Ref. Ares(2022)5521122 - 02/08/2022

METEOR

Mental Health: Focus on Retention of Healthcare workers

Report on micro-level policies

Deliverable number: D 4.3

Version: v2

This project was funded by the European Union's Health Programme (2014 - 2020).

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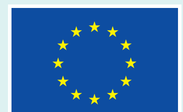
Ref. Ares(2022)4089637 - 01/06/2022

Microlevel policies and interventions in eight European hospitals

'METEOR aims to enhance knowledge on the determinants of job retention of healthcare workers, as well as on the already successfully implemented micropolicies (best practices)'



1/8/2022 Version 2

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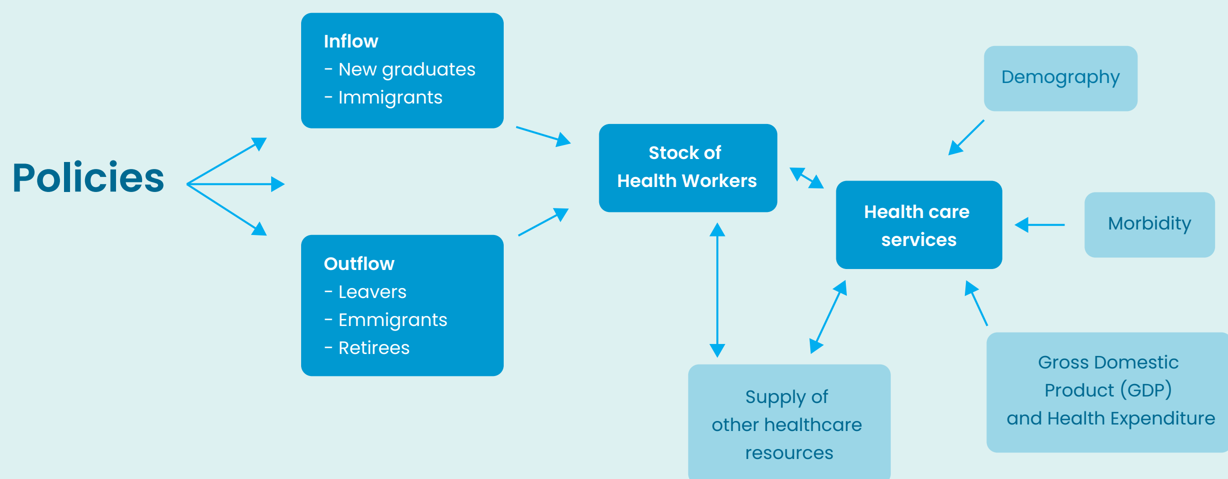
Introduction

Almost all European countries face **challenges in job retention and recruitment of healthcare workers.** These challenges represent a **multifaceted** phenomenon, which can be attributed to many factors. Literature [1] shows that they are primarily driven **by demographic changes** in the population, increasing demand for healthcare and a growing number of chronically ill patients. Life expectancy has increased consistently and is expected to continue to increase. A challenge is that our population is ageing and we must aid them by maintaining their health as much as possible[2]. As the population ages, so does the healthcare workforce, with **insufficient recruits** to replace those who are retiring. Some of the shortages are generated by financial cutbacks, limiting the recruitment of healthcare workers. These financial constraints impose an additional burden on healthcare organizations, resulting in a decline in productivity and healthcare quality and **an increase in workload, work stress, and mental health problems[3].**



METEOR (MEnTal hEalth: fOcus on Retention of healthcare workers) is a European Union (EU) financed project (Chafea – 3rd Health Programme, Multi-beneficiary Project Grant (HP-PJ, HP-JA), Topic: PJ-01-2020-1) that prevents healthcare personnel from leaving the hospital and (re) gaining healthcare personnel[4]. We are trying to find essential **determinants for leaving or staying and anticipating the best interventions on these topics.** A main objective of METEOR is that we will enhance knowledge on the determinants of job retention, as well as on successfully implemented interventions and retention policies (best practices). The four participating countries of METEOR are **Belgium, Poland, Italy and the Netherlands**. They were selected based on geographical coverage, health system organization, and the number of healthcare workers (physicians and nurses) per 1000 inhabitants. Our study will include **one academic and one non-academic hospital** within each country since they are subjected to differences in financial resources, scale, and mission. We included **eight hospitals**. Stakeholders for this study will include but are not limited to policymakers, health managers and healthcare workers. We performed an analysis of micro-level retention policies in the participating hospitals of consortium countries. The outputs of METEOR will serve as an inspiration for different EU regions and regions beyond the EU.

