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RESEARCH

Increasing joy in work in UK healthcare teams: a national quality improvement collaborative

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Abstract

In 2021, 38 healthcare teams across England and Wales took part in the national enjoying work quality improvement collaborative, which aimed to enhance staff wellbeing and create joy in work. Participating teams were supported to use quality improvement methodology and tools as part of a national learning network. At the end of the programme, 16 teams saw an improvement in at least one outcome measure, while 17 teams saw a sustained deterioration in at least one outcome measure. Aggregate data from all teams demonstrated improvements from baseline in all three outcome measures, with a 51% average improvement in the percentage of people who frequently enjoyed being at work, a 41% average improvement in the percentage of people experiencing no symptoms of burnout and a 42% average improvement in the percentage of people who were extremely likely to recommend their team as a place to work. As the first programme on this topic at a national scale, these findings provide ideas for change that can be adapted or replicated by clinical and non-clinical teams to improve their joy and wellbeing at work, and build their understanding of the barriers they may face and what is needed to overcome them. From the ideas tested and the learning from across the collaborative, a theory of change for enhancing staff wellbeing and joy in work has been created to inform future work in this area.

Key words: Burnout; Joy in work; Quality improvement; Wellbeing; Workforce

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Introduction

The relationship between staff experience in the workplace, staff wellbeing and patient outcomes has been well-established in the healthcare sector (Powell et al, 2014). With the lasting effects of the COVID-19 pandemic, it has been more important than ever for health and care staff to be supported, with healthcare workers reporting increased symptoms of anxiety, depression and post-traumatic stress disorder following the first peak of the pandemic (Gilleen et al, 2021; Wanigasooriya et al, 2021). Furthermore, research from before the pandemic indicated that healthcare staff have poorer wellbeing than those working in other sectors (Johnson et al, 2018). The potentially lasting emotional impact of COVID-19 on the workforce, combined with rapid changes in ways of working for clinical and non-clinical staff, means that organisations have a responsibility to support their staff to enhance their wellbeing and increase joy in work.

In 2017, the Institute for Healthcare Improvement published a framework for improving joy in work, identifying nine core factors that contribute to joy in work (Perlo et al, 2017) (Figure 1). The Institute for Healthcare Improvement recommends using the principles of improvement science, such as a quality improvement approach, to implement the framework; the effectiveness of this approach has been shown across a number of healthcare organisations (Shah et al, 2021).

In 2021, the Royal College of Psychiatrists invited teams from healthcare organisations in the UK to join a 1-year subscription-based quality improvement programme, with the aim of enhancing staff wellbeing and improving joy in work. To the authors' knowledge, this represented the largest evaluation of the joy in work framework in healthcare. Following a design process, the collaborative ran from June 2021 to May 2022, with the final collation of learning completed in July 2022.

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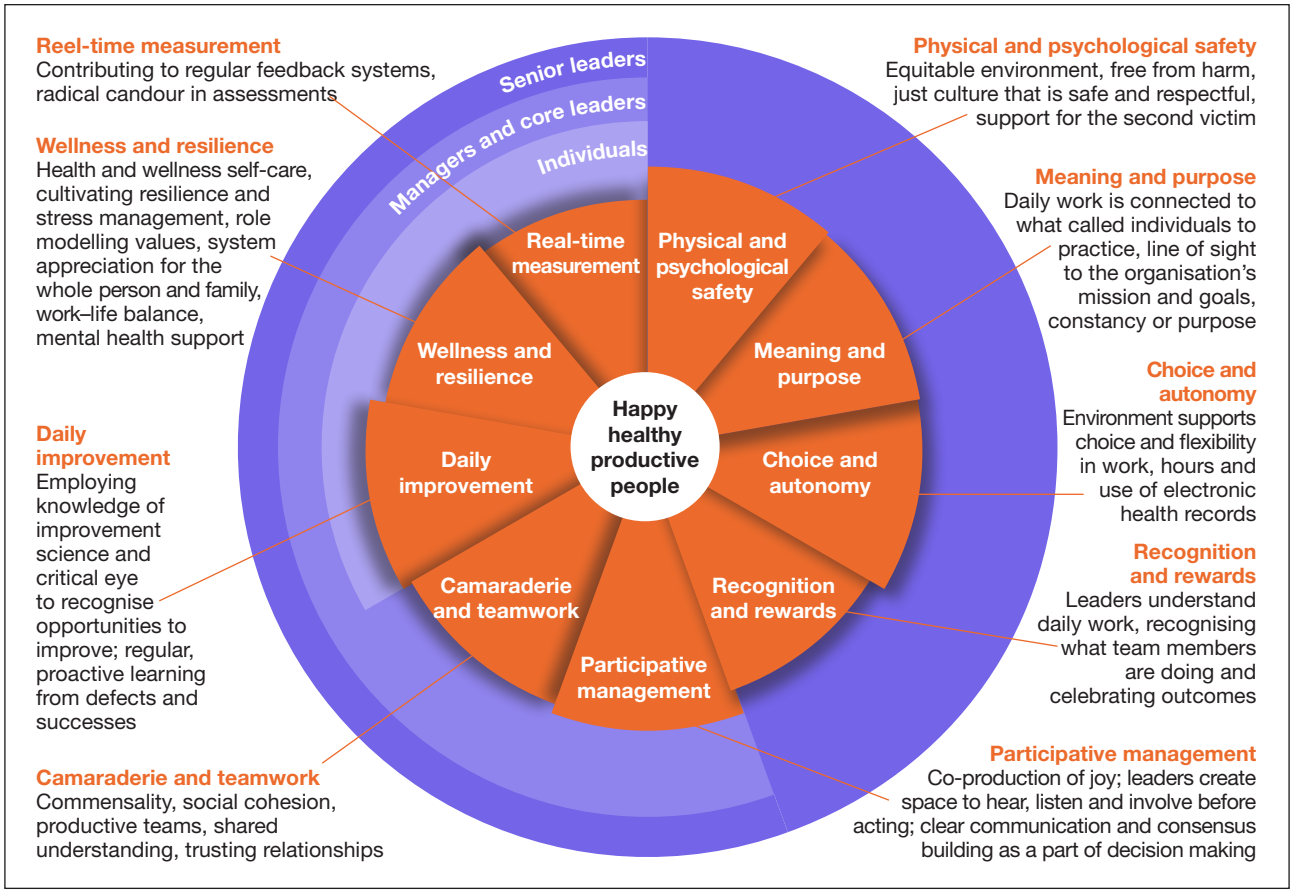

Figure 1. The institute for healthcare improvement framework for improving joy in work. Adapted from Perlo et al (2017).

