities, learning, and context.

The organisational interventions identified were varied and included: the implementation of flexible work, overhauling rota systems, improving the employee investigation process, reducing multidisciplinary meeting times, embedding quality improvement processes, and restructuring clinic appointments.

Findings

In total, eight demands were identified: workload, emotional demands, stigma, conflict, manager expectations, physical demands, and work-life conflict. More resources were identified, namely: team climate and support, empowering teams and autonomy, role clarity, line manager competence, leader motivation, staffing levels, collaboration, learning and development, organisational support, staff voice, funding, and, national guidance, legislation, and policies. Intervention activities were seen at all levels, although this is limited at the level of the individual and the overarching context. There were also more activities focused on enhancing resources than those on reducing demands.

From the material collected and the case studies analysed, we summarised six principles as essential to guiding future organisational interventions to support NHS staff wellbeing. Expanded on in the report, these principles are:

1. **Staff wellbeing is a systems issue.** Activities not only have to support the individual, but need to include activities aimed at the group, leader, organisation, and the overarching context.
2. **Tailor the intervention to the context.** If an intervention worked in one context it does not mean that it will work in another. Local issues, processes, work structure, culture, systems, and dynamics are all essential factors that require consideration when tailoring an intervention to a specific context.
3. **Involve staff in the process.** Staff involvement is key to help identify issues and devel-

op solutions. This not only facilitates ownership, but the process is useful for collective sensemaking, community building, and enhancing feelings of control for all those affected by an intervention.

4. **Get support from leaders.** They provide access to resources and support for the intervention process. Moreover, they serve as role models when engaging with intervention activities.
5. **Interventions are iterative.** Contexts are dynamic, so there is a need to continually monitor and adjust the intervention. Evaluation is needed to assess the intervention against the intended outcomes. It is also key to evaluate the process of each intervention's implementation to understand how and why it worked (or not).
6. **Plan for the long haul.** Interventions must be sustainable and planning should consider how processes and learning are embedded into existing practices and across the organisation, as well as accounting for the departure of key personnel.

As the NHS continues to change and adapt, so too will the working experiences of staff change – leading to different demands and resources to address. These will range from the individual right up to the overarching context. Organisational interventions may appear complex and overwhelming, but this report contains examples where even slight changes made a substantial improvement in the working experiences of staff. Our report highlights that change is possible and that having some success can breed confidence and motivation to address larger and more challenging issues.

PROJECT BACKGROUND

The nature of healthcare service delivery means that its workforce is exposed to inherently challenging aspects of work. These include: long and unpredictable working hours, death, trauma, distress, physical demands, hazardous diseases and substances, and a high workload^{6,7}. However, for many workers in this sector, these challenges are often balanced out by a sense of purpose about work and the meaning they derive from it. In addition to this, camaraderie and support from others, opportunities to develop, and job security are beneficial aspects for so many workers in the healthcare sector, offsetting the extraordinary pressures they face on a daily basis⁸⁻¹⁰.

In recent years, the demands of working in National Health Service (NHS) have been compounded by changes to pay and pension, labour market shortages, a reduction in autonomy, increases in patient demands and cuts to the wider public sector^{10,11}. Taken together, this means that NHS staff are having to do 'more with less' resources. Consequently, there are growing concerns around the implications of these changes to the psychological wellbeing of NHS staff^{6,7,9,12}.

This concern is evident in the most recent NHS Staff Survey¹³. Carried out in the autumn of 2022, results from the survey show that about half of all participants taking part reported feeling unwell because of work-related stress in the past year (44.8%) or had worked in the last three months despite not feeling well enough to perform their duties (56.6%). Moreover, 30.2% of staff reported experiencing musculoskeletal problems due to work in the last 12 months, with 34% of all participants taking part

reported feeling burned out "often" or "always". Out of over 600,000 participants, only 57.4% would recommend their organisation as a place to work.

These findings correspond with similar results reported in surveys from the Royal College of Nursing¹⁴, the Royal College of Physicians¹⁵, the College of Paramedics¹⁶, and the British Medical Association¹⁷, as well as that of the wider research literature^{18,19}. The results from these studies not only indicate a workforce struggling with its wellbeing, but they highlight a decline in both the working experience of NHS employees as well as a drop in levels of reported wellbeing over the last few years.

With demands arising from the recent COVID-19 pandemic, as well as the impact of Brexit on staffing levels, recent events have accelerated the challenges faced by the NHS^{20,21}. There is an urgent need for intervention and support for the NHS workforce. An emphasis on staff wellbeing is reflected in NHS England's People Plan²², which aims to have more people, working differently, in a compassionate and inclusive culture. The plan covers the seven elements of the People Promise, which describes key actions and behaviours that can lead to a better working experience for everyone.

Although demands on the NHS, and resourcing needs, lie beyond the influence of most individual workers and even NHS organisations, it does not mean that interventions to support staff wellbeing cannot or should not occur. Instead, there is need to better understand the different types of interventions that exist within the healthcare sector. In particular: what are possible interventions that

have the potential to influence staff wellbeing by changing how the working environment is designed, organised, and managed? What can be learnt from these interventions that may aid efforts to better support the wellbeing of NHS staff?

Workplace wellbeing interventions

Workplace wellbeing interventions have mainly been examined at two levels: organisational and individual^{1,23}. Organisational interventions, also known as primary interventions, aim to make changes to how work is designed, organised, and managed. Examples of these might include workload reallocation, increased staffing, and fostering better team and peer support.

In contrast, individual interventions focus on supporting individuals to better manage their working environment and to mitigate the effects of poor working conditions. This is achieved by individuals changing their thought patterns, attitudes, and behaviours, and can include training on psychological (e.g., coping, mindfulness, Acceptance Commitment Therapy) as well as technical (e.g., time management, technology) skills. Individual interventions also include those that focus on the restoration and rehabilitation of workers struggling with their health and wellbeing (e.g., talking therapy, return-to-work programmes).

When comparing the effectiveness of these different types of interventions, there is growing evidence from reviews in the healthcare sector^{2,3,24} that organisational interventions may be more effective than individual interventions. For example, a meta-analysis³ of 19 studies involving 1,550 doctors found that, compared with individual interventions (e.g., psychoeducation, mindfulness), organisational interventions that focus on prevention (e.g., shift pattern changes, improved teamwork, reduced workload) lead to a greater reduction in burnout symptoms.

These findings echo those from research exploring the antecedents of healthcare worker wellbeing,

and demonstrate that working conditions (e.g., workload, role conflict, time pressure) are more strongly associated with wellbeing than individual factors (e.g., personality, attitudes)^{6,8,25,26}.

Understanding organisational wellbeing interventions

Given their aim of creating a better working environment for all, organisational interventions are generally seen to be more effective than individual interventions. The process of first identifying, and then either enhancing beneficial working conditions or removing adverse conditions, can create an environment that benefits not just an individual person, but a much broader group of workers. By focusing on the environment, changes inherent in organisational interventions are far more likely to sustain, leading to a beneficial outcome over a longer period^{1,27}.

Organisational interventions that utilise a participatory approach - which seeks the involvement of staff in key decision making from the outset - are also more likely to be successful^{28,29}. This is because participation from all those affected by a proposed intervention leads to a better identification of underlying issues and solutions that need addressing. This approach also facilitates buy-in to the process, creates a feeling of ownership and a more collective and collaborative approach to understanding and managing wellbeing³⁰. The intervention process itself can indicate a sense of collective responsibility and sensemaking that creates an environment of mutual support and understanding^{30,31}. This contrasts with individual interventions which may imply that wellbeing is a personal responsibility, and that poor wellbeing may be indicative of personal failure³²⁻³⁴.

A further advantage of organisational interventions is that they address staff working conditions as an antecedent to both staff wellbeing and patient care^{35,36}. This builds on research that highlights the importance of staff wellbeing for patient care^{37,38}. This line of research indicates an indirect effect where working conditions influence staff wellbeing,

which, in turn, influence the quality of care provided^{26,39}. Utilising a systems perspective within healthcare makes evident that the interconnectedness of all three aspects – working environment, staff wellbeing, and patient care - are integral to a well-functioning health service. This is evidenced in interventions in Germany^{40,41} and the Netherlands⁴², where improvements to staff working conditions not only led to better staff wellbeing, but to better patient outcomes as well.

The challenges with organisational interventions

It is important to note that not all reviews find organisational interventions more effective than individual interventions^{43,44}, with some studies indicating that organisational interventions might even be detrimental to staff wellbeing^{45,46}. Organisational interventions are typically more difficult to implement, requiring the identification of relevant working conditions that adversely impact staff wellbeing with appropriate corresponding actions^{28,47}. They are therefore very much context dependent, and cannot easily be taken from one setting to another⁴⁸.

An organisational intervention also needs to occur alongside the delivery of a service or product^{49,50}, which can be challenging in an environment where there is little time, morale, or belief to engage with the proposed change^{47,51}. This necessitates a more nuanced understanding of organisational interven-

tions; one that examines the context and process in which an intervention is carried out⁵².

Understanding different types of organisational interventions

As organisational interventions can vary substantially in their focus and activity, we draw on the work of Nielsen and Christensen^{48,53} to categorise organisational interventions. First, we distinguish between activities that seek to reduce demands on staff, and those that attempt to increase the resources available. Next, we consider the level in which these demands or resources operate at.

Demands and resources

Job demands and resources draw on the popular, and evidenced-based, Job Demands-Resources (JD-R) Model that is used to explain worker wellbeing⁴. The model states that all aspects of work can be separated into two types: job demands and job resources. Job demands are those aspects of work that require effort and come at a physical, psychological, or emotional cost to the individual. Within healthcare, these include high workload, emotional trauma, and time pressure^{6,19,25}.

On the other hand, job resources refer to those aspects of work that help to complete work tasks, fulfil one’s psychological needs, and/or mitigate the detrimental effects of job demands. Examples include team support, influence in the workplace,

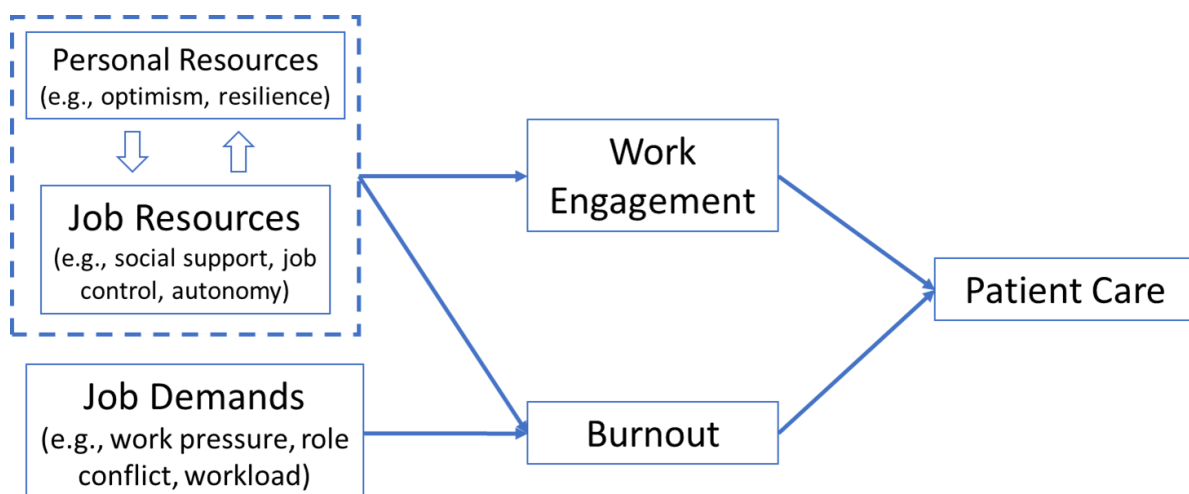


Figure 1: The Job-Demands Resources Model

and supportive leaders⁵⁴. An organisational intervention to improve staff wellbeing would strive to reduce the level of demands that staff face, and/or enhance the resources available to them.

According to the JD-R model, demands are predominately associated with ill-health (e.g., burn-out, stress). Resources are important as a motivating factor to the individual (e.g., work engagement) and to buffer the effect of demands. These can exist as personal resources within the individual (e.g., self-efficacy, resilience) or within the job environment (e.g., support, autonomy). In turn, both ill-health and low motivation in healthcare workers have been linked to lower levels of patient care^{26,55}.

The IGLOO model

The IGLOO model (Individual; Group; Leader; Organisation; Overarching context; Figure 2) provides a useful framework to structure the identification of demands and resources, and possible actions to address them^{5,48}. The individual level includes activities focused on improving an individual's personal resources (e.g., self-efficacy, resilience) or reducing the demands that one might place on themselves (e.g., drive for perfection). At the group level, activities can focus on enhancing resources, such as team support and collaboration, or reducing group demands (e.g., workload, conflict). Leader (or line manager) activities aim to increase staff resources through positive manager behaviours, such as inclusion and consideration, while affecting the level of demands through task allocations.

Addressing resources at the organisational level can occur through the design of jobs and policies which encourage autonomy and control over their

working environment for staff. Similarly, demands can be addressed through policies and practices aimed at reducing work-life conflict for staff as well as the physical demands placed on them. Finally, the overarching context refers to external policies, legislation, guidance, and resourcing at the regional and national level^{5,56,57} that impact demands (e.g., patient demands) and resources (e.g., size of available national workforce), which in turn, influence the staff working environment and their wellbeing.

Report Aim

Despite growing evidence advocating for more, and better, organisational interventions in the healthcare sector, there has been very little exploration of organisational interventions within the NHS to support staff wellbeing. Although the principle of reducing demands and increasing resources appears straightforward, one might ask: what does this look like in practice? Crucially, given the challenges in running organisational interventions, what contextual factors facilitate, or hinder, such interventions?

These questions are the starting premise of this report, which aims to:

- Identify examples of organisational interventions to improve NHS staff wellbeing.
- Map out how these interventions attempt to reduce demands and increase resources at the level of the individual, group, leader, organisation, and overarching context.
- Identify the barriers and facilitators of success for organisational interventions.
- Summarise key recommendations to encourage more, and better, organisational interventions to support staff wellbeing.



Figure 2: The IGLOO Model

OUR APPROACH

To meet the project aims, we first aimed to identify relevant organisational interventions that aimed to improve staff wellbeing in the NHS by looking to reduce demands on, or increase resources for, staff.

This was done through an open call for evidence that was distributed through the research teams' professional networks on social media, as well as through networks via NHS England and the Society of Occupational Medicine.