1 Kroezen M, Dussault G, Craveiro I, Dieleman M, Jansen C, Buchan J, et al. Recruitment and retention of health professionals across Europe: A literature review and multiple case study research. Health Policy (New York) [Internet].
2 Commission of the European Communities. Green paper on the European workforce for health. Hum Resour Health [Internet]. 2008;14. Available from: https://ec.europa.eu/health/ph_systems/docs/workforce_gp_en.pd
3 OECD. Health Workforce Policies in OECD Countries: Right Jobs, Right Skills, Right Places. 2016. (OECD Health Policy Studies)
4 See www.meteorproject.eu

Overview of four countries

Healthcare systems in European countries are faced with a wide range of **similar challenges**:

1) The **ageing European population** and the increase of chronic diseases result in a higher demand for healthcare;
2) An **increase in costs** for innovative technologies and medication;
3) **Unequal distribution** of health professionals, with shortages in some expertise fields and regions;
4) **Inequality in access** to healthcare results in growing inequalities in health outcomes.

However, healthcare systems in Europe are **diverse and reflect different political choices**. A recent literature review on recruitment and retention of health professionals across Europe states that retention policies are highly dependent on the **economic, legal, political and organizational context**. These contextual factors can act as barriers or facilitators. Comparative reviews are scarce in spite of the importance of contextual factors and have often focused on specific areas or types of professionals. This leaves policymakers and health managers limited evidence-based data to develop recruitment and retention strategies tailored to their context. In the METEOR study, we include partners from four European countries: **Belgium, The Netherlands, Italy and Poland**. These four countries account **for a geographical balance of regions in Europe**; they reinforce the projects' European reach and relevance and ensure a balanced discussion on the recruitment and retention policies in different contexts. We briefly explain each countries geographical, cultural, legal, and social diversity. The **EHCI (Euro Health Consumer Index) index** is a good starting point for assessing the variation between partner countries. The EHCI compares European national healthcare systems based on 46 indicators, including patient rights and information, access to care, treatment outcomes, range and reach of services, prevention, and use of pharmaceuticals. Currently available data (2018) suggest that EHCI total score was the highest in the Netherlands (883), the lower index had Belgium (849), Italy (687), and the lowest had Poland (585)[5].

Belgium

Since 2000, the **life expectancy in Belgium has increased by nearly four years**. The median age in Belgium is 41.9 years, and 98.3 % of the population is urban[6]. The healthcare system in Belgium is based on **social health insurance** which covers the entire Belgian population. It combines compulsory, comprehensive and universal public health insurance with freedom of choice and independent medical practice. The **mandatory health insurance** scheme covers significant risks for the whole population; and minimal risks for 90% of the population[7]. The first decisions regarding the current health system in Belgium were made after the Second World War, after which it gradually evolved towards universal coverage[8]. Belgium spends a **relatively high proportion of its GDP on health** (10.3%; the EU average is 9.8%), and nearly 80% of health spending is publicly funded. This means an average of 3812 Euros per inhabitant is spent on healthcare. **Budgetary constraints in the future are expected** to arise from increasing needs for long-term care due to an ageing population. Access to healthcare is generally good, but **out-of-pocket spending (direct spending by households) is 18%, higher than the EU average** of 16%.