Methods

Designing the collaborative

The design of the enjoying work collaborative was adapted from the Institute for Healthcare Improvement's (2003) breakthrough series collaborative model, with multiple teams working towards a shared aim and using a learning system to enable connection and sharing across teams. Each team was allocated a quality improvement coach to provide ongoing support with application of the quality improvement method. The project design was also informed by the learning from two previous national quality improvement programmes, namely the reducing restrictive practice programme (Shah et al, 2022) and the sexual safety collaborative (National Collaborating Centre for Mental Health, 2022).

The programme was primarily aimed at teams working in mental health settings, but any healthcare team in the UK was eligible to apply. All 46 teams that applied were accepted on to the programme, with each organisation providing a financial contribution to cover the running costs. Participating teams represented a range of healthcare trusts and specialties from across England and Wales. Of the 46 teams, 38 were able to complete the full 12-month programme. The teams' affiliated organisations and total number of individual participants are shown in Table 1.

At the start of the 4-month design stage, a workshop was held with a range of stakeholders, including patient and carer representatives, teams involved in examples of good practice in the field, and clinicians and healthcare professionals with an interest in wellbeing. Their shared knowledge and experiences were used to produce resources to support participating teams. This included the development of a shared aim, a driver diagram, a measurement plan with operational definitions, and instructions for data collection through a weekly survey. These resources were shared with participating teams as part of the onboarding process with their quality improvement coach.

Table 1. Organisations and number of individual participants in each team

Characteristic		Teams (*n*)	Participants (*n*)
Clinical teams	NHS	22	652
	Private healthcare	1	11
	Total	23	663
Non-clinical teams	Health Education England	12	191
	Royal College of Psychiatrists	2	25
	NHS	1	6
	Total	15	222
Total		38	885

There was regular communication between participating teams and their coaches through email, virtual and in-person meetings. All teams had access and use of the web platform LifeQI (Life QI, Exeter, UK) where they could share and view team- and collaborative-level data and tests of change, as well as communicate with one another through the discussion boards.

Intervention

Each team or service that participated in the programme formed a project team and was allocated a quality improvement coach, who provided tailored support based on their setting and the areas they wanted to focus on to increase joy in work. The model for improvement (Associates in Process Improvement, 2022) was the chosen quality improvement method, and coaches supported teams by guiding them using key tools, delivered through virtual team meetings.

To encourage and create a sense of community, learning sets were held virtually every 2 months. The purpose of these online events was to create a space where all teams involved in the collaborative had the opportunity to share ideas and engage in exercises in smaller breakout groups to enable them to learn from each other and solve challenges, as well as to hear and learn from guest speakers. A total of six learning sets were held during the year-long collaborative.

All teams had a named senior sponsor to provide oversight, support and help with removing any barriers the team faced. Team engagement, such as attendance at learning sets, contact with quality improvement coaches and levels of data collection, were tracked throughout the collaborative to gauge the level of engagement in the project. Towards the end of the collaborative, the learning sets focused on what teams could do to continue the work beyond the end of the programme. Quality improvement coaches supported this by having conversations with teams about what had been successful in their project and what they would like to implement, as well as how to keep joy in work on the agenda.

Study of the intervention

Teams recorded data for each outcome measure, using either ImproveWell (an online survey platform), paper-based surveys or an online voting platform called Mentimeter. Teams were able to pick which method of data collection suited them best, and quality improvement coaches worked with teams to remove barriers to data collection where possible.

Data from the weekly measurement were entered into the LifeQI platform by the quality improvement coaches and displayed on statistical process control charts, a tool commonly used for research and healthcare improvement (Benneyan et al, 2003). The testing period ran from 6 September 2021 to 1 May 2022, and 35 teams also provided baseline data from the period before this.

Outcome measures

All teams collected the same data to ensure consistency across the collaborative. These outcome measures were joy in work, burnout and whether they would recommend the team

as a place to work. Each week of the testing period, a survey was distributed to participating teams, either via the ImproveWell app or through online or paper-based questionnaires.

Joy in work measured as the percentage of people in the participating teams who frequently enjoyed being at work each week. This was assessed using the question 'In the past week at work, how often have you enjoyed being at work?' with respondents asked to choose between 'not at all', 'hardly at all', 'a few times', 'fairly often' and 'frequently'.

Burnout was measured as the percentage of people in the team who experience no symptoms of burnout. This was assessed using the question 'Using your own definition of 'burnout,' please select one of the options below', with the following options:

- I enjoy my work. I have no symptoms of burnout
- I am under stress, and do not always have as much energy as I did, but I do not feel burned out
- I am definitely burning out and have one or more symptoms of burnout, such as physical and emotional exhaustion
- The symptoms of burnout that I am experiencing will not go away. I think about work frustrations a lot
- I feel completely burned out. I am at the point where I may need to seek help.

Finally, the percentage of people in the team who were extremely likely to recommend their team as a place to work was measured using the question 'How likely are you to recommend your team as a place to work?', which respondents answered on a scale of 0–10. To calculate the data for this outcome measure each week, the researchers looked at the number of people who responded with a 9 or 10 and the total number of people who had responded that week.

Validated questionnaires

In addition to the three outcome measures, all teams were asked to complete two questionnaires at the start and end of the programme. These questionnaires were the validated (Olson et al, 2019) 10-question Mini Z burnout survey (which was amended to British English and adapted to the staff population) to measure staff burnout and the validated (Harter et al, 2020) 12-question Gallup Q12 survey to measure staff engagement. Both surveys were anonymous and provided a way for teams to gain deeper insights at the start of the programme to inform their theory of change, and to identify change over the year across all teams on the collaborative.

Qualitative data

The questionnaires completed at the end of the programme included an optional question asking staff to share their experiences of taking part in the enjoying work collaborative. Teams were also asked to share their reflections on taking part in the collaborative. The aim was for teams to reflect on the ideas they had tested during their enjoying work project, any impact they had noticed on themselves and their team, any challenges faced and their overall reflections on the programme.

