System-Level Interventions: Summary

As outlined above, while there is evidence for improvement in wellbeing with individual-focussed positive psychology interventions (PPIs), such as mindfulness, and PPIs[1,2] a systems approach is considered necessary to sustain HCW wellbeing at scale.[3-7]

Despite examination of evidence and calls for investment in organisation level research, consistent and specific recommendations for systems interventions have been lacking.[3] As well, recommendations such as imploring HCOs to invest in and prioritise HCW wellbeing by, for example, encouraging clinician leadership and having dedicated clinician Chief Wellbeing Officers rely upon board level decision making.[8-10] While ownership of what is in one's sphere of influence is called for, many system-level decisions and changes are out of the control of most frontline workers such as ED staff.

Following lessons from the COVID-19 pandemic, a 2022 advisory from the US surgeon general makes several recommendations.[11] One such recommendation is "*Transform workplace culture to empower health workers and be responsive to their voices and needs*."(page 21) Another is "*Show health workers how much they are valued."*(page 21) While these are laudable, logical and much needed aspirations, how are such recommendations to be achieved, particularly in settings with high levels of staff burnout[12] a stretched financial situation and major changes in the NZ health system?

Improving Quality of Care

NZ ED staff have identified three key facilitators of improved wellbeing: a supportive team culture, professional development opportunities and delivering excellent patient-centred (high-quality) care.[13] Interventions targeting these three facilitators are aligned with the goals of all emergency care stakeholders. Ensuring system-level interventions enable frontline staff to participate in improving the quality of care provided may improve wellbeing.

Improving healthcare quality is challenging,[14] especially in complex systems, such as EDs.[15] A complexity lens differs from traditional "reductionist" views of systems and improvement, and includes: the critical role diverse voices from a range of staff play in improvement; an iterative approach adaptable to local needs, strengths and priorities, rather than a linear "one size fits all" or "top-down" approach; and embracing, rather than attempting to reduce, uncertainty, diversity and unpredictability.[16] These caveats make research in complex systems challenging.[17]

During the United Kingdom (UK) response to COVID-19, a system dependent upon the voice of frontline workers, focussed on rapidly identifying and solving problems, with the goal of the improvement of healthcare quality was established in acute care settings.[18] Staff identified problems, problems were assessed by decision makers, solutions were enacted, feedback to the frontline by dedicated "bedside learning coordinators" closed the loop.[19] Identification of problems, efficient communication with those with the ability to effect change, and feedback with front-line workforce were key to making this pragmatic approach to an evolving crisis workable.

The benefits to wellbeing of quality improvement (QI) initiatives have been described. In a cluster RCT of 166 clinicians in 34 primary care clinics in the United States clinicians exposed to a multifaceted intervention focussing on organisation change, communication, workflow redesign and targeted quality improvement projects were more likely to demonstrate reduced burnout compared to controls (Odd's ratio 4.8, 95% confidence interval 1.3-18).[20]

Four healthcare initiatives (1 in the US and 3 in the UK) that relied upon staff involvement and quality improvement approaches to improving staff wellbeing were described in a case study report that found improvements in staff wellbeing as well as quality of care in all four cases.[21] Ideas for improvements were based upon staff input and suggestions, and all used digital platforms to share ideas and enhance communication among staff about improvements. The authors highlighted the challenge of measurement and survey fatigue and conclude that "*applying a systematic approach through quality improvement enables ownership by staff, creative idea generation and rigour around testing and measurement".* Of these four initiatives, two based their work upon the Institute for Healthcare Improvement (IHI) Joy in Work Framework.

The Joy in Work Framework outlines a quality improvement approach to improving wellbeing at work.[22] Staff are included by asking what matters most to them, while QI methods such as using small tests of change and measuring effects of changes are encouraged. The Framework was the basis for recent initiatives in various health settings in the UK, with demonstrable improvements in measures of staff wellbeing.

The quality team at East London Foundation Trust (ELFT) has demonstrated improvement of various measures of quality using QI methods that meaningfully included staff, healthcare consumers and their carers.[23,24] They have recognised the importance of both top-down and bottom-up buy-in for successful QI. Their initiatives are primarily focussed on improving care, and have resulted in improved outcomes for healthcare consumers, staff, and financial performance. For example, reduced incidence of violence towards staff, which benefits all stakeholders, was demonstrated from an inpatient ward. ELFT has consistently scored among the best for staff engagement and staff turnover across the UK in annual NHS surveys.[24,25]

The Enjoying Work Collaborative[25,26] began at ELFT and was subsequently led outside ELFT by the Royal College of Psychiatrists. Throughout England and Wales 38 teams in 16 healthcare organisations took part in the 12-month program in 2021-22. Led centrally, teams prioritised and worked upon locally important initiatives, supported by coaches, and informed by intermittent training via zoom. Weekly measures (for example of burnout using the Mini-Z scale) as well as before- and after- assessments (for example recommendations as this as a place to work) demonstrated some improvements. For example, staff who were extremely likely to recommend their team as a place to work increased from 31% to 41 %, while those with no symptoms of burnout increased from 24% to 33%. (Sample size varied each week). This work was conducted during the COVID-19 pandemic in the UK.

In New Zealand EDs, two initiatives are salient. From late 2020 members of our team led a pilot, known as Quality Improvement Learning System (QILS), in a single large volume NZ ED, that encouraged identification of problems and suggestions for improvement from frontline staff. In 6 months, 322 problems in ED care were identified, with solutions enacted for 176 (55%) (data unpublished). Staff feedback was generally positive, such as ease of use for highlighting on-the-floor problems by frontline staff.

A mechanism similar to QILS, to enable staff to identify problems and help with solutions, was introduced during the "migration" of a further single large volume NZ ED to a new building in late 2020.[27] Staff were kept updated about the latest changes using feedback boards. A well-used system, in 6 months over 550 service improvement "tickets" were lodged electronically by staff. Issues were assessed in "huddles" by a dedicated team who decided upon the outcome (approve, investigate, or decline). Issues were then referred to the ED post-migration team for prioritisation, which depended on how quickly the issues could be resolved (ranging from immediate, achievable now to achievable within 1 year, to extensive work required). While the project was not formally evaluated, informal feedback about this improvement initiative was positive from staff, and departmental leaders want to re-institute a similar program in the future.

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