

Clear the Clutter: Design, implementation and early findings of a whole-of-service improvement program in a large Australian public health service

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Abstract

Everyday operational inefficiencies (administrative duplication, fragmented digital systems, communication overload, and crowded workspaces) can create persistent "pebbles in the shoe" that increase cognitive load, reduce time for patient care and erode staff wellbeing. Metro South Health (MSH) developed Clear the Clutter to identify, prioritise and progressively remove these operational burdens across a large metropolitan public health service.

The objective of this paper was to describe the design, implementation and early findings of Clear the Clutter, including program reach, dominant themes of workplace clutter, and the program architecture for prioritisation and sustainability.

Mixed-method whole-of-service quality improvement evaluation approach was used, drawing on human-centred design, the IHI Joy in Work framework, CFIR implementation science and behaviour-change frameworks (ADKAR). A cross-sectional workforce survey (12 Aug - 5 Sep 2025) captured a numeric clutter impact rating (1-10) and up to three free-text descriptions per respondent. Consumer engagement (roadshows and digital channels) triangulated themes. Qualitative data were analysed using a hybrid inductive-deductive thematic approach mapped to three a priori domains: (1) tasks that no longer add value;

(2) physical and digital workspaces; and (3) cognitive and emotional overload. Outputs included 53 Key Insight Reports and an 865-item Good Ideas Database.

Results include workforce respondents = 949; consumers = 150; baseline clutter impact mean = 6.74/10. Analysis yielded ~5,800 coded items; three dominant themes accounted for ~38%, ~32% and ~30% of coded items respectively: duplicate/non-value tasks; physical/digital workspace constraints; and cognitive/emotional overload. Many ideas were low-cost, high-feasibility "pebbles" suitable for local action; others required cross-functional or system-level coordination. At reporting, the program was in Stage 3 (Implement & Improve) with executive resourcing and local enablement underway; Integrated Huddles were piloted as an emergent Tier-2 coordination mechanism.

Clear the Clutter demonstrates a pragmatic, scalable approach to surface frontline operational burdens and translate them into prioritised improvement activity. Early findings indicate substantial implementable opportunities; further evaluation should measure objective process and time-saved outcomes and assess long-term sustainability.

Keywords: operational efficiency; de-implementation; clinician wellbeing; quality improvement; implementation science; human-centred design.

Introduction

Modern healthcare environments are characterised by increasing administrative complexity, fragmented digital architectures and intensifying workload pressures. Frontline staff frequently report small but persistent operational frictions or "pebbles in the shoe": duplicated tasks, cumbersome workflows and environmental clutter that together elevate cognitive load, reduce time for direct patient care and erode "joy in work". These micro-frictions contribute to clinician stress, reduce efficiency and, when pervasive, form a psychosocial risk.^{1,2}

Systems-level reports and position papers highlight the need for multi-domain responses to clinician burnout and professional wellbeing. The National Academies (2019) advocated for coordinated organisational action, and expert commentators highlight the necessity of organisational strategies to protect clinician capacity.^{3,4} The Institute for Healthcare Improvement's Joy in Work framework and the Stanford Model for Occupational Wellbeing and professional fulfilment provide practical, system-level strategies for restoring meaningful work and capacity.^{5,6}

There is growing evidence that targeted removal of everyday operational frictions can improve workflow and staff experience. Several quality improvement initiatives report measurable benefits from workflow redesign⁷, and a recent emergency department case study described operational gains after alleviating "pebbles in the shoe."⁸ De-implementation checklists and frameworks (eg, the American Medical Association De-implementation Checklist) support structured identification and removal of non-value work.⁹

Despite these advances, few reports describe whole-of-service approaches that capture frontline insight at scale and translate it into prioritised, governed improvement pipelines. Clear the Clutter was designed to address this gap within Metro South Health (MSH), a large Queensland public health service. The program intentionally integrated human-centred design, implementation science and behaviour-change planning to: capture frontline insight; categorise and prioritise issues by feasibility, impact and escalation tier; and provide clear governance pathways for local, cross-functional and system-level responses. Integrated Huddles and a SharePoint-based Good Ideas Database were trialled as enabling infrastructure to support diffusion and sustainment. The objective of this paper is to describe the design, implementation and early findings from Clear the Clutter and to discuss implications for policy and practice.