In total we identified thirteen interventions. The team interviewed leads who were, or currently are, involved in running organisational interventions. Seventeen intervention leads were interviewed: seven had staff wellbeing or people-related roles; five clinicians; two externals who were part of a university and partnered to support an intervention being run; and three were from another role within the service (e.g., quality improvement, service manager).

The interventions came from acute medical, community health, and mental health settings, as well as one example from an integrated care system.

Each interview gathered data on various aspects of the interventions, including: its origins and rationale; its process, including barriers and facilitators of success; feedback from either formal or informal evaluations and finally, learning and the sustainability of the intervention.

Where available, we also integrated material from additional resources (e.g., reports, articles, videos) relating to an intervention that was either shared

by the intervention lead or that was available online.

We used template analysis⁵⁸ to code the material, extracting data as examples to decrease demands or increase resources across the individual, group, leader, organisation, and overarching context level.

An overview of each of the 13 interventions is provided in Table 1. Ten interventions were written up as case studies to provide a more thorough overview of the work carried out, including detail about core contextual and process factors. These are presented at the end of the report.

From the material collected, we developed six principles to guide future organisational interventions to support staff wellbeing in the NHS.

Photo by Stephen Dawson

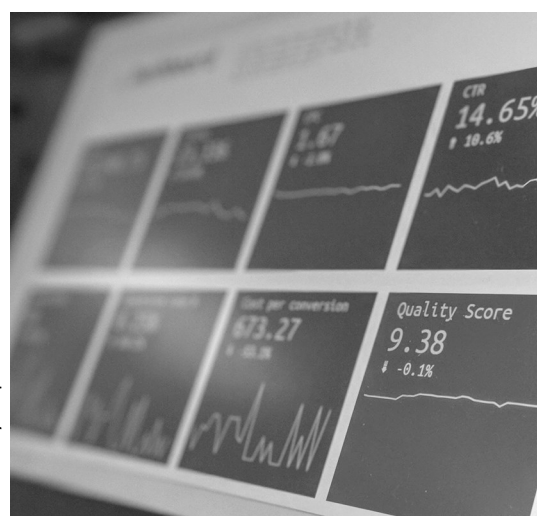


Table 1: Overview of the included interventions

1	<p><u>Co-production of a fatigue risk management strategy in maternity services</u> <i>Newcastle Hospitals NHS Trust</i></p> <p>A fatigue risk management strategy for maternity services was co-produced with staff. A series of focus groups and workshops collected experiences of fatigue at work and developed action plans. This staff-led programme led to changes including being more selective on certain procedures overnight, the use of self-rostering, awareness training on fatigue, increased staffing, and purchasing sofa beds to facilitate power naps.</p>
2	<p><u>Reducing ‘avoidable employee harm’ by improving employee investigations</u> <i>Aneurin Bevan University Health Board</i></p> <p>A review of the employee investigation process led to workshops and process changes. To create an impetus for change, a case study was first developed outlining the impact of an investigation on an individual, the workforce, and the organisation. Changes included focusing on the initial assessment phase of an investigation to assess whether an investigation was necessary. More awareness and support were provided to consider alternative options to formal investigations. After six months, there was a 66% reduction in disciplinary cases while the average number of days to conclude an investigation reduced from 156 to 120 days. This saved approximately 1,000 staff sick days.</p>
3	<p><u>Annualised hours with self-rostering in emergency medicine</u> <i>Brighton and Sussex University Hospitals</i></p> <p>The rota system for consultants moved to self-rostering using annualised hours. This new system mapped each staff member based on their skills, allowed staff to block out dates they did not want to work and gave doctors their shift patterns up to a year in advance. The system gave doctors more control, improved work-life balance, and reduced the demands on them. The Department increased consultant and registrars staff levels and reduced locum cover from £1.3 million to only using locums to cover for sickness in 2022-23. The system has been rolled out to cover junior doctors and other areas of the Trust, as well as to over 50 other emergency departments in the country.</p>
4	<p><u>Bespoke rostering for registrars in emergency medicine</u> <i>A London Hospital</i></p> <p>The rota system for senior registrars was revamped so that they could flag working and non-working preferences for nights, weekends, and late shifts. The process was overseen by a volunteer rota coordinator who ensured an appropriate skill mix and rota compliance. The system was extended to cover junior doctors, with increased satisfaction scores reported. The system was associated with better recruitment and retention, with vastly reduced unplanned locum costs for senior registrars.</p>

5	<p><u>'Start Well>End Well' – Team huddles to support teaming and psychological safety</u> <i>North Bristol NHS Trust</i></p> <p>The intervention started during the COVID-19 pandemic as a way to support the teaming process, improve role clarity, and to improve psychological safety in teams. 'Start Well>End Well' consists of three parts: step 1 – an enhanced safety briefing at check-in; step 2 - a peer-to-peer pit stop, which is a framework for debriefs; and step 3, the process for checkouts for the team to reflect, review, and acknowledge the work that was done. The process has been rolled out and adapted in teams across the Trust, with teams reporting better support, collaboration, and problem solving.</p>
6	<p><u>Reducing the length of multidisciplinary team meetings</u> <i>Kent Community Health NHS Foundation Trust</i></p> <p>The Neuro Rehabilitation Team monthly multidisciplinary meetings used to run for about six hours. This was a source of strain and unhappiness for the team. By setting boundaries about what cases should be discussed and what information shared, stopping the collection of redundant data, and having clear roles for meeting participant, the average meeting time was reduced to approximately three hours. This meant staff had more time to complete other work tasks, and the meeting structure allowed staff to feel more supported and fostered a stronger sense of community within the team.</p>
7	<p><u>Increasing wellbeing of dietitians by redesigning a clinic structure</u> <i>Kent Community Health NHS Foundation Trust</i></p> <p>Clinicians were reporting high workloads and feeling stressed during clinics. The team organised a workshop to review the issue of having insufficient time to complete paperwork and develop solutions. Clinicians broke down all their tasks before, during, and after a consultation including how long each task took. This highlighted the problem to managers and the team. Among the changes to the clinic structure was increasing the time clinicians had to complete paperwork straight after each appointment by 20 minutes, and adjusting the ratio of new to follow-up appointments. Post-intervention, staff reported increased levels of happiness and working fewer additional hours to complete paperwork.</p>
8	<p><u>Quality improvement huddles to support staff wellbeing</u> <i>A Hospital Trust</i></p> <p>Quality Improvement Huddles used for improvements to work practices corresponded with better staff wellbeing. The process involves teams identifying areas of concern and then collectively developing actions to address it. The collaborative and team element of the huddles gave space to challenge long-standing practices and issues, including the role of senior people within it. Changes to work practices in pharmacy not only increased efficiency but resulted in less overtime hours for staff, reduced sickness absence rates, and improved retention. This has been extended to 47 different areas in the Trust.</p>
9	<p><u>Developing a Trust-wide mental health programme for all staff</u> <i>Wye Valley NHS Trust</i></p> <p>The Trust partnered with the Mental Health Productivity Pilot to better support the health and wellbeing of staff more systematically. An initial review and consultation in the Trust established how the workforce is structured, what wellbeing initiatives are available, what the uptake is, and what the main challenges are. This led to the collective agreement of priority areas of actions, including improving manager competencies in managing mental health, workshops on wellbeing topics, recruiting mental health first aiders, partnering with universities to upskill the workforce and widen the recruitment pool, and revamp the return-to-work process after mental ill-health.</p>

10	<p><u><i>Using the Health and Wellbeing Framework to develop staff health and wellbeing</i></u> <i>Norfolk and Waveney Integrated Care System</i></p> <p>This Integrated Care System (ICS) used the NHS Health and Wellbeing Framework as a diagnostic tool to identify and prioritise areas to improve on. The Framework covers seven areas of work which organisations self-assess against. The results were triangulated against scores from the NHS Staff Survey, from organisational leads, and feedback from different staff network groups to determine areas of improvement. Among the areas of concern included ‘managers and leaders’, with data indicating concerns around trust and bullying. One action to address this was to develop a restorative and justice workstream to develop actions (e.g., training, revising policies) and evaluate them over the next three years.</p>
11	<p><u><i>eRostering and team rostering to improve staff wellbeing</i></u> <i>A Mental Health Trust</i></p> <p>The Trust uses electronic rostering to provide staff with more control over their working patterns, including allowing them to request eight shifts or days off on every four-week rota. This has simplified the administration process within the Trust and improved the work-life balance of staff. The Trust is also piloting team rostering in a ward where staff in the team rota themselves.</p>
12	<p><u><i>Changing mindsets to flexible working</i></u> <i>The Shrewsbury and Telford Hospital NHS Trust</i></p> <p>Data from the NHS Staff Survey and from exit interviews showed that work-life balance and lack of work flexibility were major concerns for staff. Through an online consultation, staff were able to elaborate on barriers to flexible working and suggest potential solutions. Through this feedback and additional internal consultation, changes were made to the Flexible Working Policy including making the appeal process more robust and having the People Advisory Team involved at an earlier stage to provide advice. A team-based rostering trial is being carried out with the obstetrics and gynaecology team.</p>
13	<p><u><i>A quality improvement approach to improving staff retention</i></u> <i>Sandwell And West Birmingham NHS Trust</i></p> <p>Working with two departments as part of a pilot study, a deep dive of their quantitative workforce data was taken to understand why people leave and stay. Staff were engaged with Appreciative Inquiry to understand their team strengths and how to build on these to achieve the desired state of staff experience. Quality improvement methodology helped to identify and test change ideas. In the health visitor team, the focus was on improving workload management by reducing domiciliary visits through on-site clinics and having a dedicated day a month to focus on admin and record management. In the pharmacy team the identified need was to increase feelings of voice through a new suggestion and feedback system with shared ownership for implementing suggestions.</p>

Note. Interventions 1 – 10 are presented as case studies at the end of the report.

PROJECT FINDINGS

Organisational interventions are guided by their context and therefore can target various aspects of the work environment. To demonstrate the breadth of activities that can comprise such an intervention we mapped activities from the thirteen organisational interventions against two frameworks. First, we considered what demand or resource were being addressed⁴, before classifying this at the relevant level within the IGLOO framework^{5,48,53}.

The numbers in square brackets in this section (i.e., [1]) are used to refer to the interventions in Table 1.

Demands and resources identified

The interventions did not typically set out what the demands and resources were that they were attempting to address. Instead, these were extracted by focusing on the aims of the intervention overall, and of the respective activities within them.

In total, eight demands were identified: workload, emotional demands, stigma, conflict, manager expectations, manager demands, physical demands, and work-life conflict. However, these were only seen at the level of the group, leader, and organisation (Table 2).

Table 2: The demands and resources identified across the five levels.

Level	Demands	Resources
Individual		Awareness of wellbeing Technical and career competence Psychological skills Self-efficacy
Group	Workload Emotional demands Stigma Conflict reduction	Positive team climate and support Empowering teams and autonomy Role clarity
Leader	Demands to reduce Managing expectations	Resources to increase Line manager competence Leader motivation Role modelling
Organisation	Workload Emotional demands Physical demands Work-life conflict	Staffing levels Collaboration Learning and development Employee voice Organisational support
Overarching Context		Learning and development National guidance, legislation, and policies Funding

More resources were identified across all five-levels, namely: awareness of wellbeing, technical and career competence, psychological skills, self-efficacy, team climate and support, empowering teams and autonomy, role clarity, line manager competence, leader motivation, staffing levels, collaboration, learning and development, organisational support, staff voice, funding, and national guidance, legislation, and policies.

While most of these exist at a single level, Table 2 shows that some demands and resources exist across different levels.

Efforts to address these demands and resources were then made through the activities at the levels of the IGLOO model.

Individual-level activities

As organisational interventions aim to make changes to how work is designed, organised, and managed, the focus is typically less on the individual and instead on the wider system. Nevertheless, individual-level activities can occur as part of a comprehensive approach targeting both the individual and the organisation¹. This is particularly so that individual-level activities help staff to better engage with interventions at other levels, such as by improving the knowledge, skills, and abilities⁵. Table 3 provides an overview of the activities observed.

Reducing individual-level demands

Activities in this category aim to change the inherent demands that an individual places on themselves⁴⁸. Examples of these could include pressure for perfection or to be the best clinician. However, we did not observe any such activities in the included interventions.

Increasing individual-level resources

Training and workshops aimed towards improving *wellbeing knowledge*. This covers topics such as fatigue [1], mental health and financial wellbeing [9], menopause [10], and general self-care [5]. Other methods used include monitoring fatigue levels

Table 3: Individual-level resources and their corresponding activities.

Resources to increase	
Awareness of wellbeing	<ul style="list-style-type: none"> • Training and workshops • Monitoring on a phone app • Sleep awareness and clinic
Technical and career competence	<ul style="list-style-type: none"> • IT training • More time to attend professional development and career-related training and activities • Career coaching
Psychological skills	<ul style="list-style-type: none"> • Resilience training
Self-efficacy	<ul style="list-style-type: none"> • Participatory activities showed that change was possible • Making bespoke changes to the work environment

through a phone app [1] and organising sleep clinics [12].

Activities to improve *technical and career competence* focus on improving specific knowledge related to the intervention. For example, staff had to improve their IT skills to engage in a team-rostering process [11]. This can also cover knowledge required for one's job role or careers, such as where career coaching is deployed to explore development opportunities in other parts of the NHS [10]. This was also done by providing better and more flexible rotas for doctors to engage with their professional development and Fellowship activities which contributes to one's professional competence [3, 4]. Training was also used to improve *psychological skills* through resilience training [9].

Developing organisational interventions with a participatory approach was vital in enhancing self-efficacy - one's belief in their ability to complete tasks and reach their goals⁵⁸. This showed individuals that change is possible and that their involvement mattered [3, 4, 6, 8, 13]. Similarly, changes permitting individuals to make bespoke adjust-

ments to their working environment relayed to them that they were not “just a number”, but instead, that they were a person who mattered and who had some influence over their personal and professional lives [4, 7].

Group-level activities

Table 4 presents an overview of the demands and resources at the group level, and the corresponding activities within interventions that seek to address them.

Reducing group-level demands

The most common demand targeted at the group level was *workload*, which is the discrepancy between the amount of tasks and the time available to perform these tasks in a satisfactory manner⁵⁹. This included changing meeting scope, roles, and

information recorded which reduced meeting times and allowed more time to engage in other tasks [6]; building short and simple activities into a team’s shift structure which avoided the need to take teams out of their workdays to attend longer training sessions [5]; and being able to swap shifts with colleagues without having to involve an administrator or manager [3].