Data analysis

The quality improvement coaches input their teams' data into statistical process control charts (specifically, P charts) on the LifeQI platform to measure the level of joy at work, the prevalence of staff burnout and the proportion of people who would recommend their team as a place to work. A run of eight consecutive data points above or below the mean (also known as a 'shift') was taken as a signal of sustained change.

To analyse the qualitative data, the reflections received from teams was combined with the comments staff submitted in the post-collaborative survey and reviewed by coaches. Key themes were identified from the data and the most common themes informed the qualitative results of this work.

Ethical considerations

This was a national quality improvement collaborative that was supported in each organisation by the teams' senior sponsors, who had oversight of any potential risks and were thus responsible for handling any matters under their organisation's ethical procedures. While

responses to the weekly survey were anonymous, project leads had access to a summary of their team's survey responses and could identify if any team members had reported feeling very burnt out in order to provide additional support for the team.

Results

Collaborative-level results: outcome measures

Among the 885 participants across the 38 teams, there was a 51% improvement in the percentage who enjoyed being at work frequently, from a baseline range of 17–26%. There was a 41% improvement in the percentage of participants who experienced no symptoms of burnout, from a baseline range of 25–35%. There was a 42% improvement in the percentage of participants who were extremely likely to recommend their team as a place to work, from a baseline range of 29–41% (Figures 2, 3 and 4).

Team-level results: outcome measures

Of the 38 teams, five (13%) recorded insufficient data for baseline figures to be calculated or any change to be detected. Sixteen teams (42%) demonstrated a sustained improvement in at least one of the three outcome measures. Eight teams (21%) demonstrated an improvement in the percentage of staff enjoying work frequently, with a mean percentage improvement from baseline of 128% (range 10–422%). Thirteen teams (34%) demonstrated an improvement in the percentage of staff reporting no symptoms of burnout, with a mean percentage improvement from baseline of 94% (range 36–22%). Twelve teams (32%) demonstrated an improvement in the percentage of staff who were extremely likely to recommend their team as a place to work, with a mean percentage improvement from baseline of 159% (range 36–961%).

Conversely, 17 teams (45%) demonstrated a sustained deterioration in at least one of the three outcome measures. Thirteen teams (34%) saw a decrease in the percentage of staff enjoying work frequently, with a mean percentage deterioration from baseline of −75% (range −6– −100%). Five teams (13%) saw a decrease in the percentage of staff reporting no symptoms of burnout, with a mean percentage deterioration from baseline of -34% (range -9– −100%). Eight teams (21%) saw a decrease in the percentage of staff who were extremely likely to recommend their team as a place to work, with a mean percentage deterioration from baseline of −72% (range −28– −100%). Five teams (13%) demonstrated a sustained improvement in at least one measure and a sustained deterioration in at least one measure.

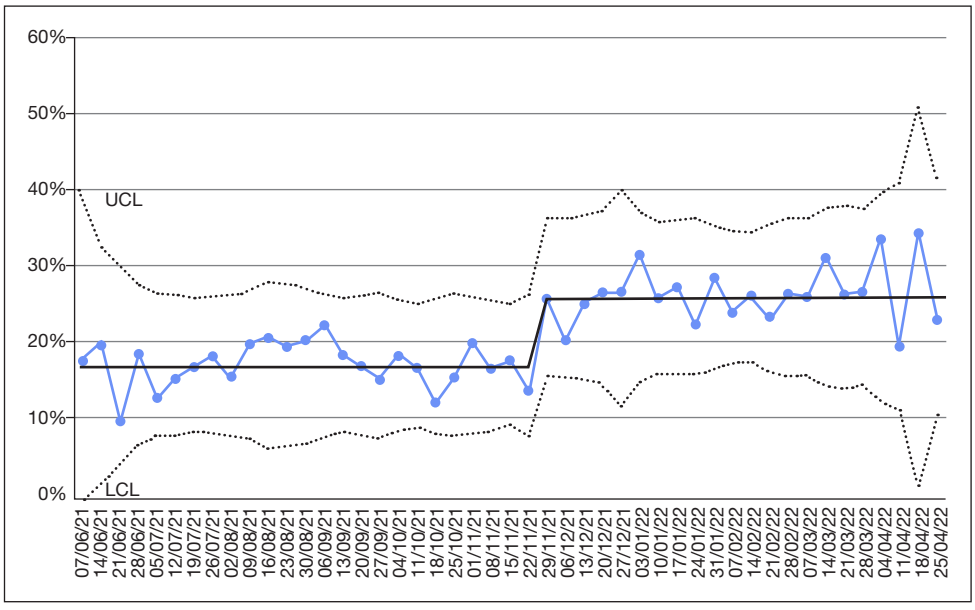

Figure 2. P chart showing percentage of participants who described enjoying work frequently (LCL=lower control limit; UCL=upper control limit; solid line=mean).

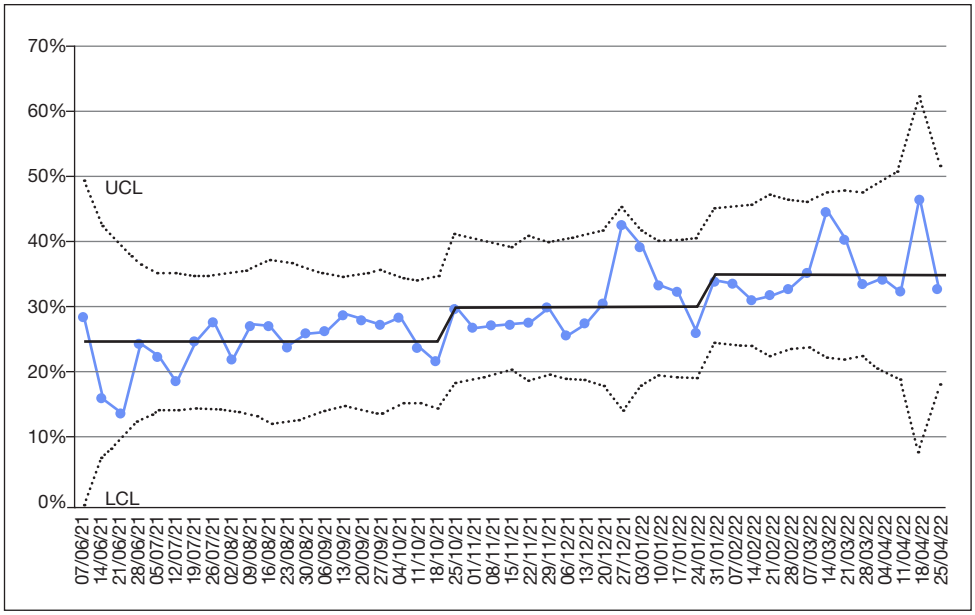

Figure 3. P chart showing percentage of participants who described no symptoms of burnout (LCL=lower control limit; UCL=upper control limit; solid line=mean).