5 Access: https://healthpowerhouse.com/media/EHCI-2018/EHCI-2018-report.pdf
6 WorldOMeter. Population: Europe [Internet]. 2020 [cited 2020 Jul 3]. Available from: https://www.worldometers.info/
7 Federale Overheidsdienst Sociale Zekerheid. Cijfers van sociale bescherming [Internet]. 2020 [cited 2020 Jul 3]. Available from: https://socialsecurity.belgium.be/
8 Gerkens S, Merkur SM. Belgium: health system review. Health Syst Transit [Internet]. 2010;12(5):1–266. Available from: http://eprints.lse.ac.uk/29128/

People with low income report highly unmet needs for medical care, resulting in growing inequalities[9]. Over the last 15 years, the **number of physicians** in Belgium has increased slowly. The Belgian healthcare system counts 3.1 practising physicians per 1000 inhabitants, and the average salary is 60,000 EUR for general practitioners and 188,000 EUR for specialists. However, about 45% of physicians are over 55, raising concerns about **future shortages**. The number of students enrolled in medical schools has increased in recent years, and more internship places have been created to ensure the future supply of physicians. Concerning **nurses**, Belgium has 10.96 nurses for every 1000 inhabitants[10]. Since 2015 Belgium has strengthened primary and integrated care for people with chronic diseases. Several pilot projects were launched in this regard, focusing on **multidisciplinary teamwork and new financing models**. In addition, a wide range of measures have been taken to facilitate the **digital transformation** of the healthcare system, for example, the development of electronic medical records, e-prescriptions and the **eHealth Plan** for 2019-2021.

Italy

Italian demography is characterized by a **low birth rate and growing life expectancy** due to the last centuries profound social and economic changes. The median age in Italy is 47.3 years, and 69.5 % of the population is urban[11]. **Life expectancy** is the second-highest in the EU after Spain. Based on principles of universalism, comprehensiveness and solidarity in funding, the Italian National Health Service (NHS) was instituted in 1978, inspiring the British NHS[12]. Since 1992, it has undergone several reforms to increase its institutional and financial autonomy and introduce competition in healthcare services. Since 2001, following a modification of the Italian Constitution, devolution of health powers and competencies at a sub-national level was stated. **Italy's health system is highly evolved** and ranks second worldwide, with the third-best healthcare performance. Healthcare today is provided by a **mixed public-private system**[13]. While the central government of Italy sets the general objectives and fundamental principles for the NHS and defines the so-called **"essential levels of care"** (Livelli Essenziali di Assistenza, LEAs), which must be equally guaranteed to all residents, regional governments are responsible for administrative healthcare functions, planning healthcare activities, organizing supply concerning population needs and monitoring quality, appropriateness and efficiency of the services provided. **Healthcare spending** in Italy accounts for 8.8% of Italy's GDP, a **lower share than the EU average** of 9.8%. This implies an average of 2,437 euros per inhabitant are spent on healthcare. As in other European countries, the ageing population and moderate economic growth are expected to put pressure on public health and long-term care spending. **Access to healthcare is relatively good, and unmet needs are low**. However, they are higher for people of a lower socioeconomic status[14].

9 European Commission. State of Health in the EU, Companion Report. 2019
10 Organisation for Economic Co-operation and Development (OECD). OECD.Stat [Internet]. 2019 [cited 2020 Jul 3]. Available from: https://stats.oecd.org/Index.aspx?ThemeTreeId=9
11 Gerkens S, Merkur SM. Belgium: health system review. Health Syst Transit [Internet]. 2010;12(5):1–266. Available from: http://eprints.lse.ac.uk/29128/
12 France G, Taroni F. The evolution of health-policy making in Italy. J Health Polit Policy Law. 2005;30(1–2):169–87.
13 Lo Scalzo, A; Donatini, A; Orzella, L; Cicchetti, A; Profili S and M. Italy: health system review. 2009;(January).
14 Gerkens S, Merkur SM. Belgium: health system review. Health Syst Transit [Internet]. 2010;12(5):1–266. Available from: http://eprints.lse.ac.uk/29128/. Matranga, D., & Maniscalco, L. (2022). Inequality in Healthcare Utilization in Italy: How Important Are Barriers to Access?. International Journal of Environmental Research and Public Health, 19(3), 1697.