Emotional demands are the demands on individuals' experiences when faced with other people's feelings at work⁵⁹. Activities to reduce this includes creating shared spaces for people to reflect on work experiences [9], and to provide space and a structure for peer-led debriefing after a difficult clinical-related incident [5].

Several intervention activities sought to reduce levels of *stigma*, which refers to receiving a negative perception due to a specific personal

Table 4: Group-level demands and resources and their corresponding activities.

Demands to reduce	Resources to increase
<p>Workload</p> <ul style="list-style-type: none"> • Reduced meeting times • Stopped collecting and discussing redundant data • Integrating training goals into the workday to avoid long training sessions • Simplifying the shift swapping process • Reducing domiciliary visits through on-site clinics 	<p>Positive team climate and support</p> <ul style="list-style-type: none"> • Reflect on what went well and acknowledging others • Teambuilding exercises • Regular in person events for distributed teams • Collaborative work patterns • Focus groups and workshops • Mental health first aiders and wellbeing champions to support others • Peer check-in process and networks
<p>Emotional demands</p> <ul style="list-style-type: none"> • Peer-led debriefing • Shared reflection spaces 	<p>Empowering teams and autonomy</p> <ul style="list-style-type: none"> • Team-based problem identification and solution development • Ability to pick external training to meet needs of the team • Flexible rotas or shift patterns
<p>Stigma</p> <ul style="list-style-type: none"> • Collective discussions and action planning around a particular issue • Sharing personal experiences 	<p>Role clarity</p> <ul style="list-style-type: none"> • Induction and training days • Developed written manuals, guidebooks, and FAQ documents • Team check-ins and huddles • Discussions to agree common standards for rostering and patient contact
<p>Conflict reduction</p> <ul style="list-style-type: none"> • Agreeing on common rules around shift requests • Sharing individual data with the group to demonstrate different work experiences • Training on building a restorative and just culture 	

attribute⁶⁰. For example, collective discussions and actions around fatigue creates common recognition that fatigue is a real problem [1], or that the challenges and failures experienced are also experienced by others [8]. Similarly, discussions around mental health within a group setting can reduce stigma and encourage help seeking [9].

Finally, *interpersonal* conflicts occur when there are disagreements between employees⁶¹. In some interventions, by agreeing common rules around shift requests and how it needs to match the service needs creates more shared understanding, reducing conflict between individuals and with the needs of service [3, 4, 11]. Similarly, by sharing the data on the range of tasks and how long it took to complete them, clinicians got a better understanding of the variation of work duties in the team [7]. Another group-level activity to reduce conflict was training on building a restorative and just culture [10].

Increasing group-level resources

A key resource at the group level is having a *positive team climate*, which is the feeling of being part of a group⁵⁹. Interventions facilitated this by making space and time to reflect on what went well in the team, as well as acknowledging the contribution of others [5, 8, 13]. Other activities included opportunities to socialise in the workplace [5, 8, 9], such as bringing people together for in-person events or organising teambuilding exercises. Participatory activities, such as focus groups, check-ins, and workshops, that allow staff to feel listened to and cared for also contribute towards developing a positive team climate [1, 4, 5, 6, 7, 9, 13]. This often involved bringing together staff from different backgrounds to work together [1, 5, 6, 7, 8, 10]. Collaborative work practices such as team-rostering were also important in building reciprocal relationships between peers [4]. For more wellbeing support, activities included developing peer check-ins and networks [5]. This also included the appointments of mental health first aiders and wellbeing champions to look after the wellbeing of team members [9, 10].

Autonomy – the degree to which one can influence aspects of work itself⁵⁹ – was another important group-level resource. The various rostering methods and flexible work offering all aimed to provide more control over when and how often an individual might work [3, 4, 11, 12]. Being able to select mental health programmes also gave teams the ability to bring in relevant training that best meets the team's needs [9]. Activities that focused on problem identification and solution development was also instrumental in enhancing a team's autonomy [1, 5, 6, 7, 8, 9, 13].

Several interventions sought to improve *role clarity* (i.e., the individual's understanding of their role at work⁵⁹). This was achieved through team check-ins or huddles to clarify and establish roles and responsibilities for a particular shift or project [5, 8]. Other activities included discussions to determine ground rules and guidance for self-rostering [3, 4, 11], as well as the amount of time required for patient appointments [7]. This was then often captured and shared through training days or in the induction of newly appointed staff [1, 2, 3, 4, 5, 8, 9, 10, 11, 12], as well as through the development of manuals, guidance, and FAQ sheets to inform day-to-day practice [1, 2, 3, 4, 5, 8, 10, 11, 12].

Leader-level activities

At the leader level, activities aim to address the demands that leaders (or line managers) put on staff or on leaders' resources to allow them to foster a better working environment for their staff⁴⁸. The relevant leader-level demands and resources along with corresponding activities from the twelve included interventions are presented in Table 5.

Reducing leader-level demands

The one leader-level demand we observed was on *managing the expectation* managers may have of their staff. Using a workshop to breakdown clinician tasks and the time it took to complete each, helped managers realise they had not fully recognised the breadth of tasks carried out by clinicians [7]. Other activities focused on encouraging a more person-centred approach with their staff and to

recognise them as individuals within a wider system, which was done through training on restorative just culture [10] and on human factors [1].

Increasing leader-level resources

A common resource that interventions aim to enhance is *line manager competence*^{62,63}. This typically entailed training covering general line manager competencies [5, 8]. In some instances, more specific topics were covered, including managing flexible work [12], managing return-to-work after mental ill-health or managing difficult conversations [9]. Another activity was to develop a line manager wellbeing competencies framework [10]. Other activities focused on equipping managers with process-related competences such as the quality improvement methodology to structure the identification of issues and actions [6, 8, 13].

Leader motivation encompasses activities to obtain leaders' support for the intervention being run. This includes the development of a case study to demonstrate the scale of the problem and its impact on the individual, workforce, and the organisation [2]. Similarly, the collection and sharing of data related to the issue were important to justify the need for intervention [2, 3, 10, 12]. Data around potential or actual benefits and cost savings were particularly important to build a business

case. This included trying to encourage leaders to take a longer-term perspective and consider that short-term disruption or inconvenience is for the benefit of longer-term improvement [12]. Regular communication – both formal and informal – kept leaders updated and interested in the intervention [1, 13]. Communication, interest, and collaboration was also sustained by involving line managers and senior leaders as active participants in the intervention process [1, 2, 5, 8, 10].

The third resource centred on improving *role modelling* among leaders. This indicates to staff that the issue is of importance, with leaders also potentially showing how to engage with the changes being made. For example, leaders and line managers themselves used new rota systems [3, 4] or got involved in huddles and team check-ins [5, 8]. Other actions include leaders attending related training events, getting involved in giving and receiving feedback, and being available to take part in these activities [1, 5, 6, 7, 8, 9, 10].

Organisational-level activities

Most activities from the interventions focused on addressing demands and resources at the organisational level (Table 6).

Table 5: Leader-level demands and resources and their corresponding activities.

Demands to reduce	Resources to increase
<p>Managing expectations</p> <ul style="list-style-type: none"> • Breaking down the tasks of staff for managers • Training on human factors or restorative just culture to recognise the individual as part of a wider system 	<p>Line manager competence</p> <ul style="list-style-type: none"> • General line manager competencies training • Training on specific wellbeing topics • Developing a line manager wellbeing competencies framework • Process-related training (e.g., quality improvement methodology)
	<p>Leader motivation</p> <ul style="list-style-type: none"> • Regular formal and informal communication • Developing case studies • Encouraging a long-term perspective • Sharing organisational data • Involving line managers and senior leaders in the intervention process
	<p>Role modelling</p> <ul style="list-style-type: none"> • Attending training • Engaging with the changes being made • Making time to take part

Table 6: Organisational-level demands and resources and their corresponding activities.

Demands to reduce	Resources to increase
<p>Workload</p> <ul style="list-style-type: none"> • Changed task assignments to avoid elective procedures overnight • Allocate more time to complete paperwork • Improved medication dispensing process • Reducing the number of investigations • Reduced rota administration through team-based rostering 	<p>Staffing levels</p> <ul style="list-style-type: none"> • Flexible work • Reallocating intervention savings to staffing • Developing apprenticeship programmes • Improving return-to-work process • Developing attendance policy • Reducing number of investigations or concluding them quicker
<p>Emotional demands</p> <ul style="list-style-type: none"> • Reviewing policies and procedures to make them less distressing • Reducing the number of complaints and errors made • Not launching an employee investigation immediately • Removing or reducing frustrating work practices 	<p>Collaboration</p> <ul style="list-style-type: none"> • Developing training programmes together • Steering groups • Co-designing activities • Building IT projects • Data collection or problem formulation together • Involving different stakeholder groups
<p>Physical demands</p> <ul style="list-style-type: none"> • Sofa beds purchased for power naps • Staff able to pick night shifts based on their circadian rhythms • Better structured shift patterns to reduce tiredness • Bringing some domiciliary visits onsite reduced the physical demands on staff having to 	<p>Learning and development</p> <ul style="list-style-type: none"> • Project champions • Case studies • Awards • Internal communication (e.g., videos, intranet, newsletter, meetings) • Further pilot interventions
<p>Work-life conflict</p> <ul style="list-style-type: none"> • Flexible rostering patterns • Advanced notice of rotas • Encouraging other forms of flexible work 	<p>Staff voice</p> <ul style="list-style-type: none"> • Surveys • Online staff collaboration forums • Staff representative groups • Union engagement
	<p>Organisational support</p> <ul style="list-style-type: none"> • Wellbeing in the vision and strategy • Relevant policies • Included in recruitment, induction, and training • Risk reporting

Reducing organisational-level demands

All activities related to *workload* changed work practices and processes. By reducing the number of investigations, this reduced the amount of work for those involved, allowing more time for actual cases and a quicker resolution [2]. Other activities include having a more careful look at the need for category 3 caesarean sections to be carried out just before the day staff came on to reduce the workload on night shifts [1]; or that team-based or self-rostering, with appropriate technology, can reduce

the amount of administration for staff and managers [3, 11].

A range of activities focused on reducing *emotional demands*. This includes reviewing and overhauling organisational policies and procedures to reduce the frustration and distress on staff. This applied to employee investigation [2], bullying and harassment [10], and flexible work [12]. Quality improvements to processes that reduce complaints and errors removed a potentially significant source of distress [8], as did not subjecting an individual to

an investigation straightway but to instead establish a better picture of the event and recognise potential mitigating factors [2]. Removing or improving work practices that were frustrating or a source of unhappiness – such as long MDT meetings – also helped reduce emotional demands.

Activities to reduce *physical demands* include educating staff about their circadian rhythms and then encouraging them to self-roster accordingly [1] and setting better structured shift patterns to reduce fatigue [3, 4]. Buying sofa beds for staff to use during breaks as well as having extra staff on call overnight were among the actions taken to encourage power naps to reduce fatigue [1]. Bringing some domiciliary visits onsite reduced the physical demands on staff having to travel [13]. Lastly, the various rostering activities [3, 4, 11, 12] - including having more advanced notice of shifts – gave staff more control to manage their work patterns in a way to reduce *work-life conflict*. Expanding flexible work to include not only part time or self-rostering but to include other formats (e.g., job shares, compressed hours, and home/hybrid working) also gave more control staff [10, 12].

Increasing organisational-level resources

To improve *staffing levels*, activities focused on offering more flexibility to both attract and retain staff to the workforce [3, 4, 11, 12], especially those who cannot work full time or have other personal commitments [3, 12]. Reallocating savings from the intervention into substantive staff posts [3, 4] and partnering with local universities to develop apprenticeship programmes [9] also helped improve staffing levels. Other activities focused on keeping individuals in the workforce. For example, developing an attendance policy to encourage individuals to work at some capacity rather than being signed off completely [10]; improving the return-to-work process so that staff are more likely to return and stay in work [9]; and reducing the number of investigations so staff stay in work or otherwise concluding them quicker so staff can return to work quicker [2].

Activities to improve *collaboration and communication* between groups included developing train-

ing programmes together [2], forming steering groups to oversee projects [1, 10, 13], co-designing interventions [1-10], building IT projects [7], and participating in data collection or problem formulation together [1-10]. Across all the interventions we saw involvement from staff from diverse backgrounds, disciplines, and leadership. Human resources, staff wellbeing, and executive leadership were often represented, with involvement too from occupational health, IT, unions, quality improvement, and organisational development. For some interventions this involved groups of people working together who had never done so before.

Sharing *learning and development* was commonly done through project champions [1, 2, 9, 10] to facilitate learning across the organisation and between project champions themselves. Other sharing was done through case studies [1, 2, 3, 6, 7, 8] and presentations [1, 2, 3, 13]. Engaging with internal communication (e.g., intranet, newsletters, videos, staff meetings) was important to share progress, learnings, and next steps [2, 5, 8, 9, 10, 12]. Being nominated and winning awards helped raised the profile of the intervention further [2, 3, 8]. In some instances, pilot or further interventions following on from the original work helped facilitate learning elsewhere [3, 5, 8, 11, 13].

Staff voice was enhanced through activities that invited feedback into organisational processes. This included staff surveys [8, 9, 10, 12], online collaboration forums [12], feedback systems [13], staff representative groups [12], and union engagement [10, 12].

Finally, *organisational support* reflects how wellbeing is seen as a priority by the organisation. This is evident where actions led to the development or adaption of the organisations vision and strategy to explicitly include wellbeing [9, 10, 12]. It also evident in activities to review policies against specific wellbeing issues, such as menopause, flexible work, non-caring responsibilities, and older workers [12]. Beyond that, it involves ensuring that wellbeing commitments are integrated into various work functions such recruitment, induction, and training [2, 9] or risk reporting [1, 8].

Table 7: Overarching context-level resources and their corresponding activities.

Resources to increase
Learning and development
<ul style="list-style-type: none">• Regional and national networks• The intervention being used a case study to support change in other organisations
National guidance, legislation, and policies
<ul style="list-style-type: none">• Lobbying and advocating for change• Using the NHS England’s Health and Wellbeing Framework
Funding
<ul style="list-style-type: none">• Pooling of financial resources with other regional organisations• Direct funding of activities from NHS England

Overarching context-level activities

The lack of activities at the overarching context is to be expected given the emphasis of organisations on their own internal context. Nevertheless, there are numerous ways in which the working environments of staff are influenced by the overarching context – and vice versa (Table 7). For example, with *learning and development*, NHS England’s Health and Wellbeing Framework provides guidance and acts as a resource from which organisations can assess themselves, or even get additional support around the implementation of it [10]. In the same way, organisations have also received *funding* from NHS England or from the pooling of resources across integrated care systems to run specific wellbeing initiatives [10].