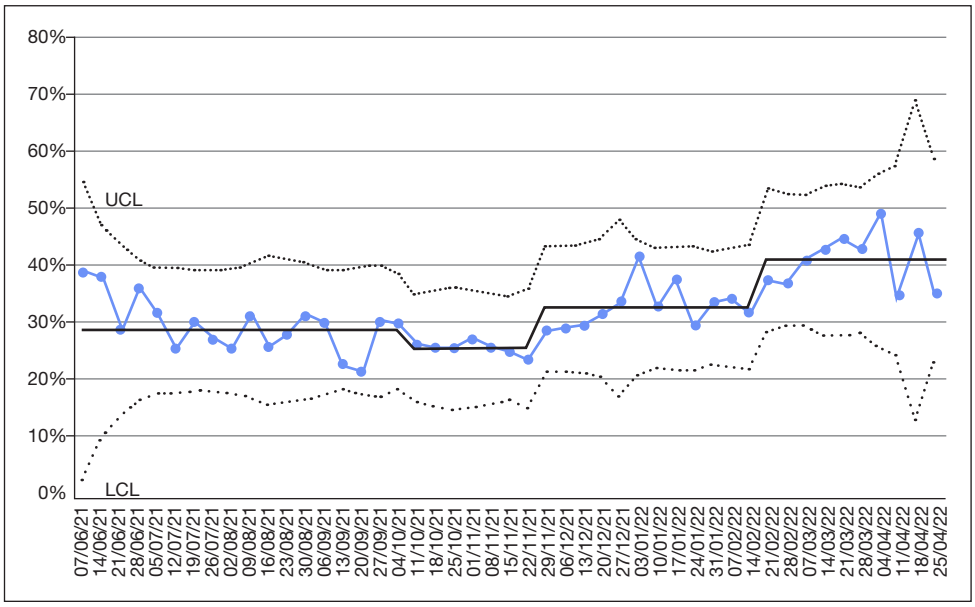

Figure 4. P chart showing percentage of participants who were extremely likely to recommend their team as a place to work (LCL=lower control limit; UCL=upper control limit; solid line=mean).

Overall, 10 (43%) of the 23 clinical teams and six (40%) of 15 non-clinical teams saw an improvement in at least one outcome measure. Out of the 23 clinical teams, six (50%) of the 12 community teams and four (36%) of the 11 inpatient teams saw an improvement in at least one outcome measure. On the other hand, nine (39%) of the 23 clinical teams and eight (53%) of the 15 non-clinical teams saw a deterioration in at least one outcome measure. Of the 23 clinical teams, six (50%) of the 12 community teams and three (27%) of the 11 inpatient teams saw a deterioration in at least one outcome measure.

Collaborative-level results: surveys

The pre-collaborative survey was completed by 629 respondents from 38 teams and the post-collaborative survey was completed by 323 respondents from 33 teams.

The results of the Mini Z burnout survey are shown in Table 2. Items were scored on a 5-point Likert scale, with 5 being the most positive answer for eight of the items and 1 being the most positive answer for the remaining two items.

The results of the Gallup Q12 survey are shown in Table 3. Each item was scored on a 5-point Likert scale (1=strongly disagree; 5=strongly agree).

While the pre- and post-collaborative surveys showed minimal changes, some results did move in a positive direction. The Mini Z burnout survey showed a 9.0% reduction in teams feeling a great deal of stress because of their jobs and a 6.6% reduction in teams feeling that the atmosphere in their primary work area was hectic or chaotic. There was also a 5.1% increase in teams feeling that they had more control over their work and a 4.3% increase in teams feeling that they had sufficient time for documentation. Meanwhile, the Gallup Q12 survey showed a 4–5% increase in teams feeling that they had the opportunity to learn and grow, do what they do best every day and receive recognition or praise for doing good work.

Qualitative results

A total of 135 staff across 33 organisations completed the free-text question in the post-collaborative survey about their experience of taking part in the programme. Responses were received between March and April 2022. A total of 18 teams also submitted a written piece to the central project team, telling their story of taking part in the programme. The most common themes identified from the qualitative data analysis were team connectivity and cohesion, wellbeing, making changes and influence.

Team connectivity and cohesion

One of the identified benefits of taking part in the enjoying work collaborative was an increase in team connectivity and cohesion. This was enabled by the change ideas tested and implemented, as well as the reflective conversations that teams had about wellbeing and joy in work, such as through appreciative inquiry sessions. In the stories submitted by

Table 2. Pre- and post-collaborative amended Mini Z burnout survey results

Question	Average pre-collaborative survey score	Average post-collaborative survey score	Absolute difference	% change
Overall, I am satisfied with my current job (1=strongly disagree, 5=strongly agree)	3.66	3.77	0.11	3.0
I feel a great deal of stress because of my job (1=strongly disagree, 5=strongly agree)*	3.13	2.85	-0.28	-9.0
Burnout (1=severe burnout, 5=no burnout)	3.80	3.87	0.07	1.8
My control over my work is (1=poor, 5=optimal)	3.31	3.48	0.17	5.1
Sufficiency of time for documentation is (1=poor, 5=optimal)	2.78	2.90	0.12	4.3
The atmosphere in my primary work area is (1=calm, 5=hectic/chaotic)*	3.02	2.82	-0.20	-6.6
My professional values are well aligned with those of my department leaders (1=strongly disagree, 5=strongly agree)	3.84	3.91	0.07	1.8
The degree to which my team works efficiently is (1=poor, 5=optimal)	3.62	3.62	0.00	0.00
The amount of time I spend on work digital systems outside of my work time is (1=excessive, 5=minimal)	3.47	3.60	0.13	3.8
My proficiency with the digital systems I use in my job is (1=poor, 5=optimal)	3.63	3.77	0.14	3.9