Like many EU countries, the number of physicians has slightly increased over the past years, but not enough to fill the turnover gap. There are growing **concerns about workforce shortages**, as more than half of all physicians are over the age of 55 and because of a lack of nurses. The Italian healthcare system counts 3.9 practising physicians per 1000 inhabitants, and the average salary is 105,000 EUR for general practitioners and 113,000 EUR for specialists. There are 5.5 **nurses** for every 1000 inhabitants. Italy is busy strengthening its primary care system. Several pilots have started to test new service delivery models aimed at people with chronic diseases, such as multi-speciality community-based centres and intermediate care facilities between primary care and hospitals.

Poland

Since 2000, **life expectancy** has increased by four years in Poland but remains three years below the EU average. The median age in Poland is 41.7 years, and 60.2 % of the population is urban. Unfortunately, the COVID epidemic reduced average life expectancy by 1.3 years in 2021 compared to 2015-2020[15]. The current healthcare system in Poland was developed due to **reforms conducted between 1999 and 2004**. Highly centralized under Communist rule, it remained fully funded by general taxation until 1999, when **mandatory public health insurance** was created, initially under the management of the occupational (for uniformed services) and 16 regional Sickness Funds. This **decentralization** hindered patient mobility between regions because of complicated bureaucratic procedures. The National Health Fund (NFZ) was created in 2003 through the merger of the Sickness Funds.

Since its creation, the mandatory public health insurance contribution, paid to the Sickness Funds and then to the NFZ, has become the primary source of public funding, financing about 85% of the cost of public purchase of healthcare services. The Polish healthcare system has been experiencing severe difficulties for many years, mainly due to **one of the lowest public spending** in the European Union, with 5.2% in 2020 GDP (7% of GDP is recommended by WHO to ensure patient safety). Total healthcare spending per capita is at 1,681 EUR in 2020[16]. The **injection of extra funds is necessary to address the main barriers to healthcare**. It is worth indicating that **access to healthcare is somewhat limited**, and the time of expectation for any medical treatments and operations is exceptionally long. For example, with cataracts the expected time for a lens transplant in public hospitals equals about one year. In addition, changes in the healthcare system in Poland have created **growing external pressures on physicians**. For instance, inefficient use of time due to administrative requirements, the loss of autonomy at work, and decreased control over the work environment play a significant role in developing **mental distress**. Furthermore, the Polish healthcare system's fundamental organizational problem is the **lack of medical staff**, including physicians. Poland had 2.4 practising physicians per 1000 inhabitants; and 5.1 nurses for every 1000 inhabitants. The average salary of general practitioners is 30,740 EUR per year[17]. Simultaneously, the Polish population has been facing a rapid increase in the number of older adults. As the population ages, there are increasing demands on the healthcare system to answer the health needs of the elderly. This situation leads to the **excessive workload for physicians**. The COVID-19 pandemic and military conflict in Ukraine are currently a massive challenge for the Polish healthcare system.

15 https://www.oecd-ilibrary.org/sites/ae3016b9-en/1/3/2/index.html?itemId=/content/publication/ ae3016b9en&_csp_=ca-413da5d44587bc56446341952c275e&itemIGO=oecd&itemContentType=book
16 Health resources - Health spending - OECD Data
17 https://wynagrodzenia.pl/moja-placa/ile-zarabia-lekarz-rodzinny

The Netherlands

Life expectancy in the Netherlands is almost one year higher than the EU average. The median age in the Netherlands is 43.3 years, and 92.5 % of the population is urban[18]. The Dutch health system features a mix of competitive insurance for curative care, a single-payer system for long-term care and locally organized tax-funded systems, in which the government plays a substantial role. Health insurance in the Netherlands is **mandatory**. Healthcare in the Netherlands is covered by two statutory forms of insurance: **Basic Insurance** and **Long-term nursing and Care**. Healthcare spending by the Netherlands accounts for 10% of the GDP, which implies a 4,269 EUR per capita. The system has been financially stable, but increased spending will pressure the budget**,** mainly because of an ageing population and the corresponding rise in chronic conditions, and the introduction of high-cost technologies. Government regulation guarantees **universal and equal access** to quality care, covering about 99.9 % of the population. **Out-of-pocket spending also stands below the EU average**. This implies that access to the health system is excellent, with almost no differences in unmet needs between socio-economic groups. Nevertheless, **waiting times and workforce shortages** have increased, potentially threatening accessibility. The healthcare system in the Netherlands counts 3.7 practising physicians per 1000 inhabitants[19].