In contrast, some interventions [3, 10] have been used as examples for other external organisations on how to better support staff wellbeing within national initiatives led by NHS England [1]. Finally, the work on addressing fatigue has led to activities (e.g., speaking in the Houses of Parliament) advocating for *policy and legislative changes* to better management and recognition of fatigue in the NHS and in Europe [1].

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IMPLICATIONS

From the case studies and interviews in this project, we identified eight demands and eighteen resources (Table 2). We further identified the corresponding activities that aimed to reduce the demands the staff faced while increasing the resources available to them.

Activities at all levels are evident, although they are limited at the level of the individual and the overarching context. Moreover, we see more activities focused on enhancing resources than on reducing demands. This may be because activities focused on reducing demands are more challenging to address within the NHS, and that enhancing resources may be an easier or more viable option. This matters because demands are more strongly linked to burnout, while resources are more strongly linked to work engagement and motivation^{4,64}. Therefore, efforts to target staff burnout and ill-health need to recognise the importance of managing demands.

Recognising the need for more, and better, interventions to support staff wellbeing in the NHS, we build on the previous section to summarise the findings from this project through six principles to guide future organisational interventions to support staff wellbeing:

1. **Staff wellbeing is a systems issue**
2. **Tailor the intervention to the context**
3. **Involve staff in the process**
4. **Get support from leaders**
5. **Interventions are iterative**
6. **Plan for the long haul**

The six principles for organisational interventions to support staff wellbeing are expanded on below, linking the research literature with the examples from the twelve case studies.

1. *Staff wellbeing is a systems issue*

Efforts to address staff wellbeing need to recognise that demands and resources occur across various levels. The IGLOO model⁵ provides a useful framework to examine factors at the level of the individual, group, leader, organisation, and the wider overarching context. It recognises that while interventions can, and should, look at individual interventions, this alone is not enough⁶⁵. There is compelling evidence that interventions that operate across various levels are more likely to be effective and to be sustainable^{2,3,24}.

A more comprehensive approach would integrate activities across multiple levels to better involve the different stakeholders, and to mitigate demands and enhance resources^{48,65}. This is evident in all case studies included in this project. For example, to manage fatigue, activities at the individual level raised awareness about the dangers of fatigue and the role of power naps. At the organisational level, physical demands was reduced by encouraging power naps on new sofa beds while workload was reduced by not scheduling elective procedures on night shifts where possible.

From the intervention activities mapped across the different IGLOO levels, organisational interventions do not need to have a specific health component

to them. Instead, at its core it identifies activities that focus on improving how work is designed, organised, and managed⁶⁶. In these case studies, examples have included changing clinic structures, rota patterns, and meeting processes, although other studies also highlight the need to get the basic hygiene factors in place that all staff need to work, such as access to food and parking⁶⁷.

Some case studies were supported and guided from the overarching context-level through national initiatives such as Health and Wellbeing Framework. Other relevant programmes also exist that activities at the different levels could potentially sync with, including the initiatives around Wellbeing Guardians or the BMA Fatigue and Facilities charter. However, it is equally possible that these policies and practices from national-level actors, including NHS England, Northern Ireland, Wales, and Scotland, the regulators, and Royal Colleges also contribute to the demands that NHS staff face⁶.

Although less common, activities could include lobbying national level policies and legislation. This could be more general around the funding and resourcing of the NHS or target specific issues such as the pension caps⁶⁸ and the immigration process for migrant healthcare workers²¹. These do not have to be healthcare specific, as legislation and policies of other related sectors (e.g., social care) have implications for the demands on the NHS. Other societal-level legislation and practices, such as benefits, and child and eldercare support, will also impact the availability of the workforce⁵⁷.

2. Tailor the intervention to the context

To fit the context, interventions must have a clear rationale for why they are needed and what they are trying to achieve. This requires a good understanding of what the salient issues in that context are. For some of the case studies this was driven from the lived experience of those affected (e.g., poor rotas affecting work-life balance), while for others it emanated from the specific issues raised in staff surveys or from gaps highlighted in the NHS

Health and Wellbeing Framework. Other case studies worked backwards, developing activities to address specific outcomes such as staff retention or sickness absence. These helped clarify what the desired outcomes of the case studies were and what activities could potentially achieve them.

In an environment where resources are stretched, having a clear justification for the intervention and its associated activities helps with prioritising issues to address, as well as questioning whether existing interventions are still appropriate. Remaining clear on who the intervention is for and why it was being done in a certain way is equally important in order to obtain buy-in and support from staff, managers, and the wider organisation²⁷. There were multiple examples from the case studies where stakeholders only got involved in the intervention when they understood what its aims were, and what the purpose of their involvement was.

However, the success an intervention does not rely solely on the activities. Electronic rostering was seen as effective in allowing flexible work in one of the case studies but was a problem in the context of another. Therefore, rolling this – or any of the interventions – to another context does not guarantee success.

Intended outcomes are more likely to happen when an intervention takes into account the context in which it operates in^{27,65,69}. These factors include the culture, working conditions, stakeholders, and existing wellbeing programmes within the organisation. This may mean having to adapt an intervention structure, such as where team building exercises were integrated into huddles during shifts as there was no time for traditional training activities. It may also mean having to account for organisational dynamics, like when resistance from the Executive had to be overcome given that they had already invested considerable funds into another programme. In doing so, it may be worth considering the conditions under which an intervention will function well, and for whom⁵².

3. *Involve staff in the process*

A clear theme across the interventions in this project was the importance of staff participation. This has long been recognised as best practice in the wellbeing literature⁷⁰, with recent calls advocating for more co-designed and participative wellbeing interventions in the NHS^{67,71}.

As indicated at the start of this report, participation is important for several reasons. This is evident in case studies where staff across various functions took an active role in interventions, participating to determine its process (i.e., how the intervention will run), content (i.e., what the intervention does), and goals (e.g., to achieve specific outcomes or to implement a process)⁷⁰. One case study described co-designing a strategy with staff as an indicator of the respect towards staff's experience and understanding of their working environment. This also highlights how the participation process itself can be used as a staff engagement process, and contribute to feelings of being listened to, recognised, and appreciated⁷².

Another case study gave clinicians the opportunity to break down the tasks done during clinic to raise awareness for managers about what the clinicians' roles entailed. Consistent with research literature on participation and buy-in⁵³, the case studies further highlighted that there was almost no resistance to changes being implemented as the intervention activities were based on priorities that staff had set and actions staff had recommended.

The participation process in groups itself serves as resource by facilitating a sense of belonging and connectedness^{27,53,73}. Here, case studies demonstrated how bringing staff together to discuss aspects of the intervention helped develop a sense of team identity and community. Where discussions centred around wellbeing-related topics (e.g., fatigue, mental health, menopause) this raised awareness of the issue and was instrumental in reducing stigma related to that topic. Through their involvement in the interventions, staff not only got a better sense of their own wellbeing, but were also more aware about what conditions, behav-

iours, and attitudes they needed to experience that wellbeing³⁰. This is seen where staff co-designed a fatigue management strategy to incorporate activities and changes that benefitted them.

Another benefit from participation is where the collective group motivates and encourages each other⁵³. For example, in the quality improvement case study where successes gave confidence to make further changes, or where a team decided to challenge the status quo and change the way meetings were carried out or how clinics were structured.

This ties in with the collective sensemaking and cohesion that can arise when groups come together to problem solve^{30,31}. Several case studies reported how staff appreciated the different perspectives of their colleagues and managers⁷⁴. For example, when agreeing common rules for self-rostering, participants learned that their own requests needed to be balanced against that of their colleagues as well as the needs of the service. This led to a more collegiate environment where staff were more likely to accept shift swap requests to help others.

4. *Get support from leaders*

Organisational interventions cannot be successfully implemented without leadership support. Leaders are essential given they are the gateway to resources and support for the intervention process^{74,75}. Moreover, they serve as role models in how they engage with intervention activities, with case studies showing that huddles and team check-ins were only effective when leaders also took part in the process. Therefore, it is vital that leaders themselves believe and understand the intervention.

Managers may find themselves having to navigate between fulfilling their operational responsibilities, whilst also taking on feedback and change that is being provided by frontline staff and/or by the organisation⁴⁷. This can result in additional demands for managers or even be seen as a threat to their competence as managers. This was evident in one

case study on flexible work, where managers were resisting changes to shift patterns because they did not have the capacity to take on the additional work this would entail. Managers also expressed concerns that they could not reject applications for flexible work as this would lead to resentment from staff and potential conflict with the organisation.

Efforts must be made to bring on board leaders and managers^{74,76}. Examples from case studies included listening to the concerns raised from managers; building a case that short-term disruption (e.g., revising the rota pattern) can yield benefits later (e.g., better staffing levels); and involving managers in the participative process. Having examples of similar interventions and their benefits, through experience sharing from project champions or the sharing of organisational data (e.g., sickness days reduced, savings made), were also shared as useful steps to an intervention's success.

Finally, the process for managers to get involved should be made as easy as possible, with case studies doing so by demonstrating how their interventions provided additional administrative support to managers, as well as time to engage with intervention activities through reducing their work tasks.

5. Interventions are iterative

Organisational interventions are a continuous and iterative process. While numerous models exist to guide the organisational-intervention process^{29,49,77,78}, underpinning them all is the "Plan-Do-Check-Act" model. Interventions do not end once its activities are implemented. Instead, this should be followed by steps that allow for the monitoring and adjustment of the intervention, as well as the evaluation of it. Continuous monitoring should occur to allow for adjustments to be made to the intervention process to maximise the desired outcome²⁹. This was seen in the case studies where feedback from staff showed that illiteracy and low technological confidence were barriers in staff engaging with the intervention process, requiring further adaptation to the interventions.

Organisational interventions also need to be evaluated to assess whether the intended outcomes were achieved. If there is no evidence of any improvement, then there is little need to dedicate resources to the running of a particular intervention. Being able to report clear and measurable improvement is vital in obtaining the buy-in of stakeholders. In the case study on annualised hours, the intervention led to further interest and the roll out of the intervention in other areas within and external to the organisation. Several formal and informal evaluation approaches are evident across the case studies, including the use of surveys, organisational data, interviews, and staff feedback.

Evaluation is not only about whether the intervention worked, but evaluating the process of its implementation to understand how and why it worked (or not)⁵². For example, in two of the case studies, favourable outcomes were being observed until key individuals within the intervention changed their job roles. It is also important to consider the impact of the intervention on the wider system²⁹, such as where efforts to encourage more flexible working by the Trust led to more conflict with line managers when flexible work requests were not approved.

6. Plan for the long haul

If organisational interventions are meant to be continuous and iterative, then ensuring learning and sustainability is essential. This is especially the case where interventions are started and led by key figures, where the departure of such individuals has already been mentioned as contributing to the lack of longevity of some of the case studies. This makes it important to be practical and embed interventions within the existing organisational processes and practices^{27,29,77}. Not doing so hinders constructive collaboration, creating friction with other aspects of the organisation, and increases the likelihood that new ways of working are abandoned when the opportunity to do so arises⁷⁹.

Some case studies actively involved other stakeholders to facilitate the intervention's success; in doing so this changed the stakeholders' process and practices, embedding new ways of working across the organisation and increasing the intervention's sustainability. The rostering case studies shared examples where rota systems had to be integrated with the payroll system or with agencies to recruit bank or locum staff. Other examples included formalising intervention tasks so that it constituted paid time, or that dedicated staff were recruited to help with its administration.

Case studies also shared examples of using intervention data that was already routinely collected, including the NHS Staff Survey, feedback from one-to-ones with managers, sickness absence, and rota gaps. Some were attuned to the need to not only collect evaluation data but that specific data (e.g., locum spending, sickness absence days) was seen as more influential in winning support to sustain the intervention. This was not always the case, as some case studies did not realise the value of gathering evidence until much later, and in one instance it was too late to do so.

Alignment of the intervention with other organisational objectives further supports sustainability²⁹. While staff wellbeing alone should suffice as an objective, case studies attracted additional support and interest where they tapped into organisational goals around staff retention, patient safety, and cost savings⁸⁰. An example here includes updating the risk register to include wellbeing indicators. Similarly, some case studies built on existing processes and resources available within the organisation, including the work of quality improvement and patient safety initiatives.

Sustainability includes considering how transferable an intervention is to other areas of the organisation or to other organisations altogether^{29,81}. Although not many case studies had done so, those some took on board the second principle from above – tailoring the intervention to the context. In addition, project champions, developing of training material (e.g., handbooks), and sharing of learnings were also key facilitators.

Challenges included finding appropriate support from leaders and staff, different levels of resourcing, and even that there the need the intervention was addressing was not seen as an issue in the new context.

Conclusion

Case studies play a significant role in facilitating learning from organisational interventions to support staff wellbeing. Returning to the second principle above – organisational interventions are about context. By drawing on the collective experiences from the interventions in this project, we identified six principles that could guide others who are looking to improve staff wellbeing in the NHS. These interventions overlap with some principles highlighted within the research literature^{27,29,48,67,69} that reinforce these points.

This report also offers a framework to explore demands and resources at various levels within a healthcare organisation, with activities from thirteen interventions in the NHS mapped against it.

Taken together, our research shows that organisational interventions occur within a dynamic and changing context, and that interventions are not fixed events with a set start or end. Therefore, organisational interventions are never really “finished”.

As the NHS continuous to change and adapt, so too will the working experiences of staff – leading to different set of demands and resources to address. These will range from the individual right up to the overarching context. Organisational interventions may appear complex and overwhelming⁴⁷, but this report contains examples highlighting that even small changes can make a substantial improvement in the working experiences of NHS staff. Collectively, the interventions highlight that change is possible and that having some success can breed confidence and motivation to address larger, more challenging issues.