**negatively weighted item*

Table 3. Mean pre- and post-collaborative Gallup Q12 burnout survey results

Question	Mean pre-collaborative survey score	Mean post-collaborative survey score	Absolute difference	% change
Do you know what is expected of you at work?	4.21	4.19	-0.02	-0.5
Do you have the materials and equipment to do your work right?	3.86	4.01	0.15	3.9
At work, do you have the opportunity to do what you do best every day?	3.41	3.56	0.15	4.4
In the last 7 days, have you received recognition or praise for doing good work?	3.28	3.43	0.15	4.6
Does your supervisor, or someone at work, seem to care about you as a person?	4.20	4.16	-0.04	-1.0
Is there someone at work who encourages your development?	3.86	3.94	0.08	2.0
At work, do your opinions seem to count?	3.72	3.81	0.09	2.4
Does the mission/purpose of your organisation make you feel your job is important?	3.70	3.78	0.08	2.2
Are your colleagues committed to doing quality work?	4.16	4.22	0.06	1.4
Do you have a best friend at work?	2.98	3.02	0.04	1.3
In the last 6 months, has someone at work talked to you about your progress?	3.82	3.91	0.09	2.4
In the last year, have you had opportunities to learn and grow?	3.80	4.01	0.21	5.5
Gallup Q12 survey total (sum of averages)	**45.00**	**46.04**	**1.04**	**2.3**

teams at the end of the collaborative, many described how team bonding and cohesiveness had increased. One team shared that taking part in the collaborative:

> **'Made a positive difference as it has given the team chance to reflect and understand how each other feels in better detail than asking 'how are you' in a team meeting.' (Non-clinical team).**

Another team shared that their team:

> **'Feels more cohesive now, people have got to know each other more… personally, but also in terms of their strengths, previous experiences, how they work etc. This has been invaluable in terms of working together as a multidisciplinary team.' (Clinical team).**

Wellbeing

Teams also described how taking part in the collaborative had 'brought enjoyment and wellbeing at work to the forefront of the conversation' (non-clinical team) and 'enabled [them] to take a step back and put wellbeing front and centre' (non-clinical team). Conversations around wellbeing and joy in work supported many staff to focus on, or be more aware of, their own wellbeing. One team member described:

> **'The open and honest conversations we have had around wellbeing have made me rethink my outlook on work and ensure I am approaching it in a way that's right for me.' (Non-clinical team member).**

It also encouraged discussion and action to address day-to-day work challenges that impact staff wellbeing, such as staff not feeling that they have permission or time to take breaks. One team stated that:

'People are self-aware and kinder to self to take breaks, trying to prioritise our wellbeing.' (Clinical team).

Another clinical team observed that staff had begun to state when they needed to take a break, noting that they may not have felt able to do this before.

Making changes

Teams tested a range of ideas during their enjoying work project, and many described how these positively impacted their teams, for example:

'As a team, [we] have made a few small changes that have had a large impact on us as individuals and as a team.' (Non-clinical team).

A clinical team described how the project helped them to improve their ways of working by giving them time to discuss and adapt their practice to 'help things move forward'. Many described feeling empowered to suggest ideas and try things out:

'[We feel] confident that anyone, at any time, can say "Hey, how about we try doing this?" and just give it a go.' (Non-clinical team).

Others noted that the enjoying work project had given the team a sense of confidence and belief that they could take control over creating a positive work environment.

Influence

Many teams identified that some of the key factors that impact wellbeing and joy in work were outside the scope of the project and could not be directly influenced by staff. For example, one clinical team member noted that 'the impact of rising case numbers and those awaiting admission [have] a more significant impact on myself and the team' than the changes made as part of their enjoying work project. This issue also impacted staff engagement in the project, with one team stating that:

'Bigger things we do not have control over remain issues, which has meant it can be difficult to fully engage [in the enjoying work project].' (Clinical team).

Meanwhile, a non-clinical team reported that one of their biggest challenges was 'balancing how busy we are with devoting time to this project', explaining that a 'culture of 'busy' made it hard to get the team to focus on wellbeing. This led to staff in some teams feeling disconnected from the project and feeling that it had not made a substantial difference, with one team stating:

'[We do not understand] how this project and the fixed questions [outcome measures] can help my team to make a difference in their day-to-day job and performance.' (Clinical team).

Despite these challenges, many teams described their plans to continue the positive work they started during the collaborative, with a key action being to embed wellbeing and joy in work into business as usual. For example, one clinical team stated that they planned to keep joy in work 'on the agenda' in service development meetings. Other teams expressed the need to continue providing an opportunity for staff to suggest and test ideas, with one stating that:

'In the next few months, we will run a brainstorming session with the wider team to generate new change ideas.' (Non-clinical team).

Change ideas and concepts

The number of change ideas tested during the collaborative varied between teams, with an average of three per team. As part of the analysis, the change ideas were grouped into change concepts, then the distribution of these change concepts was examined, along with the frequency of individual change concepts tested by different teams. Over the course of the collaborative, a total of 146 change concepts were tested by 35 of the 38 participating teams. Three teams did not test any change ideas but continued to participate throughout the programme.

The different change concepts and the number of teams that tested them are shown in Table 4. These concepts were classified as either primary or secondary drivers, according to the driver diagram created at the start of the project. The four primary drivers in this diagram were team culture, relationships and teamwork, supporting staff, and ways of working.

Of the 16 teams that saw a sustained improvement in any of the three outcome measures, the mean number of change ideas tested was 4.4, whereas the 22 teams that did not see an improvement tested a mean of 3.4 change ideas.

Discussion

The enjoying work collaborative is the first quality improvement programme at a national scale in the UK to address staff joy in work in the healthcare sector. The skills gained by teams throughout the collaborative were not just relevant to approaching the question of wellbeing and joy in work, but also enabled teams to reflect and work towards creating a culture where everyone feels empowered to make suggestions to improve things, learn from each other and feel safe to speak out about challenges. It also enabled teams to apply a quality improvement approach, learnt through the programme, to other projects in their organisation.