Characteristics of eight hospitals in four countries in 2020-2021

	AZ Delta	UZ Leuven	Spaarne Gasthuis	Amsterdam UMC	AOUP Paolo Giaccone Hospital	San Giovanni di Dio Hospital	Multidisciplinary Hospital	K. Gibiński University Medical Center
Country	BE	BE	NL	NL	IT	IT	PL	PL
Year	2020	2020	2021	2021	2021	2021	2021	2021
Nurses (n)	1891	3089	1200	2507	800	412	247	562
Physicians (n)	424	1828	320	2318	516	674	94	512
Hospitalisations (n x 1000)	55	52	34	28	16	12	19	41
Surgeries (n x 1000)	50	48	20	42	16	8	9	15
Births (n)	2365	2417	3000	3154	737	1352	0	1721

18 European Commission. European Semester Thematic Factsheet: Health Systems. Vol. 27, European Commission Paper. 2014

19 European Commission. State of Health in the EU: the Netherlands. Eur J Polit Res [Internet]. 2019;36(3):465–71. Available from: https://ec.europa.eu/health/sites/health/files/state/docs/2019_chp_nl_english.pdf

azdelta
Uw ziekenhuis.

AZ Delta - Roeselare, Belgium

Basic Information

1891 nurses

424 physicians

55.000 hospitalisations yearly

Best practices to share

- **HR Partners**: In 2020, AZ Delta created a new position: the **human resource (HR) partner**. The HR partner aims to work closely with the different managers and check regularly and proactively if departments are moving forward with goals related to their department concerning team spirit, job satisfaction or workload. With the creation of the HR partners, AZ Delta wants to increase its focus on prevention and react early to intervene and prevent additional problems. This program is in a start-up phase, and will be evaluated in the coming period.
- **Coaching:** Since 2017, AZ Delta has provided coaching for all its employees. Every employee can approach HR with a specific request on a broad range of topics: leadership, resilience, stress, coping, returning after burnout, and career coaching. Many employees approached them through word-of-mouth publicity, although HR did not seek much publicity. This confirms their belief in the need for this coaching. HR created a **toolbox** with their favourite options so that multiple HR partners can provide this coaching when requested. When th HR partners realize that more professional help is important , they refer to specialists (e.g. psychologists, psychiatrists). Team coaching, in particular, has been proven to be a success, and concerning job retention, in particular, career counselling is also highly successful.
- **Confidential psychological consultations**: The **well-being of physicians**, in particular, is a concern in EU hospitals. In AZ Delta, they mention that nurses have more social support (supervisor, manager), which physicians do not have. Physicians might feel more isolated in their work, which increases pressure on their mental health. For that reason, AZ Delta has recently sent out a survey to their physicians regarding resilience and stress coping mechanisms (based on the survey of network Icuro). In this survey, AZ Delta asked whether the respondent needed a confidential consultation concerning their well-being, of which multiple physicians took advantage.
- **Marketing campaigns**: AZ Delta works on its internal and external image. They mainly want to share that they are people-oriented and care about the person behind the job. For that reason, a broad **marketing branding campaign** was developed, including flyers, social media posts, job fairs and postcards.
- **Exit questionnaires**: AZ Delta introduced an exit questionnaire, which is a survey that people who leave their jobs voluntary are requested to complete. They recently evaluated the response rate to this survey and discovered a response rate of 50%. A more in-depth evaluation is planned to understand why employees are leaving.

UZ LEUVEN

UZ Leuven - Leuven, Belgium

Basic Information

3089 nurses

1828 physicians

52.000 hospitalisations yearly

Best practices to share

- **In-house training**: UZ Leuven provides multiple lifelong learning opportunities for its personnel, which they call 'in-house training'. UZ Leuven is an academic/university hospital, and they emphasize the importance of training and lifelong learning for all their employees. Training covers multiple topics, including clinical training, IT courses, leadership workshops, psychosocial sessions, and Covid-19 webinars.