THE CASE STUDIES

1. Co-production of a fatigue risk management strategy in maternity services	27
2. Reducing 'avoidable employee harm' by improving employee investigations	30
3. Annualised hours with self-rostering in emergency medicine	33
4. Bespoke rostering for registrars in emergency medicine	36
5. 'Start Well>End Well' - Team huddles to support teaming and psychological safety	39
6. Reducing the length of multidisciplinary team meetings	42
7. Increasing wellbeing of dietitians by redesigning a clinic structure	45
8. Quality improvement huddles to support staff wellbeing	48
9. Developing a Trust-wide mental health programme for all staff	50
10. Using the Health and Wellbeing Framework to develop staff health and wellbeing	52

CO-PRODUCTION OF A FATIGUE RISK MANAGEMENT STRATEGY IN MATERNITY SERVICES

Newcastle Hospitals NHS Trust

Setting

The maternity service at Newcastle Hospitals NHS Trust, which includes one of the biggest maternity units in the United Kingdom. This intervention involved the whole labour ward team including midwives, obstetricians, theatre nurses, anaesthetists, and healthcare assistants.

The rationale for the intervention

The service was interested in addressing fatigue at work given its detrimental impact on staff wellbeing and patient safety. The consultant anaesthetist involved in the project was joint co-chair of the Joint Fatigue Working Group from the Association of Anaesthetists, Royal College of Anaesthetists, and Faculty of Intensive Care Medicine. With fatigue being a concern in the specialty nationally, there was a strong desire to move beyond discussions and to implement a strategy that would make a genuine difference to fatigue in the labour ward.

The intervention

The intervention drew on participatory action research to co-produce a fatigue risk management strategy, working with researchers from Northumbria University. This process included three cycles of action research where groups were brought together to create action plans and take forward ideas.

First, a series of focus groups and workshops were run where staff from all backgrounds could take part. These sessions sought to collect experiences of fatigue at work, and for actions, interventions, and recommendations that could mitigate fatigue.

Next, the findings were summarised for a fatigue risk management group, which consisted of 15 people representing various functions of the service from healthcare assistants to the senior midwife and clinical director. The group then discussed and ranked the proposed suggestions in terms of priority and feasibility.

Finally, working groups took forward the various actions highlighted. These included:

- Increasing awareness among staff about the importance of sleep and the dangers of fatigue, including the value of 20-minute power naps.
- Sofa beds were purchased for the service for staff to be able to use during breaks.
- Using an app linked to a FitBit to determine wearer's fatigue level.
- A review of work tasks to reduce workload overnight. This included having a more careful look at the need for category 3 caesarean sections to be carried out just before the day staff came on.
- Establishing self-rostering so that midwives could choose a night shift pattern that fitted their circadian rhythm.
- Having an extra trainee anaesthetist on call overnight so that other trainees could take power naps.

The intervention's impact on staff wellbeing

The intervention supported staff wellbeing through two processes: (i) the participatory process itself, and (ii) the actions to address fatigue.

The participatory approach facilitated a sense of control and ownership of the process. It also created a collective recognition that fatigue at work was an important issue to address. This was vital as it helped to address existing stigma around fatigue – a belief that fatigue has to be accepted as part of a healthcare worker's role.

This approach also allowed for staff to raise important areas of their work that needed addressing. This meant that it was possible to identify changes to working practices that staff knew were possible and that would likely make a difference to their experience of fatigue.

“The power that if you can do things which really touch the day-to-day lives of people in work situations and it's got to be theirs, it's got to be real. It's got to be also, their conceptualisations, their emotions, their experiences.”

Groups of staff took on different aspects of the overall approach to fatigue. Some were involved in increasing awareness amongst their peers through education. Others developed and implemented the ideas staff proposed to manage fatigue (e.g., self-rostering, getting funding for sofa beds).

“The people working everyday live it. But what could we do to try and make some changes to try and engender change on the ground across different staff groups and levels?”

Intervention outcomes

- There is an acceptance that fatigue is a legitimate issue that warrants addressing. There has been a change in work practices, such as power naps being built into the night shifts for all staff groups.
- Fatigue has been added to the Trust's risk register and is being examined by the Trust's risk group.
- There has been interest from other departments in the Trust to engage with this intervention.
- Ownership of the intervention is evident across the hospital, with champions from different levels and backgrounds.
- The work on addressing fatigue has led to activities (e.g., speaking in the Houses of Parliament) advocating for better management and recognition of fatigue in the NHS and in Europe. This includes having the same regulatory requirement for managing the risks of fatigue in healthcare as exists in other safety critical industries and extending the driving for work regulations to include driving to and from work so employers have a duty of care to ensure employees get home safely.

Key learning points and contextual factors

- Having staff who understand what the issues were helped with getting support for the action. This created a sense of ownership

which resulted in staff championing and implementing people's ideas.

- This bottom-up approach also helped to normalise and embed new ways of learning.
- Any method for involving staff must recognise the context in which they work. For example, it was not possible to set dedicated times for focus groups. Consequently, focus groups were a lot more informal where the research team set up in staff rooms at various times across a number of days to involve as many staff who were interested in taking part.
- The COVID-19 pandemic affected the intervention not long after it had begun. However, the need for rapid change helped facilitate the intervention and the subsequent adjustments, as well as staff engagement around the initiative.
- Support from senior leadership was essential to the process. The challenge was not only obtaining resources, but acknowledging the impact fatigue has on clinical performance and staff safety to begin with.
- Stakeholder support can come from diverse areas. At the Trust, this included the Trust's Guardian of Safe Working Hours and the Assistant Medical Director for Quality.
- Continual engagement of different stakeholders across the Trust was pertinent to

the development of this intervention. This ranged from informal corridor discussions to more formal meetings aimed at increasing awareness, involving stakeholders, and addressing concerns raised.

- Over time, the research and facilitation team started to withdraw from the process to empower the service itself to take ownership of the intervention. This allowed for greater learning and sustainability of processes.

Further information

- [Improving management of staff fatigue during night shift: A collaborative whole team project](#) [Report for the Health Foundation]

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REDUCING 'AVOIDABLE EMPLOYEE HARM' BY IMPROVING EMPLOYEE INVESTIGATIONS

Aneurin Bevan University Health Board

Setting

Aneurin Bevan University Health Board (ABUHB) is responsible for the planning, delivery, and commissioning of NHS Wales services for a population of over 660,000 citizens. It employs over 15,000 staff.

The rationale for the intervention

Employee investigations refers to the investigation of allegations made by and against staff (e.g., conduct, grievance). ABUHB started a programme of work to improve its employee investigations because its:

- Human Resources (HR) team identified that during a 15-month period, over 50 per cent of investigations had led to no sanctions for individuals who had been taken through them.
- Employee Wellbeing Service had been concerned about the number of clients who had experienced significant stress and trauma as a result of going through the employee investigation process.

These were the main drivers for change which led to the development of an intervention by the HR team and the Employee Wellbeing Service.

The intervention

The focus of the intervention was to reduce 'avoidable employee harm' by reducing the number of employees subjected to investigations, and to reduce the duration of investigations that take place.

This was achieved by encouraging investigating officers to focus on the initial assessment phase of an investigation. This involved obtaining, completing, and reviewing all relevant documentation so that as much information as possible was available to make the best decision as to whether to proceed with an investigation, or not. In addition, as part of this process, HR provided support to managers to enable them to consider alternative options to taking a formal route.

Underpinning this focus was an intention to take a more person-centric approach, and to develop a culture that considered opportunities for learning instead of punitive approaches such as disciplinary action.

To facilitate this change:

- An impact assessment was undertaken, reviewing an individual's experience of the investigation process in order to understand its impact. It drew on experts from a number

of professional groups: clinical and business psychology, employment law, general practice, quality improvement, HR and leadership development. This allowed for a better understanding of the impact not only on the individual, but also on the organisation's culture, reputation, and economic costs.

- HR reviewed their data on investigations. Over a period of 15-months it was found that over 50 per cent of investigations received no sanctions, and that the average length of an investigation was 156 days.
- Training material was created to inform a training day that focused not only on the process aspect of investigations, but on the people-aspect too. This was achieved through case studies, discussions, and teaching material that emphasised mitigating factors, unintended consequences, and broader perspectives.
- The training day brought together various stakeholders, including HR, investigating officers, commissioners, and staff side representatives. This was not only important to present and understand the different perspectives, but to highlight that this initiative was an important concern pertinent to different stakeholders.
- The HR operational team played a key part in the programme. The team were encouraged to reflect on their own values and acknowledge the culture of blame and missed opportunities for improvements and learning. They also considered their practice through the lens of the ABUHB's People Plan, values, and behaviours. In addition, they were empowered to use coaching and influencing skills when advising managers on whether an investigation or an alternative, informal action could achieve the best outcome.
- This was followed by subsequent monitoring and reviewing of the pilot by analysing staff feedback, ongoing HR support to teams, identifying and championing early adopters and progress.

The intervention's impact on staff wellbeing

The investigation process can be a traumatic and anxiety-provoking process for those going through it. The individual in the initial impact assessment had reported a score indicating post-traumatic stress disorder 14-months after the investigation had finished. By taking a more person-focused approach which aimed to reduce the number, and the length, of investigations, the intervention had the potential to support staff wellbeing by:

- Reducing 'avoidable employee harm' – not only for the person being investigated, but others involved in the process, such as: colleagues, witnesses, investigating officers, trade union representatives.
- Improving feelings of psychological safety within the wider organisation.
- Better understanding of how the application of policies could impact wider retention and recruitment.
- Reducing the associated economic impact on service delivery.

Intervention outcomes

- In its first six months, the programme led to a 66% reduction in new disciplinary cases being commissioned (from 42 to 14 cases). The average number of cases per month was 2.2 (down from 7.2), with a corresponding reduction in the average number of days taken to conclude an investigation (from 156 to 120 days).
- Extrapolating from the average cost of an investigation, the reduction in the number of cases has generated a potential saving of £700,000 for the health board.
- Anecdotal feedback from ABUHB teams indicates that less time is spent on investigation,

"The impact assessment, developed with an expert reference group, provided a case study to illustrate the potential harm to individuals and the organisation. The HR data provided an insight into the scale of the problem and the issues involved. Together they made a compelling case for change."

and with more timely resolution. What is also observed is less staff stress and a reduction in sickness absence.

- The reduction in cases and the length of investigation was associated with approximately 1,000 staff sick days saved.

Key learning points and contextual factors

- Executive leadership buy-in is essential. The impact assessment and HR data, along with aligning this work to ABUHB's People Plan was crucial in gaining executive support. Their commitment to making employee investigations the last resort also gave a strong signal to the organisation.
- Data is key. The data collected within the organisation helped identify and describe the issue, and consequently, to justify the intervention.
- Language supports culture change. The focus on 'avoidable employee harm' moved the focus from delivering a process well to the actual health and wellbeing of those involved.
- Staff side support is very important. This was about providing colleagues confidence in the programme, its structure, and what it was seeking to achieve.
- Showcasing learning and champions is vital. This entails sharing what people have learnt and how they have changed their thinking and their behaviours as a result of the intervention.
- Clear communication which entails being open and transparent is paramount. Ena-

bling colleagues to understand the focus of the improvement and why it is important.

- Alignment with wider organisational work ensures more effective adoption and embedding. This programme is now part of ABUHB's safety culture work and focus on employee experience, enabling more effective join up and integration.

Further information

- ['Employee investigations - Looking after the process and the people'](#) [Video]
- [Improving Investigations to Reduce Avoidable Employee Harm](#) [Institute for Healthcare Improvement Blog]

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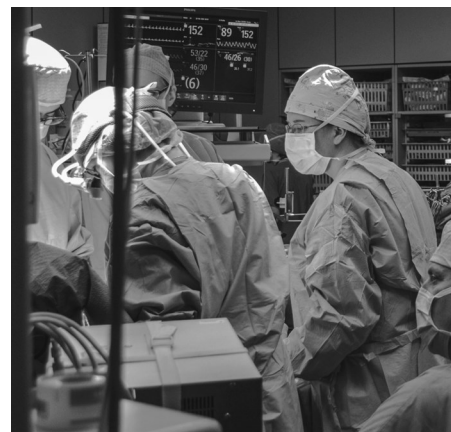
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"Early adopters – champions of the programme – were key to leading and explaining to others the need for change. They quickly 'got on board', adopting the new approaches to improve our employee investigations, demonstrating that change was achievable and the real difference that it could make."



ANNUALISED HOURS IN EMERGENCY MEDICINE

Brighton and Sussex University Hospitals

Setting

Brighton and Sussex University Hospitals became a major trauma centre in 2012 and new A&E consultant rotas were needed with provision of 24/7 hour consultant cover.

The rationale for the intervention

The Emergency Department had insufficient levels of consultant and registrar coverage, with high levels of burnout and turnover. With Brighton becoming a major trauma centre there was need for 24/7 'shop floor' consultant cover.

The rota system being used did not give doctors much influence over their working patterns, making it difficult to plan for personal events and responsibilities, or to engage in non-clinical tasks (e.g., teaching, Fellowship, professional development). The rotas were created using Excel templates and were cumbersome and administratively heavy.

A consultant within the Department recognised that an alternative approach to rostering could be a solution and spearheaded the change.

The intervention

By implementing an annualised self-rostering system, it was hoped that staff would have more control over their working patterns and still be able to meet the services needs of the Emergency Department.

This was done by viewing the rota as the team's collective hours. The clinical hours for all team members combined were added up, with annual leave, study leave, and bank holidays removed. The available number of hours was then compared with hours needed to fulfil service needs, any discrepancies then had to be filled through staff recruitment or locum staff.

The process was not compatible with existing rostering programmes, and therefore the system was first built on Microsoft Excel. Later on, through a partnership with HealthRota, a programme was developed that allowed for this form of annualised e-rostering.

In using HealthRota:

- Junior doctors can 'block out' dates they do not wish to work up to a year in advance.
- The rota automatically maps the appropriate number of staff with the necessary skill mix onto the shifts that need to be covered - allowing for staff flexibility and efficient cover provision.
- Doctors know their shift patterns up to a year in advance and can plan accordingly.

"I'd been a consultant for a year and I thought you know as a junior doctor, I thought this is rubbish, this awful, but when I'm a registrar it'll be better and as a registrar it was awful. I thought as a consultant it would be better and as a consultant it was just as bad, so I did it to stop me leaving."

- Shifts can easily be swapped via the app, without needing to go through rota co-ordinators.

The intervention's impact on staff wellbeing

The annualised rota system supported staff wellbeing by providing doctors with more control and better work-life balance. It also helped with retention and improved staffing levels, meaning a better provision of resources and support within the system for doctors. Overall, this means that:

- Doctors have the ability to plan their personal lives up to a year in advance, providing them with more control and allowing them to focus on personal and family matters (e.g., planning holidays, childcare).
- The annualised system affords part-time staff with greater flexibility. For example, doctors can do their jobs over an entire year, or, have extended periods off and making up their hours by working more intensely for the rest of a year.
- The usability of the system reduces the demands and workload that doctors have in managing their shifts (e.g., blocking out dates, swapping shifts).