The overall aim of the project was to increase joy in work, reduce burnout and make teams a place that team members would recommend to others. The overall results showed improvements across the three outcome measures, with a 50% increase in the percentage of staff who enjoyed being at work frequently, a 41% increase the percentage of staff experiencing no symptoms of burnout and a 38% increase in the percentage of staff who were extremely likely to recommend their team as a place to work.

The measures with the greatest percentage change in the pre- and post-collaborative surveys were teams feeling stressed because of their jobs (9% reduction), teams feeling that the atmosphere in their work area was hectic or chaotic (7% reduction), teams feeling that they had control over their work (5% increase) and teams having opportunities to learn and grow (6% increase). This indicates a general reduction in stress and improvements to teams' working environments following participation in the project. As the first part of this 1-year collaborative focused on helping teams to set up their projects, teams spent about 9 months testing change ideas. The authors believe that a longer testing period may have led to larger increases in percentage changes, as this would have allowed teams to test their ideas for longer, develop them and measure the impact over time.

A variety of change ideas were tested across a wide range of different teams, in both clinical and non-clinical settings. The changes introduced during the project are potentially transferable to any team seeking to improve enjoyment in work, reduce burnout and increase team members' recommending their team as a place to work. The learning from the collaborative has allowed the authors to create a set of resources, including a revised driver diagram showing the key areas that teams worked on to improve wellbeing and joy in work (Figure 5). The most commonly tested change concepts across the teams that took part in the collaborative included protecting time for breaks, sharing appreciation across the team, making time and space for non-work conversations, promoting wellbeing and protecting time for reflection. This can provide valuable insights to inform other projects aiming to improve joy and wellbeing at work. Many teams, even those that did not see an improvement in their quantitative data, shared stories related to positive changes in their team. These included changes in team culture and improvements in team connectivity and cohesiveness, wellbeing and ways of working.

Table 4. Number of teams testing ideas in each change concept based on the four primary drivers

Primary driver	Secondary driver	Change concept	Teams implementing change concept (*n*)	Ideas implementing primary driver (*n*)
Team culture	Having a work–life balance	Protecting time for breaks	7	20
		Supporting staff to 'leave work at work' through discussion with the team psychologist and encouraging staff not to check emails outside of their working hours	2	
	Everyone can share what is impacting their wellbeing, and be heard	Allocating space and time for staff to share challenges and provide feedback	4	
	Everyone makes suggestions and tests ideas to make things better	Providing channels (such as a form) for staff to raise and solve small frustrations at work	3	
		Providing structure for highlighting and strengthening what makes a good day for staff	2	
	Having ownership over your own work	None	0	
	Being able to bring your whole self to work	None	0	
	Recognition and feeling valued	Providing refreshments and treats for staff	2	
Relationships and teamwork	Sharing appreciation and celebrating successes in the team	Establishing a box, board and/or online tool to share appreciation for each other	11	47
		Allocating regular time together to share positive feedback	7	
	Increasing connections and bonding as a team	Networking	3	
		Holding in-person get-togethers	3	
		Making time and space for non-work conversations	12	
		Arranging for the team to socialise outside of work	4	
		Celebrating staff birthdays	3	
		Eating together	4	
Supporting staff	Making wellbeing business as usual	Having conversations about wellbeing in one-to-one meetings, team meetings and the office in general	3	51
		Holding walking meetings/taking a break from the screen	6	
		Allowing for breaks in between meetings	2	
		Establishing wellbeing champions/buddies	2	
		Encouraging physical activity, such as a team step challenge and time away from the desk to take a walk	3	

Table 4. Number of teams testing ideas in each change concept based on the four primary drivers (continued)

Primary driver	Secondary driver	Change concept	Teams implementing change concept (*n*)	Ideas implementing primary driver (*n*)
Supporting staff (continued)	Protected time to focus on wellbeing	Holding wellbeing sessions, having dedicated time for wellbeing each week, or holding facilitated wellbeing or team mindfulness sessions	7	
		Allowing staff to have ownership of their day and work more flexibly	1	
	Opportunities for individual growth and development	Sharing examples of good practice and lessons learnt in team meetings and at the end of projects	2	
		Holding career clinics to discuss available opportunities for development with staff to help with motivation and retention	2	
		Providing in-house learning (learning sessions or visits to other teams)	4	
		Facilitating regular attendance and presentations at conferences	1	
	Improving the staff environment	Improving the physical environment for staff	6	
		Increasing availability of refreshments	2	
		Improving the office environment by purchasing standing desks	1	
	Time and space for reflection	Establishing protected time for individual and/or team reflection	9	
Ways of working	Communication within the team	Improving communication within the team (clinical)	6	30
		Improving communication within the team (non-clinical)	6	
	Flexibility in how the team works	Increasing flexibility on working patterns by introducing a 9-day fortnight model	1	
	Shared goals, meaning and purpose	Coming together to reflect on team/ organisation goals, meaning and purpose	2	
	Reviewing and improving how we do things	Changing existing processes, such as how referrals are triaged and reinstating patient allocation to healthcare assistants	2	
		Improving staff induction and information about the team and/or service	3	
		Making meetings shorter and more efficient	4	
		Protecting time for planning & focused tasks	2	
		Improving the assessment rota to support staff to take annual leave	1	
		Improving data collection on joy in work by reminding the team about the survey, discussing it in supervision and looking at alternative ways to collect the data	2	
	Personal safety	Improving the physical safety of staff through the use of personal alarms	1	