- **Yearly needs assessment**: Every year, UZ Leuven conducts **in-depth needs assessments** by interviewing the managers and other leading positions about the training needs in their departments. The HR department develops different trainings according to the specific needs. Actions following these needs assessments included, amongst others, key notes by external experts and online webinars on multiple topics.

- **Internal job market**: As an academic hospital, UZ Leuven provides the possibility for career counselling, which they refer to as the **'internal job market'**. Employees can request a consultation with an internal career coach (from the HR department), where they discuss career expectations, job satisfaction and long term career goals. In the past years, this has helped some people to change their position within the hospital. This is a win-win for everyone: the hospital does not lose a skilled employee, and the employee can find a job that better suits their current needs.

- **Flexible employment percentages**. UZ Leuven highlights and acknowledges the importance of a healthy work-life balance. For that reason, they welcome questions related to changes in the employment percentages, such as part-time or full-time. Once they receive such a request, they take it very seriously, discuss this with the employee and try to find a solution with all partners involved.

- **Remuneration**: Besides salary, UZ Leuven provides multiple additional remunerations, such as vouchers, seniority premiums, group insurance, or hospitalization insurance. These extras are a small, but appreciated, addition to their regular salaries and increase the motivation of employees.

- **Annual feedback interviews**: UZ Leuven organizes annual feedback interviews to discuss how employees see their future, expectations, and what they would like to see differently. This is proven to be successful for multiple reasons: on the one hand, UZ Leuven has an idea of how employees view their jobs, and on the other hand, employees feel heard and supported by their hospitals.

- **Psychosocial support for residents**: UZ. Leuven has developed structural support for their residents, namely **staff member coaches** that are independent, confidential and easy to contact for topics such as general well-being and mental health. These coaches are different from the supervisors of the residents. Supervisors decide on residents' evaluation, so they are not always perceived as a haven to contact for personal topics.
- **'Care' staf**f: UZ Leuven has created a new position to enhance structural peer support, called 'Care' Staff. This 'Care' Staff consists of employees who want to support for their colleagues. Employees can voluntary contact the 'care' staff with a wide range of questions about their well-being at work
- **Marketing branding**: The ' Value Project' was created to increase the hospital's visibility and communicate UZ Leuven's core values to current and future employees.
- **Exit interviews**. UZ Leuven has set up a system where employees leaving their jobs can voluntary request an interview with the HR manager to discuss the main reasons. Currently, UZ Leuven is organizing a task force to improve the implementation of exit interviews for leaving.
- **Shared Governance Initiatives.** UZ Leuven experiments with and implements initiatives to promote employee empowerment and shared decision making. These initiatives make their employees accountable for decisions with regard to policies, procedures and processes. An example is the Magnet4Europe project that 'will develop an evidence-based model for the organizational redesign of clinical work environments in order to enhance workers' wellbeing, retention, productivity and patient outcomes.' More information can be found on: https://www.magnet4europe.eu/

Spaarne Gasthuis

Spaarne Gasthuis - Haarlem and Hoofddorp, the Netherlands

Basic Information

1200 nurses

320 physicians

34.000 hospitalisations yearly

Best practices to share

- **Commitment to a web-based protocol** called "Me & Spaarne Gasthuis". A focus on the sustainable employability of our employees from four different angles: me & my balance, me & my health, me & my work, and me & my development. Within this website, all personnel can perform a self-scan. With this scan, they can discover their current situation concerning development, balance, work and health. Afterwards, they will receive **personal advice** on how to take off their areas of interest. This platform is uniquely insightful for employees within and outside the organization. Mainly me & my development and my work contribute to the retention of employees.
 See https://ik.spaarnegasthuis.nl/

- **Strategic personnel planning**, i.e. informational sessions with all supervisors and medical managers in the primary process in which internal and external developments , formation, and employee files are being discussed. Expectations about natural turnover (including pension) and a personnel review (which employee will leave and for what reason, which employees will stay, and may require more guidance) are checked during these meetings.

