Organisational-level interventions for Workplace Mental Health in the UK Health System.

The first half of this digest summarises a report (March 2023) with four aims, to:

1. Identify *examples of organisational interventions* to improve NHS staff wellbeing;
2. Map out how these interventions attempt to *reduce demands and increase resources at five levels* (the individual, group, leader, organisation, and overarching context);
3. Identify the *barriers and facilitators of success* for organisational interventions, and:
4. Summarise *key recommendations* to encourage more, and better, organisational interventions to support staff wellbeing.

The second half summarises the organisational interventions in the study (pp. 26-54 of the report)

Study Background

The study was led by Dr Kevin Teoh and Dr Rashi Dhensa-Kahlon from Birkbeck, University of London, in collaboration with researchers from the University of Sheffield, the University of Nottingham, and the Norwegian Science and Technology University.

It was funded through the Birkbeck Wellcome Trust Institutional Strategic Support Fund and supported by the Society of Occupational Medicine.

Definition of organisational intervention: Also known as primary interventions, organisational interventions make changes to how work is designed, organised, and managed.

The report is available here and a webinar about this study is available here

Scope

13 organisational interventions were studied. They include 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, see the report annex for summaries.

Methodology

Interviews: With 17 individuals and teams that have run organisational interventions in the NHS to support.

Desk reviews: Reviewed published material related to 13 interventions.

Analytic frameworks: Demands and resources that these interventions aimed to address were identified, then intervention activities were mapped across five levels: the individual, group, leader, organisation, and context. The analysis used two theories:

1. The Job Demands-Resources Model[1]: identifies the demands in a particular workplace, how they can be reduced or removed and focuses on identifying what resources need increasing or improving to help staff do their work, meet their psychological needs, or

[1] Bakker, AB and Demerouti E. 2018, 'Job demands-resources theory: Taking stock and looking forward', *Journal of Occupational Health Psychology*, vol. 22, no. 3, pp. 273-285.

mitigate the effects of demands.

2. IGLOO2: views demands and resources at different levels - the individual, group, leader, organisation, and overarching context. IGLOO is a framework that provides a systematic approach to understanding the value of org. interventions, and building recognition of antecedents to staff wellbeing, and actions needed to intervene, exist across different levels.

Findings

In total, eight demands were identified: workload, emotional demands, stigma, conflict, manager expectations, physical demands, and work-life conflict.

In total, fourteen resources were identified: 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.

Other findings:

- Demands were only seen at the level of the group, leader, and organisation.
- Resources were found at all levels.
- There were more org. interventions that enhanced resources than reduced demands. This is likely because activities that reduce demands are likely more challenging to address than enhancing resources.
- Because demands are more strongly linked to burnout, while resources are more strongly linked to work engagement and motivation[3] more effort is required to reduce demands by targeting staff burnout and other forms of ill-health.

Take aways

The research team provided a summary of their learnings from across the interventions in the form of 'six principles to guide organisational interventions to support staff wellbeing' These are:

1. Staff wellbeing is a systems issue
2. Interventions must be tailored to fit context
3. Staff should be involved in the process
4. Getting support from leaders is vital
5. Interventions are iterative
6. Long-term planning is necessary

Relevance and implications for the Vic Emergency Services Sector

The work environment of the National Health Service (NHS) in the UK is very different to the Emergency Management sector in Victoria yet there are several overlaps that make this study

[2] Nielsen K, Yarker J, Munir F and U. Bültmann 2018, 'IGLOO: An integrated framework for sustainable return to work in workers with common mental disorders', *Work Stress*, vol. 32, no. 4, pp. 400-417.

[3] Teoh KR-H, Hassard J and T. Cox 2020, 'Individual and organizational psychosocial predictors of hospital doctors' work-related well-being', *Health Care Manage Rev*., vol 45, no. 2, pp. 162-172.

relevant. For instance, both sectors, regardless of country, have high pressure work environments, shift work, and the risk of exposure to trauma. In addition, the topic of this digest aligns with WorkSafe's mandate about organisational factors for psychosocial safety. Notwithstanding the fact that exposure to trauma is unavoidable and so evidence-based programs are needed, changing work design is, as it is for the UK NHS, the less common yet most important kind of MH intervention overall because it can reduce or eliminate primary causes of stress.