"For the junior doctors it was they could get part-time jobs, not just full-time jobs. They could get non-clinical time, but they could also get married without having to swap shifts for their stag do/hen do and honeymoon, for example."

Intervention outcomes

- Survey results show that a large proportion of doctors report that the rota had been 'very beneficial' to their professional life and career (67%) and to the overall quality of their life and career (73%).
- Burnout is as well controlled as possible; doctor wellbeing has improved with a better

work-life balance and the flexibility to work when preferable.

- After five years, the Trust went from seven consultants and seven registrars in the Emergency Department to 23.8 full-time equivalent consultants and 20 registrars.
- The cost of using locums in the Department has reduced from £1.3 million before the annualised rota to only using locums to cover for sickness in 2022-23.
- Locum savings have been used to recruit for all available staff posts.
- The HealthRota rotas have led to recognition including the department being named the Royal College of Emergency Medicine's education team of the year, and receiving awards from the British Medical Journal and the Health Service Journal.
- The annualised rota system has been rolled out to other departments in the Trust (e.g., medicine) and to over 50 other emergency departments in the country.

Key learning points and contextual factors

- Participation from doctors was a key factor in getting buy-in and in fine-tuning the rostering process.
- The process was iterative in nature where different groups required different processes and needs, and there was a need for the implementation team to listen and adjust accordingly.
- Group commitment and agreements had to be made through consensus from the team.

"You won't ever be able to bring a system unless it has three benefits. One for the patients, and that's been the key one. We've had a 68% reduction in emergencies on the wards because we've got better staffing at the weekend. The next thing is about finances, and we've cut, for example, £1.3 million in locum costs in A&E alone. And then the final thing is staff welfare and benefit."

For example, teams needed to appreciate that there are ongoing needs to work week-ends, and that no staff member does more than three nights in a row.

- This ensured transparency of process but also further helps buy-in.
- The collection of data to demonstrate savings and benefit to the staff, the patient, and the organisation, was vital in bringing stakeholders on board.
- A systems perspective is needed to understand how an intervention fits with other functions. For example, rotas have ramifications for other stakeholders such as Finance and HR on matters such as compliance, staffing, and payroll.
- Although the HealthRota system substantially reduces administration, there still is a need for adequate administrators who have an understanding of doctors' rota patterns and their implications to manage the programme.

Further information

- [Using e-rostering to improve staff wellbeing and retention](#) [NHS England Digital Playbook Case Study]
- [EM-POWER: A practical guide to flexible working and good EM rota design](#) [Royal College of Emergency Medicine Guide]
- [HealthRota: An evaluation of a digital rostering platform for managing hospital doctors' rotas and leave](#) [Future Healthcare Journal Article]
- [Brighton creates a blueprint for tackling burnout, capacity issues and transforming workforce management with annualisation & e-Rostering](#) [HealthRota Case Study]

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Photo by Miguel Ausejo on Unsplash

BESPOKE ROSTERING IN EMERGENCY MEDICINE

London Hospital Trust

Setting

A busy Emergency Department within a London Hospital Trust provides emergency medical services for the local community and beyond.

The rationale for the intervention

Doctors in the Emergency Department were being staffed using a template-based rolling rota. This is a fixed rota, over a set period (eight to twelve weeks), and doctors get assigned a set of shift patterns in that rota which then gets repeated. This existing system of rostering creates a myriad of issues. Since shifts are mandated, any need for doctors to swap shifts (such as for personal reasons including childcare, weddings, or emergencies) has to be actioned on their own accord. Often this results in a set of undesirable or uncompliant shifts.

The rolling rota presented a lack of control and autonomy, was not conducive to work-life balance, and was also a big detractor to a career in emergency medicine.

An intervention was initiated when a new Clinical Lead took over who had an interest in improving the work-life balance of staff. At the same time, a Senior Registrar volunteered to take over rota allocation. The volunteer was motivated to do something better with the rotas and believed it could be improved for the benefit of themselves, their colleagues, and the department.

Both individuals believed that better rotas would help attract individuals into emergency medicine, and would help to support and retain senior registrars to progress into emergency consultant roles.

The intervention

- This intervention aimed to provide more control to registrars over their working patterns by creating a bespoke work pattern design.
- The volunteer rota coordinator mapped the minimum levels of safe staffing required across different shifts, including nights and weekends. The cohort of registrars were then asked over a six-month period to flag 'working and non-working' preferences for nights, weekends, and late shifts.
- A plan was created on Microsoft Excel over a six-month period with the corresponding staffing levels required before the rota was populated with individuals who were able to work at specific times that suited them. Where doctors had specific requests around shifts (e.g., not working every Tuesday afternoon due to childcare) this could potentially be accounted for. This created individualised rota patterns that met safe staffing requirements.
- As the intervention progressed guidance was created around what were reasonable requests and what were not. The Excel template also evolved to automate certain processes and to simplify the rostering process.
- This intervention resulted in a system where doctors received their rotas six months in advance – allowing them to better plan their time. Crucially, it meant that they had the weekends they wanted, they had the holiday they wanted, and the much-needed time off for personal matters that they needed, while

they were still meeting their shift requirements. Moreover, this also allowed doctors with Fellowships to be released for Fellowship time and activities.

- The success of this rostering system led to changes to the junior doctor rotas. However, the inability to get the names of junior doctors on rotations until the last minute meant it was not possible to approach junior doctors for their shift patterns. Instead, the template rotas were reviewed and adjusted to be more person centric. Feedback from the cohorts meant that adjustments were made every six months to make further improvements.
- Training on this bespoke rota was embedded within the induction days for senior registrars and for junior doctors. This was accompanied by a guidebook which provided more details, including a Frequently Asked Question section, and a dedicated email account to manage requests and questions.
- After managing this intervention for four years, the volunteer rota coordinator left the Trust and the Clinical Lead stepped down. Rota management was handed over to another consultant who did not continue this approach. Instead, an electronic roster was trialled.
- A second consultant has now taken over, who worked as a registrar under the bespoke system and is drawing on the principles, resources, and guidance from the intervention to integrate into their current rostering system.

“I think if you are constantly exhausted and wishing that you weren't there, I don't think you have the best experience from, delivering care but also, in learning and potentially being attracted to emergency medicine as a career if your experience of it is a hellish time in your life where you wish it wasn't there.”

The intervention's impact on staff wellbeing

Having poorly designed rotas is physically challenging for clinicians, making it difficult for them to get into any living or sleep routines. The bespoke rota gave doctors more control over their shifts and showed individuals that they were not just a number with an assigned shift pattern they had to fulfil. By giving options as to when doctors would and could work (as well as when they could not) it recognised that they were people with professional and personal commitments. This provided time and energy for doctors to pursue interests and relationships outside of the workplace.

Having more flexibility and control over their time also allowed doctors to build up their professional portfolios, which in turn, led to increasing their competence, supporting their development, and encouraging career progression. This should lead to stronger feelings of motivation, satisfaction with their roles, and improved overall mental health. It also increased the range of qualifications and the level of staffing resources available to draw from within the Department.

Intervention outcomes

- Feedback surveys from the Foundation Year 1, Foundation Year 2, and Specialty Training doctors suggest increased satisfaction with the rotas over time.
- The Department had a positive reputation with regards to the rota system, and retention during this period was very good. The Department had the best levels of staffing historically for senior registrars and vastly reduced unplanned locum costs for senior registrars.
- In the first year the volunteer rota coordinator developed the rotas in their personal time outside of work. The value of this work is recognised since, from the second year onwards of using this new system, rota allocation was managed during paid work time.

“You know if you work in a place that does make you feel cared for, prioritised, that you know you're not number and I think it changes people's perceptions on ... their longer-term engagement with the specialty”

- Anecdotally, a stronger sense of community developed that recognises ‘everyone is in this together’. This includes an understanding of what safe staffing means and how an individual’s needs must be considered alongside that of their colleagues and the Department. Individuals were also a lot less defensive and were more likely than before to accept shift swaps or take on additional shifts when cover was needed.
- This was particularly evident during the first wave of COVID, where the registrars banded together to ensure all shifts (which included more than in normal circumstances) were always covered, despite an unprecedented average level of sickness (about 25% at the peak).

Key learning points and contextual factors

- Human Resources had to be consulted and involved to ensure that they were satisfied that rotas were compliant with different regulatory and statutory requirements. Awareness had to be built with HR representatives, so they understood what was being done and why.
- The volunteer rota coordinator had to be fully appraised of all relevant legislation (e.g., the Junior Doctors Contract Amendments 2016) to ensure rotas were compliant.
- Both the Clinical Lead and the volunteer rota coordinator had been in the Department for several years and had good relationships with the registrars. There was a belief that they had the best interests of the Department at heart, and that the volunteer rota coordinator had the ability to deliver on this new rota system.
- It was important to build trust, particularly

with new starters. This meant an onboarding process for new starters when joining which not only covered the rostering process, but the purpose of this - to give more control back to the individual doctor. It also involved the volunteer rota coordinator being available to respond to queries and concerns and adjust the process where appropriate.

- Establishing clear rules and boundaries about what is in scope and what is not was vital. This helped with transparency, ensuring everyone understood how the system worked. This facilitated further buy-in and perceptions of fairness.
- Rota coordination is an administratively heavy task which should be undertaken by someone who understands the role and needs of clinicians as well as compliance. Given their already heavy workloads, many clinicians are reluctant to take on the additional job of rostering staff. Some senior clinicians prefer a template rota as these are easier to administer and are familiar to them since this is largely how rostering takes place within the NHS. When rotas are administered by admin staff there can be a lack of true understanding of a clinician’s role, such as appreciating the implications of working a run of night shifts, or the challenges from moving onto different shift patterns. Where rotas are self-administered, the challenge can lie in ensuring appropriate levels of staffing of all shifts and that rotas remain compliant.
- In this instance, not leveraging technology further to make the rota creation process easier made it tougher to hand this intervention over to a new person. The lack of formal evaluation data also meant that it was difficult to develop a business case for further resources to embed and grow the intervention.

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'STARTWELL>ENDWELL' – TEAM HUDDLES TO SUPPORT TEAMING AND PSYCHOLOGICAL SAFETY

North Bristol NHS Trust

Setting

North Bristol NHS Trust provides community healthcare and hospital services to Bristol, South Gloucestershire, and North Somerset, employing over 13,000 staff.

The rationale for the intervention

'StartWell>EndWell' came out at the start of the COVID-19 pandemic in response to challenges around how best to support the formation of new teams to care for patients with COVID-19. This presented a climate of significant pressure and uncertainty, anxiety around PPE (or lack of), and a reality that staff were working with colleagues and in settings they were not necessarily familiar with. Senior medical colleagues shared concerns about the impact this would have on colleagues' wellbeing, and ability to work effectively as a team, and asked the Staff Psychologists for help, within the reality that there was a lack of time for staff to access training and support.

Therefore, the question was: how best could colleagues collectively enhance the existing teaming process - by including behaviours that foster a cul-

ture of support and psychological safety, alongside core operational processes?

The intervention

A group of senior medics, nurses, and quality improvement colleagues with the Staff Psychology Team co-developed the approach.

'StartWell>EndWell' is a flexible framework that consists of three core elements: step 1 – the check-in; step 2 - a peer-to-peer PITSTOP (i.e., hot debrief); and step 3 - the process for end of shift checkouts.

- Step 1 is the team check-in - an enhanced safety briefing. This supports staff to arrive well, providing an opportunity for staff introductions, to check-in with colleagues, review work allocations and equipment, discuss any current or anticipated difficulties, and to encourage a climate of speaking up (e.g., if someone has concerns) whatever their role.
- Step 2 is a peer-to-peer hot debrief process, which is encouraged when teams experience something challenging during their day. This

provides an opportunity to briefly pause together, review what is happening and what the team needs moving forward during their shift, as well as signposting to additional wellbeing support as needed.

- Step 3 is a team check-out process that encourages colleagues to share the remaining workload, to review what has gone well and what the team are proud of, to thank one another, and to promote self-care so that colleagues can transition from work to home, to rest, and to recharge.

Where teams are interested in the intervention or a local need is identified, initial conversations with the 'StartWell>EndWell' Team start with exploring their unique context, their existing strengths and needs and whether 'StartWell>EndWell' approaches may be useful with this in mind. Core to the approach is encouraging teams to adapt the framework, to help embed and sustain it long term.

The StartWell>EndWell team provide ongoing support to teams through training, observing huddles, and further adjusting the intervention framework to suit the team.

The discussions also offer an opportunity to signpost other training or wellbeing offerings that run within the Trust.

"it came from this need of thinking about wellbeing, thinking about effectiveness, but with the very real challenge of there being very little time."

The intervention's impact on staff wellbeing

The premise of 'StartWell>EndWell' is to support healthy and effective team process. By embedding principles of psychological safety, human factors, compassionate leadership, and behavioural science into routine work processes, the programme facilitates peer connection, team effectiveness, and a healthy working climate where colleagues feel able to speak up. It also enables all colleagues to be

aware of and encouraged to access the wide range of additional wellbeing support available within North Bristol NHS Trust. By building in space for gratitude, it also facilitates recognition, appreciation, and value for all those involved.

Intervention outcomes

- There has been significant interest in accessing the resource within the Trust, and a number of clinical and non-clinical teams have embedded elements of the intervention into their every-day practices, e.g., introducing daily check ins (either at the start of the day or a time that suits their context), having a buddy system for checking out.
- Outcomes of the intervention can focus on a myriad of different factors. In some contexts, there might be a stronger emphasis on staff wellbeing, but in others, it may be patient safety. Underpinning both is the teaming process which 'StartWell>EndWell' aims to address.
- As well as a fully editable framework, the team have created PITSTOP training materials and step-by-step guidance notes, and a StartWell>EndWell implementation pack which has been shared freely with colleagues working across health and social care.
- Within North Bristol NHS Trust, over seventy staff have attended an interactive PITSTOP training session, which supports them to use the approach as needed in their area.
- Plans for 'StartWell>EndWell' to be weaved into existing safety briefing template across the Trust with the hope that it becomes part of the culture of the organisation ('the way we do things here').
- Facilitating a number of trust-wide and team-specific workshops to support teams in adapting and embedding the approach.
- Qualitative evidence indicates that teams value the work, for example teams have shared an increased sense of morale and

“What we’re really seeing is that actually the teams that seem to be able to navigate challenges well, are often the teams that feel like they’re making a difference, that this difference is recognised, and that they feel like they’re making a difference together, that there’s a sense of belonging, a sense of being part of a supportive unit.”

belonging, feeling more able to speak up (e.g., around fatigue, and the challenge of shift work), and are more aware of the wider wellbeing support available.