- Project **'catching the potential'**. A process that focuses on co-solving labor shortages by making employees reflect on their current contract. A survey is used to map out the satisfaction of employees with their current contract size and determine whether there is a possibility for expansion of contract hours. The next step is to start a dialogue session in conversation with the employees. Therafter, an investigation is started to check for obstacles that can be solved and whether increasing working more hours is more attractive: **Obstacles will be converted into opportunities**. Employees feel heard in this process and are happy with the developments. Due to these changes, several employees have expanded their contracts.

Amsterdam UMC - Amsterdam, the Netherlands

Basic Information

2507 nurses

2318 physicians

27.848 hospitalisation yearly

Best practices to share

- **TOP-V program:** focuses on **team development and professionalization of nurses.** The main goal of the TOP-V program is to prepare our nurses and their teams for the complex healthcare of the future. The TOP-V program is a team development program focused on the talent management of individual nurses. The aim is that nurses keep being challenged in their job and get the chance to develop their talents during their careers.

- **Program nurse reinforcement**: for the program nurse reinforcement nurses were asked for ideas and suggestions from their daily practice for to develop of new policy plans. The nurses were involved in developing a multi-year program to attain more autonomy and shared decision making among peers. The program exists of different goals and interventions all devised by nurses, therefore the motto is: 'for us, by us' One example of an intervention from the program is to facilitate nurses during their night shifts with VR glasses, healthy snacks and powernap seats.

- **Week of the work balance**: Less work pressure, more job satisfaction and remaining sustainably employable is the motto of the Week of the Work Balance in Amsterdam UMC. The organizers drew up a varied program for this, full of short, accessible activities: **workshops, walk-in sessions, and lectures**.

- Career guidance: **Team career development** offers a place where all employees of Amsterdam UMC can turn to with questions with questions about their career and development.

- **Shoulder to shoulder program**: in this program medical students in their waiting time for juniorships are being educated during the shoulder to shoulder program to facilitate nurses by taking over specific proceedings. The goal of the program is to reduce work pressure among nurses and to offer medical students a meaningful job during their waiting time.

- **Regulation temporary gratification** in case of working overtime.

- **Webinar Managers concerning Employee Retention**: Action is required to retain employees in times of shortage in the labour market. Investing in employee retention is more critical than ever before. The main questions were how to approach this problem, and which interventions do achieve impact. HR recently organized the Webinar **'Bind and continue to fascinate'** to support and inspire managers collaborating with Effectory.

- **Exit questionnaires**: Amsterdam UMC uses an exit questionnaire, a survey for employees that leave the organization. The results of the exit questionnaire are being evaluated every three months and are used to identify trends in why people leave the organization. The data gathering through the exit questionnaires helps gain insight into what measures can be taken to boost employee retention and improve employee morale.

AOUP P. Giaccone - Palermo, Italy

Basic Information

800 nurses

516 physicians

16.000 hospitalisations yearly

Best practices to share

- **Implementation of human resources**: To reduce healthcare professionals' workload, **extra physicians were hired with temporary contracts** to support the activities of the medical staff already in service.
- **Economic incentives**: Nurses already in service were questioned if they were available for extra paid work assignments for nursing and midwifery staff. Likewise, an additional salary was provided for the group of anaesthetists.
- **Specific projects**: A project was conducted by the Psychology / Psychiatry Section on the mental health and well-being of the staff in service. Listening groups were started with weekly meetings lasting one hour to recover the mental well-being of health workers and spaces for sharing problems due to the SARS-CoV-2 emergency. Moreover, a shared protocol was signed between AOUP Paolo Giaccone and the university to realize a project based on work-related stress and safety. **Online questionnaires** were administered to employees and used to test their individual well-being of the healthcare workers in workplaces and facilitating problem sharing. Aims were gathered to improve company standards in terms of management and organization.