ANNEX: Summarises of case studies of organisational interventions.

This list is a summary of case studies presented from pages 26-52 of the report.

A fatigue risk management strategy
WHO: Maternity services, Newcastle Hospitals NHS Trust
HOW: Co-produced with staff, beginning with focus groups and workshops to collect experiences of fatigue at work and develop action plans.
WHAT: 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
RESULTS: The intervention supported staff wellbeing through two processes: (i) the participatory process itself (facilitated a sense of control and ownership of the process), and (ii) the actions to address fatigue, including address existing stigma around fatigue – a belief that fatigue has to be accepted as part of a healthcare worker's role. The intervention also gave staff confidence and safety to raise important areas of their work that needed addressing.

Improving employee investigations
WHO: Aneurin Bevan University Health Board
HOW: Reviewed the employee investigation process in a workshop and developed a case study that outlined the impact of an investigation on an individual, the workforce, and the organisation.
WHAT: Changes included focusing on the initial assessment phase of an investigation to assess whether an investigation was even necessary. More awareness and support were provided to consider alternative options to formal investigations.
RESULTS: After six months, there was a 66% reduction in disciplinary cases while the average number of days to conclude an investigation was reduced from 156 to 120 days. This saved approximately 1,000 staff sick days.

Annualised hours with self-rostering in emergency medicine
WHO: Emergency Departments, Brighton and Sussex University Hospitals
HOW: Engaged a consultant after the department started grappling with insufficient levels of consultant and registrar coverage and high levels of burnout and turnover. Identified 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 and that the rotas were created with Excel and were cumbersome and administratively heavy.
WHAT: The rota system for consultants moved to self-rostering using annualised hours. The 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.
RESULTS: The system gave doctors more control, improved work-life balance, and reduced 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 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.

Bespoke rostering for emergency medicine registrars
WHO: *Emergency Department, London Hospital*
HOW: The 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 existing 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.
WHAT: 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.
RESULTS: The system has been found to lead to better recruitment and retention, with vastly reduced unplanned locum costs for senior registrars.

Team huddles
WHO: North Bristol NHS Trust
HOW: A group of senior medics, nurses, and quality improvement colleagues with the Staff Psychology Team co-developed the approach to support teams with operational and emotional needs (and psychosocial safety) at work.
WHAT: Known as 'Start Well End Well' the intervention has three steps:

Step 1 - An enhanced safety briefing at check-in
Step 2 – A peer-to-peer pit stop (a framework for debriefs)
Step 3 -Checkouts for the team to reflect, review, and acknowledge the work that was done.

RESULTS: The process has been rolled out and adapted in teams and teams have reported better support, collaboration, and problem solving.

Shorter and better structured meetings
WHO: The Neuro Rehabilitation Team, Kent Community Health NHS Foundation Trust
HOW: The Clinical Lead, along with the team, came together to figure out a way of improving the experience of multidisciplinary team meetings which had come to be a source of strain that staff did not look forward to yet eliminating the meetings was not an option.
WHAT: Restructured multidisciplinary team meetings 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 participants. Shortened meetings approximately half, from an average meeting time of six to three hours.
RESULTS: Shorter meetings reduced the source of team strain and unhappiness and gave staff more time to complete other work tasks. Restructuring allowed staff to feel more supported and fostered a stronger sense of community within the team.

Clinic restructure

WHO: dietitians at Kent Community Health NHS Foundation Trust
HOW: Clinicians were reporting high workloads and feeling stressed during clinics. A workshop was held to review the issue of having insufficient time to complete paperwork and come up with solutions. To highlight the problem to managers and the team, clinicians broke down all their tasks before, during, and after a consultation.
WHAT: Clinic changes include increasing the time to complete paperwork after each appointment by 20 minutes and adjusting the ratio of new to follow-up appointments.
RESULTS: Staff reported increased levels of happiness and working less hours.

Quality Improvement Huddles

WHO: A Hospital Trust
HOW: 'Quality Improvement (QI) huddles' started in pharmacy when the Chief Pharmacist had learnt that another organisation had been able to improve a struggling department with a process that involved teams identifying areas of concern and then collectively developing actions to address it.
WHAT: 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 decides 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.
RESULTS: 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. Change 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.