Methods

Design and program phases

This paper reports the completed baseline discovery and the program design for ongoing evaluation within a whole-of-service quality improvement program structured across four phases: Discovery (Phase 1), Prioritisation (Phase 2), Implement and Improve (Phase 3), and Sustain and Scale (Phase 4). The program is currently operating in Phase 3 (Implement and Improve).

Conceptual frameworks

The program used complementary frameworks to guide discovery, prioritisation and implementation.⁸ Human-centred design (HCD) supported co-design of instruments and local solutions; the Consolidated Framework for Implementation Research (CFIR) guided assessment of contextual determinants¹⁰; and the ADKAR model (Awareness, Desire, Knowledge, Ability, Reinforcement) structured behaviour-change planning and adoption activities.¹² CFIR and the Proctor implementation outcome taxonomy informed the planned measurement of implementation outcomes (acceptability, adoption, fidelity, feasibility, sustainability).^{10,11} The IHI Joy in Work principles provided an organising aim around restoring meaningful, safe and equitable work.⁵

Evaluation design — two linked evaluation stages

A two-stage evaluation design was used across the program lifecycle.

Evaluation Stage 1 (Completed - Discovery & Baseline): cross-sectional workforce and consumer engagement to capture baseline staff-rated clutter and rich qualitative data used for prioritisation. Stage 1 generated the baseline dataset (workforce respondents n = 949; consumer respondents n = 150), a measured baseline staff-rated clutter impact (mean = 6.74/10), 53 Key Insight Reports and an 865-item Good Ideas Database.

Evaluation Stage 2 (Ongoing/Prospective Tracking): embedded outcome measurement captured prospectively during Phase 3 implementation. Stage 2 data collection is ongoing and is triggered when staff submit a completed initiative ('Pebble Story') to the SharePoint Good Ideas Database; these submissions capture paired post-implementation data for later analysis.

Setting and participants

Metro South Health (MSH) services included four large Brisbane metropolitan hospitals, Community and Oral Health Service, and Addiction and Mental Health Service. Stage 1 participants were frontline clinical and non-clinical staff (n = 949) and consumers engaged via roadshows and digital channels (n = 150). Participation in Stage 2 (Pebble Story submissions) is open to staff and teams undertaking local initiatives during Phase 3.

Survey instrument and quantitative measures (Stage 1 → Stage 2 linkage)

The Stage 1 workforce survey (12 Aug – 5 Sep 2025) combined a single-item numeric clutter rating (1–10), structured items on common operational problems (eg, duplicate documentation, inbox volume, equipment shortages), facility/directorate/professional stream identifiers, and free-text prompts inviting frustrations, positive practices and suggested solutions. The instrument was co-designed with frontline staff via HCD workshops and piloted for clarity and actionability. Baseline staff-rated clutter from Stage 1 was mean = 6.74/10.

Stage 2 measurement is embedded in the SharePoint 'Pebble Story' form: when a team logs a completed initiative they re-rate clutter (1–10), provide a brief wellbeing impact response (1–5 Likert), record feasibility/complexity, optionally enter estimated time saved, and add short free-text learning statements. All post-implementation measures are captured at submission to create paired pre/post measures for completed initiatives.

Qualitative data collection and analysis (Stage 1)

Free-text responses from Stage 1 were pre-processed (spell normalisation; removal of direct identifiers) and analysed with a hybrid inductive–deductive coding approach. A priori domains (themes); non-value tasks; physical/digital workspace; cognitive/emotional overload, and seeded the codebook, which was iteratively refined as subthemes emerged. Multiple coders independently coded a 10% random sample to assess consistency; discrepancies were resolved by consensus and the codebook updated. Inter-rater agreement was assessed using Cohen's kappa.

Responses were initially grouped using the AI-supported analytics tool Abacus and reviewed and validated by the Clinical Improvement Unit (CIU). Abacus automatically detected themes across open-text responses by grouping similar

words/phrases (for example, “slow system,” “computer lag,” “crashes”) into single themes (for example, “System performance”). “Mentions” denote how often a theme was raised across all responses; a single respondent could contribute multiple mentions. Themes were quantified by mention frequency to prioritise system-level issues; this method may under-represent rare or highly specific concerns.

A thematic analysis was then applied to refine and validate AI-generated groupings. Findings were cross-checked using AI-supported Dovetail analytics and confirmed through manual review by CIU analysts to ensure qualitative rigour, and validated by a team of clinicians. Outputs were quantified to provide indicative distributions and to identify high-frequency signals for the 53 Key Insight Reports; whole-of-MSH and consumer reports were also produced. To protect privacy and ensure robustness, reports were generated only for themes with ≥ 10 mentions. Qualitative Pebble Stories submitted in Stage 2 will be analysed using the same framework to detect change and diffusion of practice over time.