San Giovanni Di Dio Hospital **-** Agrigento, Italy

Basic Information

412 nurses

674 physicians

11.827 hospitalisations yearly

Best practices to share

- **Implementation of human resources**: The most crucial step is the implementation of human resources. In this way, the personnel shortage was balanced with new employees. This allowed maintaining a high level of satisfaction in new employees and also the remaining employees whose workload is reduced. This contributed to an **efficient and stimulating work environment.**
- **Staff motivation: the "Growing Together" project**. Experienced senior doctors support newly hired young doctors. This allows newly hired staff to use updated protocols while working in a satisfying professional environment.
- **Economic incentives:** the well-being of health professionals is meant as a 360 degrees concept. The economic interest is vital; therefore, extra incentives were given to employees and thereby increasing their level of satisfaction.
- **Listening to requests:** Listening to requests from our employees was very important, especially when dealing with the need to change jobs or move to another ward of the hospital. In this way, healthcare workers experience an enhanced sense of integration and increase their sense of belonging to the hospital. This occurred primarily in the anaesthesia and cardiology units.

Introduction to the current Polish situation

The following arguments available in current publications somewhat explain the situation of Polish hospital medical staff and indicate what remedial actions should be taken to reduce the retention phenomenon.

- According to the diagnosis titled 'Why medical workers dropping out of public health care? Diagnosis by OKO.press (30.01.2022) available at the website[20], the main determinants of retention include disproportionately **lower earnings, the sinister atmosphere at work, workload due to lack of medical staff, no opportunity to prove competencies, no teamwork, bureaucracy, lack of patient care time, dishonesty in the form of documenting procedures.** Staff shortages and underestimated medical benefits are the main reasons for the problematic situation in Polish hospitals.
- A record number of medical doctors have applied to leave Poland during the first quarter of the year 2021, according to the country's Supreme Medical Council (NRL). A study conducted in the year 2021 by Cracow University of Economics (UEK) found that 9% of physicians want to emigrate after the COVID-19 pandemic and 6% want to retire. One in ten nurses also want to either move abroad (3.8%) or retire (6.3%)[21].
- Authors of a publication titled 'Migrations of nurses and doctors from Poland: data for the years 2014–2020 based on the sample of the capital city of Warsaw' suggest that problems in the Polish health care system concerning the ageing of the Polish society and the generation gap among Polish doctors and nurses will be a massive challenge for policymakers in Poland. Therefore, the migration of the young generation of nurses and doctors from Poland should become a vital element of the human resources policy in Polish health care right now[22].
- Results of another study confirmed that more physicians (N=315) recruited during courses at the Medical Center of Postgraduate Education in Warsaw reported the disadvantages of their work than its advantages. Every fifth physician declared a willingness to change their profession. The willingness to change the profession was strongly related to the overall negative assessment of own work. Presumably, due to the COVID-19 pandemic, more and more physicians will negatively evaluate their work, which may prompt them to change their profession. This situation requires monitoring the impact of COVID-19 on the workforce and taking remedial measures[23].

In summary, the above arguments suggest that, apart from the economic and political sphere, there are many factors related to the organization of work, the reduction of may aid the flow of staff leaving. Therefore, the activities undertaken under the METEOR project are essential for developing good practices, which are hoped to improve the working conditions of doctors and nurses employed by hospitals.

20 https://oko.press/7-przyczyn-ucieczki-medykow-z-publicznej-ochrony-zdrowia/ [in Polish]
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Multidisciplinary Hospital - Jaworzno, Poland

Basic Information

247 nurses

94 physicians

18.960 hospitalisations yearly

Best practices to share

- Improvement of **work safety** by adapting the number of hospital beds to the number of staff members.
- **Free medical care** for employees, including prophylaxis and diagnostic procedures in occupational medicine.
- A hospital is an institution where physicians, nurses, and other health care workers can pursue **public health specializations**.
- The hospital runs a **Vocational Training Center** in which medical staff have the opportunity to join free periodic theoretical and practical training.

K. Gibiński University Clinical Center - Katowice, Poland

Basic Information

562 nurses

512 physicians

41.451 chospitalisations yearly

Best practices to share

- There are **no medical staff retention programs** in the hospital regarding mental health; healthcare workers leave the hospital mainly because of insufficient salary, the intensity of the work and the necessity of night shifts. They plan to work in outpatient clinics. This outcome will be implemented in the **new strategy** of the hospital.

This project was funded by the European Union’s Health Programme (2014 - 2020).

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