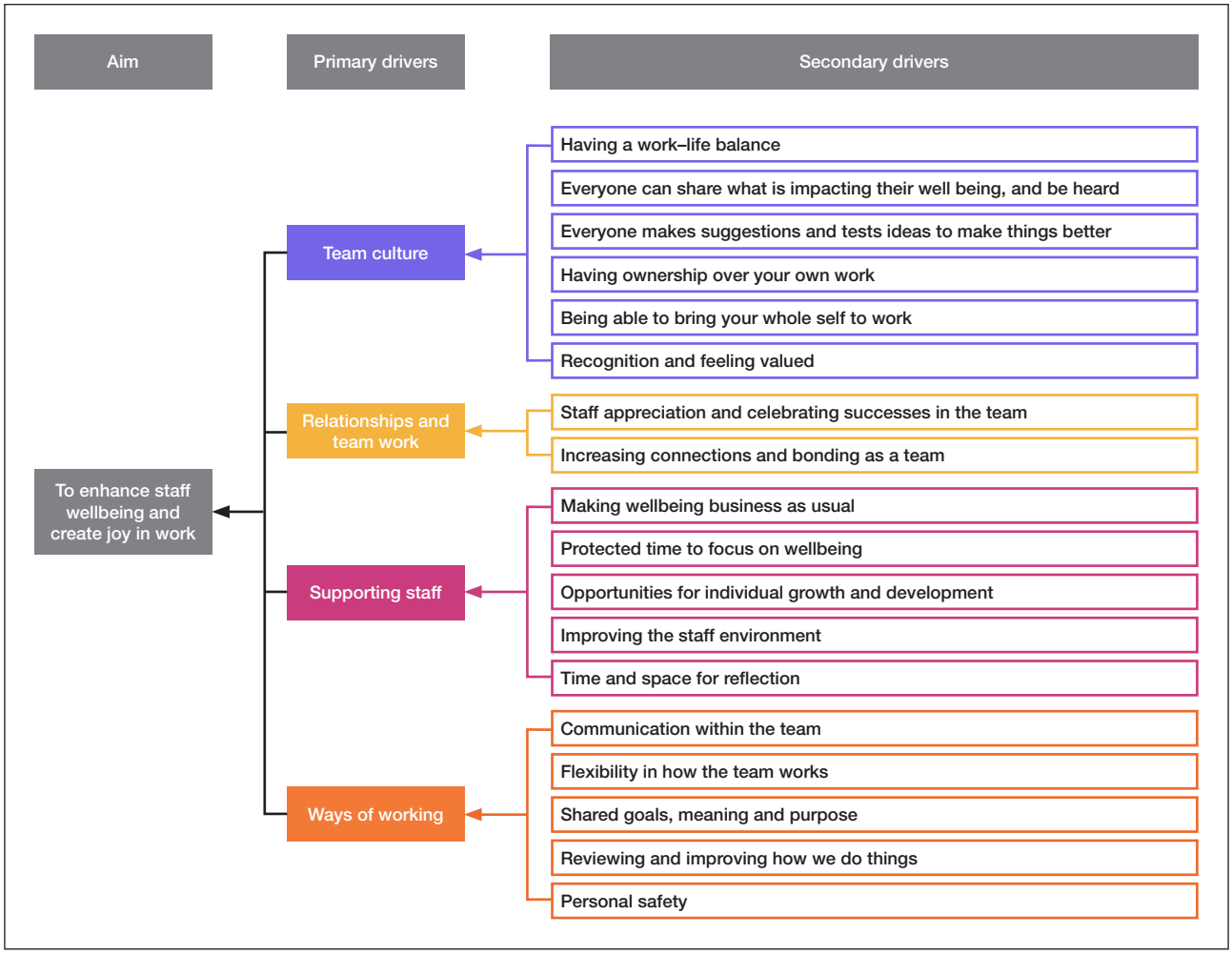

Figure 5. Driver diagram showing the new theory of change created at the end of the project.

On average, teams that saw improvements tested more change ideas than teams that did not see improvement. However, the overall number of change ideas tested by each team was low, which suggests that the types of change ideas tested may have had a greater impact on improvement than the number of ideas tested.

Insights from the qualitative feedback indicated that teams experienced improved group cohesion and felt that they had agency to suggest changes to ways of working to improve joy in work as a result of taking part in the collaborative. However, feedback also showed that some factors influencing joy in work felt outside of participants' control, such as the increased demand their team was facing, or the decisions and policies made at senior or organisation level. Providing additional support for senior leaders in this collaborative could have been useful for addressing or mitigating these factors.

From the perspective of the national team delivering the collaborative, the factors that contributed to the teams' ability to successfully engage in this type of work included support from dedicated quality improvement coaches, a project team with clearly defined project roles and effective leadership, and a senior sponsor who could support teams to remove barriers, advocate for this work and establish a learning community, with spaces to share learning across different teams. These elements resonate with the findings of East London NHS Foundation Trust's learning from an organisation-wide enjoying work collaborative, which has run over the past 5 years (Aurelio et al, 2022).

Some teams in the collaborative saw a decline in one or more outcome measures. Several factors may have influenced this, including difficulties with prioritising staff wellbeing because of workload pressures. Many teams were short staffed and/or were unable to access the resources required to make progress with their projects. COVID-19

Key points

- Following participation in this national collaborative to improve joy in work, over half of participating staff reported enjoying being at work more frequently.
- Empowering and supporting teams to make changes can improve joy in work, reduce burnout and increase the percentage of staff who would recommend their team as a place to work.
- When given dedicated support and time to focus on their project, staff can introduce positive changes and improve their joy in work.
- Some areas of joy in work are outside of teams' immediate control and may require the input of senior management, or organisation-wide change.

and the onset of the Omicron variant in the middle of the collaborative may have had a significant impact on some clinical teams' ability to engage with the collaborative, with some having to pause work on their projects to manage increased demand in their services. Furthermore, the addition of this project to the teams' current workload during such challenging circumstances may have had the unintended consequence of becoming an additional stressor. As indicated by the qualitative feedback, this project may have highlighted areas that hindered joy in work but were outside of participants' control, which could have increased stress.

Limitations

It was beyond the scope of the collaborative, and would be difficult with such a heterogeneous group, to examine the impact of this programme on clinical outcomes and cost-effectiveness. However, increasing joy in work can improve patient outcomes, safety and experience, leading to lower costs (Perlo et al, 2017), so it is possible that the improvements resulting from the collaborative led to improved patient care and outcomes. As this was the first large-scale collaborative aiming to enhance staff wellbeing and create joy in work, it would be interesting to see if the findings are replicated in future national or organisation-wide quality improvement collaboratives. Further work could also investigate which change ideas were most effective in improving wellbeing and joy in work.