- Over 70% of trusts in the country have been in touch to ask for copies of the ‘StartWell>EndWell’ programme, with some further developing the approach across their trust.
- The team have been invited to speak to a national audience, including at NHS E&I and other conferences.

Key learning points and contextual factors

- There seems to be a real appetite for supporting team wellbeing and effectiveness, but a gap between the need and how to meaningfully foster this in practice.
- To support enthusiasm and engagement, and increase sustainability of the approach, the StartWell>EndWell team firstly benefits from taking time to get to know a team and their strengths, needs, context, and what elements of ‘StartWell>EndWell’ would be most helpful to begin with.
- The framework itself is guide, rather than an ‘off-the-shelf’ finished product. For this to be sustained, it needs to be co-developed with a team and adapted to their context, and part of an ongoing process of service improvement.
- Being mindful of the language used and the reactions this can evoke. There has lately been pushback around the term “wellbeing”

and about what can be seen as “quick wins” or individual-focused interventions. Care is needed to explain the aim and rationale for ‘StartWell>EndWell’.

- Having senior medical colleagues, particularly those who are visible, has been important to not just champion the approach but role model and champion it (senior leaders are culture carriers who set the tone).
- StartWell>EndWell is more straightforward to implement in new settings where it can be embedded from the start as part of ‘how we do things here’. In existing teams, the exploratory collaborative approach described above is key and perhaps starting with one small shift at a time.
- To sustain the intervention and to scale it up across an organisation there is a need for more dedicated staffing resources to do the on-the-ground work with teams, and active support from the senior board. It’s also important to identify key champions in local areas.

The ‘StartWell>EndWell’ team would like to extend appreciation to wider colleagues who helped shape the approach.

Further information

- For enquiries about StartWell>EndWell or to request the implementation pack, please email StartWell>EndWell@nbt.nhs.uk.

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REDUCING THE LENGTH OF MULTI-DISCIPLINARY TEAM MEETINGS IN COMMUNITY CARE

Kent Community Health NHS Foundation Trust

Setting

The Thanet Neuro Rehabilitation Team is part of the Community Rehabilitation service in Kent Community Health NHS Trust. The team, with six staff members, provides therapeutic rehabilitation for housebound adults with a neurology diagnosis for the Thanet community in east Kent.

The rationale for the intervention

The Neuro team's monthly multi-disciplinary team meeting (MDT) – which comprised of assessing the progress of cases under the team's care, as well as providing peer support to colleagues - was taking approximately six hours from start to finish. The process of the MDT was copied from the Stroke team several years before. However, in Neuro Rehabilitation, over time, the MDTs were seen as a source of strain that staff did not look forward to. Eliminating these meetings was not an option. The Clinical Lead, along with the team, came together to figure out a way of improving the MDT experience for all.

The intervention

Discussions with the team resulted in agreement that it was the length of time which was the primary problem. Through discussions and trialling new processes over a six-month period, the length of the MDT meetings was brought down from six to three hours, by:

- Changing how cases were being discussed. Instead of reviewing all cases, the meetings focused on the team's active caseloads. This meant that there were fewer cases to review but more time could be spent on each.
- Boundaries were set as to what should be shared – i.e., asking the team what needed to be discussed for each case to be reviewed. Associated information that was not relevant (e.g., an entire case history) was thus avoided.
- The meeting process was changed so that each person could present their active case (s) for discussion as well as ask for feedback. This was seen as an improvement on the previous process of the team being guided

“They were really happy to see each other, they felt as though clinically they were actually benefiting from it rather than just like a tick box exercise. They felt that it was a good use of time and because it reduced the time down, and that then the treatment that we're giving their patients was a lot more efficient.”

by a spreadsheet where specific factual information had to be populated for each case.

- A decision made by the team to focus on the exact nature of data required, per case, to be stored in an Excel spreadsheet. The original process of keeping track of cases and updating them on an Excel spreadsheet took up a lot of time. The intention was to remove the Excel spreadsheet altogether; however, the existing health record system was not able to quickly and easily provide the accurate information when needed. Instead, the team reduced their workload by focussing on inputting data that they needed, rather than collecting and inputting data that was, in hindsight, redundant.
- Roles were created for each team member and these were rotated across each person and at each meeting. Everyone had a task. When one person presented their cases, another would complete the spreadsheet, and another would complete the electronic health record.

The intervention's impact on staff wellbeing

The changes to the MDT processes reduced the amount of time the meetings took. This meant there was more time for each staff member to dedicate to alternate tasks, improving their capacity to deal with their workloads.

Instead of being led by working through a spreadsheet, often gathering redundant information, staff took turns to share their caseload. This gave everybody a dedicated and focused space to share their

own experiences, and to get feedback on their work. Therefore, there was more insightful and deeper discussions that were more useful for learning and reviewing patient care.

The clarity in roles during the meeting led to a shared understanding of each other's duties. It also meant everyone knew what had to be done and there was a set process in which this would occur, saving further time in having to establish who was doing what.

The new format also meant the team could challenge each other about information that might not be relevant, and to bring discussions back to the purpose of the meeting.

Having shorter meetings provided more informal time for the team to connect before and after meetings. This was important for team bonding and dynamics, allowing colleagues to catch up both about work and more informal matters.

“if you don't believe in the changes and you don't feel as though it's working, the chances are you're just going to revert back to what you're doing before because they're not really watching you anyway.”

Intervention outcomes

- The length of MDTs reduced from about six to three hours.
- Despite the reduction in time, the average time for discussing each patient's case increased to 4.4 minutes compared to 3.3 minutes before the intervention.
- Anecdotally, rather than being something that was dreaded, MDTs became a meeting the team looked forward to. There was a stronger sense of a community, and the meetings were seen as an important source of learning and personal development.

Key learning points and contextual factors

- Working to address an issue that the team had identified made it easier to get people on board, and to justify why changes were needed. This buy-in was important for the sustainability of the intervention.
- Change requires an iterative process. Across the MDT meetings the team would change aspects of the meeting, assess how it went, before tweaking the meeting further based on what worked and what did not.
- Considering the implications of changes is vital. Although there was an intention to remove the team spreadsheet of cases, this was not possible as the existing system would not be able to replace it.

Further information

- [Reducing The Length of a Multi-Disciplinary Team Meeting](#) [Kent Community NHS Trust QI Project]

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Photo by National Cancer Institute



RESTRUCTURING THE COMMUNITY DIETETIC SERVICE CLINIC STRUCTURE TO IMPROVE STAFF WELLBEING

Kent Community Health NHS Foundation Trust

Setting

The Community Dietetic Team is part of the Kent Community Health NHS Foundation Trust. The team, with 33 dietitians and assistants, provide nutrition advice on a wide range of general and specialist nutritional needs for children and adults.

The rationale for the intervention

As part of the service the team offered, clinics were held either in the morning or in the afternoon, with back-to-back appointments. These were a mix of new patients (40 minutes) and follow-ups (20 minutes) patients.

During the pandemic, patients being seen were more unwell and complex than usual. This meant a higher workload with more administrative paperwork, onward referrals and safeguarding concerns to manage.

At the same time, in their one-to-one sessions with managers, staff within this team reported falling behind on their paperwork, as well as high workloads, and feeling stressed.

"We do have to work hard in the NHS there's just no denying it, and the harder we have to work as staff the more tricky things become, so they need to feel that the process even if they're working hard is a fair process to, you know, and we've listened to everything they say."

The operations managers within the service saw the implementation of a new computer system being rolled out centrally as an opportunity to rebuild a new clinical structure.

The intervention

To start, the team organised a workshop to bring together clinicians and managers to review the issue. It was clear to everyone that paperwork was the issue, and that the clinic system had to be overhauled. To better understand the situation:

- Clinicians carried out a time-and-motion study, where they broke down every task they did pre-consultation, during consulta-

tion, and after consultation. This was detailed down to the individual minute to understand what the different tasks were and how long they took. The time per task was then averaged out across the team.

- It was evident that paperwork took considerably longer than expected, and that there was an increase in paperwork over the years. For example, historically there were less complex consent forms and fewer safeguarding checks.

These steps led to changes where:

- Clinics now ran for an entire day, allowing patients more flexibility to pick a suitable time slot to be seen with their clinician.
- The structure of the clinic was changed to a 'see do see do' approach, allowing clinicians to complete paperwork straight after each appointment. This was achieved by increasing all new and follow up appointment by 20 allowing for the completion of the necessary paperwork.
- The ratio of new appointments to follow-up appointments was adjusted to better meet the needs of the service. This helped with service delivery and to manage waiting lists.

The intervention's impact on staff wellbeing

In the old system, the back-to-back appointments, and the difficulty in completing all the required paperwork, meant that staff were exhausted by the end of their clinics.

The new structure allowed clinicians to feel a lot less rushed, allowing them to feel less stressed. There was less of a need to work longer hours, allowing for better work-life balance.

"Our staff know what the issues are... they're the ones doing the day job all day everyday and as we know, recruitment and retention is a nightmare in the NHS at the moment. So you know to retain our staff, we have to make sure that we're listening to their feedback"

Having more tailored structure that could account for different staff working patterns (e.g., part time) meant fewer workarounds, errors, and corresponding demands when things did not go to plan.

In providing a longer appointment there was less time pressure on the clinicians during appointments, reducing the frequency of follow up appointments and future demands on the service.

The additional time ensures clinicians feel that they have scope to provide a better level of care. This in turn would reduce the level of moral injury (i.e., the distress where someone is not able to provide the level of care that they want) within an individual.

Intervention outcomes

- Staff wellbeing improved post-intervention, with 44% of the team reporting being happy (up from 6% before). In comparison, the number of people reporting being unhappy post-intervention was lower than pre-intervention (6% down from 17%).
- Before the intervention, no team member was able to complete their paperwork during clinic hours, while post-intervention 29% said they were able to.
- The time it took to complete paperwork after clinic also reduced. Pre-intervention, 60% of team members indicated it took them an extra 3 hours or more to complete their paperwork, and 40% said it took between 2-3 hours. Post-intervention, 26% reported it took them less than an hour, 24% took between 1-2 hours, and 2% took 3 hours or more.
- Clinicians also reported that rather than having to get started on paperwork at the end of the day, the change in structure meant they were only having to touch up final bits of paperwork at the end of the day.

Key learning points and contextual factors

- Account for the need for learning and familiarisation. Here, this was done by building

additional time into the system for the first couple of weeks for clinicians and administration staff to get used to the new process.

- The intervention remains a work in progress. There are aspects that still need to be adjusted, such as adjusting clinic times by patient diagnosis and ensuring administrative staff are booking clinics correctly.
- Staff involvement was key to the intervention's success. The primary changes to clinic structure were not what was originally proposed, with staff input essential to change the structure to one that was relevant to the work of all team members.
- The rationale for the changes was driven by time data shared by staff. As the changes made were based on input from staff it meant that there was little pushback from staff to the intervention.
- The active involvement of staff during the intervention contributed to a sense of feeling listened to. It also helped with a collective understanding of how individual needs had to be balanced against the needs of others and the expectations of the service overall.
- The demands of patients and the health service are constantly evolving. An awareness of this is vital because there needs to be ongoing evaluation of the service to ensure

Further information

- [Increasing Wellbeing of Dietitians by Redesigning a Clinic Structure](#) [Kent Community NHS Trust QI Project]

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that it is relevant for patients as well as clinicians. Just because something has always run a certain way does not mean that it is always appropriate.

- The involvement of managers together with clinicians helped managers better understand the roles and duties of clinicians, and the expectations that managers had of their staff.
- The longer time allocated for new patients also meant that more time is lost when a patient does not turn up. This could not be filled to catchup with paperwork as clinicians were generally on top of their paperwork. Instead, a list of urgent patients that could potentially be contacted was created to try and fill this gap when it occurred.



Photo by Drew Hayes

QUALITY IMPROVEMENT HUDDLES TO SUPPORT STAFF WELLBEING

A Hospital Trust

Setting

This Hospital Trust is a major provider of integrated hospital and community services for people living in the area.

The rationale for the intervention

Quality Improvement (QI) huddles started in pharmacy. The Chief Pharmacist had learnt that another organisation had been able to improve a struggling department and believed that it could also lead to improvements in her own department.

The intervention

QI huddles start with an idea for an improvement. Together the team discusses what the problem is, why it might be happening, and generate potential solutions. The team then decide if an action has the potential to be high or low impact to address the issue, and if the action would be hard or easy to run. They then vote on the actions to be taken and decide who might lead on the action and what the first step might be. The huddle then ends with a celebration (e.g., of an accomplishment) to help people focus on successful outcomes.

The first huddle in pharmacy identified a common problem faced by new staff – they could not read the pharmacist’s handwriting. This was a contributing factor in many failing their logs. Through discussion and explanation this long-standing issue was resolved in a week.

This reframed how the pharmacy department viewed their problems and gave them the motivation and confidence to make other improvements.

The successes in the pharmacy led to the role-out of this initiative to other areas of the organisation, including the spinal unit as well as finance.

“I found out an awful lot of stuff that was known but not known to me. In as much as there were problems that I didn't encounter because of my level of my experience, but new members of staff all came up with the same problem.”

The intervention’s impact on staff wellbeing

Wellbeing is typically not the main focus of the QI huddle but instead is seen as a potential by-product. In improving an aspect of work, the QI huddle can reduce frustration and improve focus on a task deemed important for staff, which in turn leads to a better state of wellbeing. By increasing efficiency, QI huddles can also reduce overwork and reduce the level of effort needed from staff.

The collective identification of issues leads to a shared understanding. This facilitates perspective taking from the vantage point of others and helps bring to light issues relevant for all but which some may be unaware of.

The focus on action and team empowerment increases the sense of agency and control that an individual or team has over their working environment. This helps to foster a sense of belonging, voice, and increased motivation.

QI huddles can focus on very different improvements. Therefore, the link to wellbeing will be different. For example:

- Working to reduce the number of overtime hours led to better work-life balance and more rest opportunities.
- Changing process to ensure medication is immediately topped up in the wards meant staff do not have to physically rush around searching for medication when needed.
- Reducing the number of pharmacy staff failing their logs because they could not read the handwriting of the pharmacist reduced feelings of failure and self-doubt.
- Changes to process in pharmacy meant fewer pharmacology errors and misunderstandings. Therefore, time was saved in having to clarify information or rectify errors.
- Reducing the number of complaints received saved time which would otherwise be spent on addressing each complaint. This process shift also avoided the emotional demands that this process entails.
- Changing the process of how electric wheelchairs were returned to the spinal injury centre reduced musculoskeletal demands on staff.

Intervention outcomes

Overall, at the Trust level:

- The QI huddles now run in 47 different areas of the Trust.
- Where QI huddles are operating, this is often accompanied by an increase in engagement scores on the NHS Staff Survey.

Focusing on specific examples:

- Changes to work practices have led to pharmacy staff finishing the day between 5.30pm – 6pm rather than 7pm – 9pm.
- In pharmacy, sickness absence rates reduced and retention improved.
- Developing training material to contain audio to make it more accessible to staff with lower rates of literacy.

Key learning points and contextual factors

- Leadership buy-in is needed for huddles to run successfully. Leader involvement reinforces the notion that huddles are important and time worthy.
- The collaborative and team element of huddles gave space to challenge long-standing practices and issues, including the role of senior people within it.
- As teams started to improve their work and environment through huddles, it gave them the confidence and support of others to address larger issues.
- Huddles work best when teams take ownership to identify issues and develop solutions. This facilitates learning and sustains the intervention over a longer period.
- Huddles work to make improvements to the current working environment within the existing parameters but cannot address major issues like lack of staffing or physical space. However, issues can be escalated to senior leadership for their involvement.
- Teams cannot address all aspects. This means involving more specialised colleagues where relevant (e.g., occupational health, organisational development).
- Although there is a core structure to the huddles, there has to be adjustment to the local context to account for differences in work practices (e.g., literacy, virtual teams) and resources available (e.g., data, technology).
- Sharing successes and good practice is important to provide recognition to teams and individuals. This helps motivate and sustain the huddles. It also facilitates learning across the organisation.

“I got praised for that. You know, that made me feel good. I’ll do that again. What else could I do? Which kind of feeds the positive rather than the negative base”.

DEVELOPING A TRUST-WIDE MENTAL HEALTH PROGRAMME FOR ALL STAFF

Wye Valley NHS Trust

Setting

Wye Valley NHS Trust employs over 3,600 staff to provide health services to the people of Herefordshire and further afield.

The rationale for the intervention

In July 2020, the Trust appointed a new Human Resources Director. The Trust had high sickness absence due to mental health and was experiencing great challenges in supporting staff during the COVID-19 pandemic. This triggered the search for a better way to support the health and wellbeing of staff more systematically. The Trust reached out to the Mental Health Productivity Pilot (MHPP) for support to do so.

The Mental Health Productivity Pilot was launched in 2019. It is a collaboration of Midlands universities and partners working together to support Midlands' business communities and their employees improve workplace mental health and to reduce the impact it has on sickness absence, presenteeism, and productivity.

The intervention

The MHPP approach first takes a deep dive into the Trust, to establish how the workforce is structured, what wellbeing initiatives are available, what the uptake is, and what the main challenges are.

This involved an initial survey, organisational data

analysis, and conversations with key stakeholders (e.g., Human Resources, managers, and Occupational Health).

Reviewing the key themes, several priorities were identified. First, the HR Director felt there was a need for more ownership for staff to get involved in wellbeing and to drive this work forward.

Next, it was felt that the COVID-19 pandemic made it difficult to change work patterns, and instead the emphasis was on giving staff space to share their thoughts and feelings, and to know where to go for additional support.

In addition, managers wanted more assistance with supporting staff struggling with their mental health as well information around how to manage conversations around mental health.

This was done through several ways:

- Training for managers on managing mental health conversations, including the provision of resources and toolkits to facilitate such conversations.
- Workshops on topics identified by staff, including: financial wellbeing, self-care, and mental health stigma and discrimination.
- Developing partnerships with local universities to upskill the workforce and widen the recruitment pool (e.g., apprenticeship programmes).
- Creating spaces, at the local level, for healthcare workers to work on their own wellbeing initiatives (e.g., creating wellbeing

sessions, requesting training needs, building peer support).

- Improving knowledge of mental health first aid and increasing recruitment of mental health first aiders.
- Reviewing sickness absence data and trends and developing more targeted support for managers, occupational health, human resources to identify root causes, rehabilitation, and return to work processes.

A cornerstone of the intervention was to listen to staff feedback and adjust the intervention accordingly. For example, managers raised the need for more specialised support for the management of the return-to-work process for staff.

“We always communicate the findings of the survey and the focus groups back to staff and say this is what you've said, and this is what we're going to do about it, so it's very much and you said, we did.”

The intervention's impact on staff wellbeing

The intervention focused on developing a culture of mental health and wellbeing. The aim was for staff to feel supported and know where to go to for more help.

By focusing on support and improving peer networks, this meant that staff had opportunities to get both emotional (e.g., how are you feeling?) and informational (e.g., can I help you with this task?) support.

There was a focus on raising awareness around reducing stigma associated with mental health, and to improve the conversation around it. The intervention also worked with senior leaders to embrace a culture where staff mental health is seen as non-negotiable.

Intervention outcomes

- Health and wellbeing has been included as a key agenda for the Trust's five-year plan.
- This has led to a visible emphasis on the im-

portance of mental health. This is evident in: highlighting the Mental Health at Work Commitment the Trust made in job advertisements, integration into the induction process, inclusion of wellbeing as an agenda item in meetings, and discussion of wellbeing as part of the supervision process for all staff.

- The Trust have rolled out and attracted significant interest in their mental first aid programme, and now have over 150 champions within the organisation.

Key learning points and contextual factors

- Recognise the importance of managers. Here, many of the initiatives targeted managers first before rolling out to staff. This was to increase their awareness of what was being done, to role model good behaviour, and to equip them with tools so they were better able to support their staff.
- Although challenging, it is important to emphasise the longer-term benefit of the work being done. This was helpful in getting staff and managers to engage in the process when time poor.
- The intervention process has to continuously evolve. Specifically, evolution occurred in: the engagement methods used with staff, delivery modes, and training topics covered based on the feedback from staff and stakeholders.
- It is vital to consider how information about the intervention is communicated to staff. There was a need to be mindful of how messages and interventions might be received by staff who were busy, stressed, and struggling with the pandemic.

Further information

- [The Mental Health Productivity Pilot](#) [Programme website]

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USING THE HEALTH AND WELLBEING DIAGNOSTIC TO GUIDE WELLBEING PROGRAMMES IN ICS

Norfolk and Waveney Integrated Care System

Setting

The Norfolk and Waveney Integrated Care System (ICS) brings together NHS organisations, councils, public services, and voluntary and community partners to work together as one integrated health and care system.

The rationale for the intervention

The Health and Wellbeing diagnostic project at Norfolk and Waveney ICS started in response to the launch of the Evolved Health and Wellbeing Model in January 2022.

Coming out of the COVID-19 pandemic there was a need to better support staff wellbeing to improve staff retention and recruitment, and to meet service delivery needs. This led the Integrate Care Board to place a stronger emphasis on staff wellbeing so that staff can provide better care for patients.

The intervention

The intervention is based on the Health and Wellbeing (HWB) Culture Change Toolkit that reflects the NHS HWB Framework. It contains 63 questions grouped into seven HWB domains that represent 16 elements. These seven domains are: professional wellbeing support, data insights, environment,

managers and leaders, fulfilment at work, relationships, and improving personal health and wellbeing.

Each participating organisation in the Norfolk and Waveney ICS self-assessed against the HWB Culture Change Toolkit. Results were then collated to obtain an overall metric for the ICS. The data was triangulated against scores from the NHS Staff Survey, from organisational leads, and feedback from different staff network groups to determine areas for improvement.

Overall, the ICS had an average rating of 'Significant Progress'. This means several successful interventions are in place across many providers, supported by strong data to suggest the provision is working for most. However, two areas were scored as being of concern: 'managers and leaders' and 'data insights'.

Working together with each organisation's leadership team and stakeholders (e.g., wellbeing leads, wellbeing guardians, unions), priorities were then agreed. This led to a series of workstreams to develop actions aimed at addressing the priorities.

"The problem with health and wellbeing is it is still very reaction based... We've never actually sat down before and gone wellbeing is important, what can and should we actually do?"

For example, to address ‘managers and leaders’, a restorative and just culture workstream was set up to address bullying and harassment within the service, and to improve feelings of trust towards managers. Over a three-year period, this involves:

- Training staff on the Restorative and Just Culture Training Programme.
- Linking organisational data and metrics to restorative and just culture outcomes.
- Revising disciplinary, grievance, and bullying and harassment policies.

Other workstreams addressing associated priorities have also been identified with corresponding actions being developed. These include:

- Standardising methodologies across the ICS, with better and more consistent use of data to inform decision making.
- Developing leadership competencies and training that focus on managing HWB.
- Better supporting women’s health by working towards being an accredited menopause friendly organisation. This involves rolling out menopause advocate training programme across the ICS and revising organisational policies to fit this.
- Developing an attendance policy that encourages staff to engage with work to some degree if able to. This is in contrast to an absence policy which forces staff out completely for a period of time, potentially to the detriment of the individual and the organisation.

“We’re called knitters like we knit together people and make people talk to. Either by having those sort of positive or challenging group discussions... it’s really helpful.”

The intervention’s impact on staff wellbeing

Through the identification of wellbeing priorities with the diagnostic tool, a more realistic understanding of the wellbeing needs and offerings are able to be mapped. If done right, this can foster a

culture where staff feel supported, respected, and looked after.

The participation process involving leaders, various leads, staff networks, and working groups with the front line staff, provides a sense of agency and control over the working environment. Amongst staff, this also helps facilitate a sense of being listened to and recognised by the wider organisation.

The specific interventions or actions being developed would affect staff wellbeing in different ways. For example, work towards eliminating bullying and harassment in the organisation would reduce levels of psychological distress experienced by the victim or bystanders. Similarly, having more person-centred policies and procedures would encourage greater role clarity and feelings of support by a particular individual.

Intervention outcomes

The programme is approaching its first year of operation and there has been little formal evaluation. However, some indicative outcomes include:

- Greater collaboration across different groups than before which address staff wellbeing issues (e.g., with the unions).
- Interest in the training programmes (e.g., restorative and just culture, menopause advocacy) is high, with additional places being funded by organisations within the ICS as well as from groups such as the union and NHS England.

Key learning points and contextual factors

- Wellbeing interventions and actions need to be grounded in data. The HWB Diagnostic provides a local justification for a need

“The staff are the single most important thing before the patients get the care; if the staff are happy, well looked after, and cared for the patients benefit”.

which leads to the development of corresponding actions to explicitly address workers' needs.

- Not all organisations have relevant data to identify needs or to evaluate interventions. Therefore, it is difficult to know for sure whether one's wellbeing approach is working.
- It can be hard to balance what needs to be done quickly, as structural, and cultural change takes a long time to unfold.
- Active communication is needed to inform and involve frontline staff across the organisations within the ICS. Engagement with staff networks (e.g., BAME networks) or representatives (e.g., unions) are important to not only getting feedback on the intervention process, but to sharing the findings and decisions with the wider workforce.
- Involving stakeholders that are needed to support the intervention is vital. The workshops and discussions in this intervention involved senior managers and the wellbeing leads from the various organisations. This meant top-level support was available.
- Collaboration across different groups (e.g., human resources, unions, organisational

development) or organisations (e.g., different trusts) was important for learning and for sharing resources. This reduced the collective workload of the group.

- Expectations have to be managed. It is a challenge to balance what one would like to do (e.g., spend more time with senior stakeholders, more involvement of frontline workers) against the reality of not having the time or resources to do so.
- The wellbeing programme is not mandatory. Therefore, it must be made clear what organisations and individuals gain from taking part. External speakers and case studies are brought in to share learnings to encourage further engagement and uptake with the programme.

Further information

- [Using the NHS Health and Wellbeing Framework successfully](#) [NHS England Report]

Key contact

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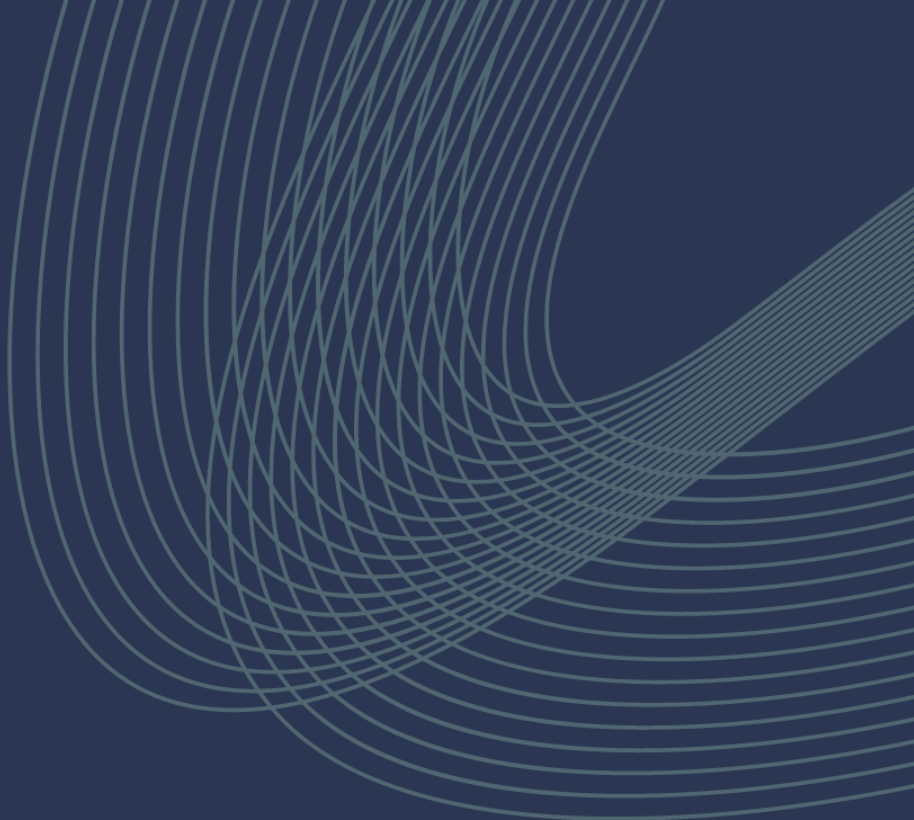
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