Data collection was a challenge for some teams, which impacted their ability to measure improvement over time. This also affected the reliability of data because of small sample sizes as, for a number of teams, only a small proportion of staff completed the weekly survey. To increase response rates, some clinical teams that are not office based implemented paper forms to give out to staff. It should be noted that none of the participating teams were from Northern Ireland or Scotland, which may affect the generalisability of the findings to these countries.

As the Mini Z survey was adapted for the needs of the population participating in the collaborative, the average total cannot be compared to the survey authors' guidance (Linzer at al, 2020) on scores indicating a joyful workplace. However, the supportive workplace subscale had minimal adaptations, so the authors' guidance that scores of >20 are indicative of a highly supportive practice is applicable. The average score of 18.66 for this subscale suggests that teams across the collaborative could improve to achieve highly supportive workplace scores on the Mini Z survey.

Conclusions

This collaborative led to increased enjoyment of work, reduced burnout symptoms and a greater proportion of staff who would recommend their team as a place to work. The learning from this collaborative, including the driver diagram and resources, can be used as a basis for any future work on enhancing staff wellbeing and joy in work, in both clinical and non-clinical settings. This project shows that, when staff are given the right resources, environment and support, they can be empowered to make changes.

At a time when healthcare staff are experiencing high levels of exhaustion, and when recruiting new staff has been increasingly difficult, a programme that enables teams to discover their autonomy to improve the factors that contribute to joy and wellbeing could have enormous value to the healthcare system. When organisations place importance on joy in work in line with other organisational priorities, it sends an important message to staff about the culture and values that the organisation holds.

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Figure 1 was reproduced with the kind permission of the Institute of Healthcare Improvement. All resources developed as part of this project are available from the Royal College of Psychiatrists at: https://www.rcpsych.ac.uk/improving-care/nccmh/quality-improvement-programmes/rcpsych-enjoying-work.

Conflicts of interest

The authors declare that there are no conflicts of interest.

Declaration of funding

The collaborative and all associated costs were funded by the subscription fee paid by participating teams. This fee was set at £4300 (plus VAT) per team, with a 10% discount applied if an organisation put forward more than one team. The required fee was calculated through bottom-up costing of how much the collaborative would cost to deliver. As a charity, the National Collaborating Centre for Mental Health did not take any profit or include a profit margin in this costing.

Most teams either applied for funding internally within their trust, or a senior manager or budget holder in the trust identified the funding and asked for volunteer teams within their organisation. Teams had already secured funding for the fee when they registered for the collaborative, so the authors do not have information about teams that may have wanted to join but were unable to obtain funding. As part of the promotion of the collaborative, a webinar was held about the potential benefits of the project to help teams to make an argument for funding within their trusts.

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References

Associates in Process Improvement. Model for improvement. 2022. http://www.apiweb.org/index.php (accessed 12 April 2023)

Aurelio M, Ballingall N, Chitewe A et al. Using quality improvement to deliver a systematic organisational approach to enjoying work in healthcare. Br J Healthc Manag. 2022;28(11):292–304. https://doi.org/10.12968/bjhc.2022.0072

Benneyan JC, Lloyd RC, Plsek PE. Statistical process control as a tool for research and healthcare improvement. Qual Saf Health Care. 2003;12(6):458–464. https://doi.org/10.1136/qhc.12.6.458

Gilleen J, Santaolalla A, Valdearenas L et al. Impact of the COVID-19 pandemic on the mental health and well-being of UK healthcare workers. BJPsych Open. 2021;7(3). https://doi.org/10.1192/bjo.2021.42

Harter JK, Schmidt FL, Agrawal S et al. The relationship between engagement at work and organisational outcomes. 2020. https://www.mandalidis.ch/coaching/2021/01/2020-employee-engagement-meta-analysis.pdf (accessed 19 May 2023)

Institute for Healthcare Improvement. The breakthrough series: IHI's collaborative model for achieving breakthrough improvement. 2003. https://www.ihi.org/resources (accessed 12 April 2023)

Johnson J, Hall LH, Berzins K et al. Mental healthcare staff well-being and burnout: a narrative review of trends, causes, implications, and recommendations for future interventions. Int J Ment Health Nurs. 2018;27(1):20–32. https://doi.org/10.1111/inm.12416

Linzer M, Smith CD, Hingle S et al. Evaluation of work satisfaction, stress, and burnout among US internal medicine physicians and trainees. JAMA Netw Open. 2020;3(10). https://doi.org/10.1001/jamanetworkopen.2020.18758

National Collaborating Centre for Mental Health. Laying the foundations for improving sexual safety on mental health, learning disabilities and autism inpatient pathways. 2022. https://www.rcpsych.ac.uk/docs/default-source/improving-care/nccmh/sexual-safety-collaborative/sexual-safety-collaborative-booklet---sexual-safety-on-learning-disabilities-and-autism-inpatient-pathways.pdf?sfvrsn=2e7d8c2b_6 (accessed 22 May 2023)

Olson K, Sinsky C, Rinner ST et al. Cross-sectional survey of workplace stressors associated with physician burnout measured by the Mini-Z and the Maslach Burnout Inventory. Stress Health. 2019;35(2):157–175. https://doi.org/10.1002/smi.2849

Perlo J, Balik B, Swensen S et al. IHI framework for improving joy in work. Cambridge (MA): Institute for Healthcare Improvement; 2017

Powell M, Dawson J, Topakas A et al. Staff satisfaction and organisational performance: evidence from a longitudinal secondary analysis of the NHS staff survey and outcome data. Southampton: NIHR Journals Library; 2014

Shah A, Harken J, Nelson Z. Quality improvement in practice - part two: applying the joy in work framework to healthcare. Br J Healthc Manag. 2021;27(9):234–240. https://doi.org/10.12968/bjhc.2021.0022

Shah A, Ayers T, Cannon E et al. The mental health safety improvement programme: a national quality improvement collaborative to reduce restrictive practice in England. Br J Healthc Manag. 2022;28(5):128–137. https://doi.org/10.12968/bjhc.2021.0159

Wanigasooriya K, Palimar P, Naumann DN et al. Mental health symptoms in a cohort of hospital healthcare workers following the first peak of the COVID-19 pandemic in the UK. BJPsych Open. 2021;7(1):e24. https://doi.org/10.1192/bjo.2020.150