Prioritisation, governance and SharePoint workflow

Key Insight Reports combined frequency counts, exemplar (anonymised) quotes, feasibility indicators (quick wins = ‘pebbles’), and recommended next steps. A three-tier governance model guided prioritisation: Tier 3 (local pebbles) for unit-resolvable changes; Tier 2 (cross-functional) for pilotable issues (eg, Integrated Huddles); and Tier 1 (system level) for strategic projects requiring executive resourcing. The SharePoint and Good Ideas Database is the operational hub: when teams submit a completed ‘Pebble Story’ they provide post-implementation evaluation data (paired clutter re-rating, wellbeing impact, feasibility, time-saved estimates and completion metadata). Submissions feed an automated Power BI dashboard and route items to the appropriate governance tier for action and tracking.

Implementation planning maps ADKAR elements to communications, training and sustainment activities and identifies ADKAR-aligned tactics for adoption, and benefits realisation.¹²

Implementation outcomes and dashboard metrics (prospective Stage 2 measures)

Implementation outcomes follow Proctor et al. and are mapped to Power BI fields.¹¹ Primary Stage 2 metrics (captured at submission and via CIU registers) include:

- Frequency: number and proportion of Good Ideas submitted and progressed (by directorate and theme).
- Feasibility / Complexity: traffic-light classification at submission (Green = pebble/low complexity; Amber = small-medium; Red = complex). Aspirational 6-month benchmarks for planning: Green 10% implemented; Amber 5%; Red 1%.
- Effectiveness / Program outcomes: paired pre/post staff-rated clutter scores (1–10) and a brief wellbeing impact score (1–5) collected at Pebble Story submission.
- System-level outcomes (eg, % reporting reduced duplicate tasks, improved environment functionality, reduced cognitive/emotional overload) will be aggregated from post-implementation entries and periodic follow-up surveys as submission volumes allow.
- Fidelity & Sustainability: Audits of documented changes and dashboard maintenance checks at 6 and 12 months; BAU registration of sustained changes.

Power BI visualisations display submission volume (by tier/theme), feasibility distribution, progression status (logged → in progress → completed), paired pre/post clutter distributions for completed initiatives, and a rolling register of time-saved estimates. These views enable executive sponsors to monitor diffusion and prioritise Tier 1 resourcing.

Analysis approach

Stage 1 quantitative analyses report descriptive statistics (means, proportions, SDs) and compare theme distributions across facilities and professional streams. Qualitative codes are summarised with exemplar quotes in Key Insight Reports.

Stage 2 analyses are prospective: once sufficient Pebble Story submissions accumulate, paired pre/post comparisons for clutter scores, and summary tests for wellbeing Likert changes. Implementation outcomes (frequency, feasibility, adoption rates) will be reported as counts/proportions with 95% CIs as

appropriate. Mixed-methods triangulation will link quantitative changes to thematic learning from Pebble Stories to explain mechanisms of change.

Ethics, governance and data oversight

This program was implemented as a service improvement initiative and was approved through executive governance rather than a human research ethics committee. Formal approvals were obtained from the program sponsor (Chief Operating Officer) and Executive Directors, with operational endorsement via the COO–ED operational group and strategic oversight by the Executive Strategic Governance Committee (ESGC). Stage 1 survey participation was voluntary; respondents were informed about the purpose of the activity and provided consent for use of de-identified responses for service improvement and reporting. Stage 2 Pebble Story submissions collect organisational metadata and team-level learning statements; provision of individual identifiers is optional and subject to local privacy approvals.

Data governance and AI transparency

All data captured on SharePoint are managed under Metro South Health data security and retention policies; Power BI dashboards are access-restricted by role. Open-text responses were initially processed using AI-supported analytics (Abacus and Dovetail). All AI outputs were validated by Clinical Improvement Unit analysts and validated by a team of five clinicians. Tool versions, analytic settings and validation decisions were logged and retained in the program repository to ensure transparency, reproducibility and alignment with MSH governance. Any outputs shared externally are de-identified and subject to the same suppression thresholds used for internal reporting.

Limitations of the evaluation design

Stage 1 provides a strong baseline and rich qualitative signals, but Stage 2 outcomes are prospective and rely on teams submitting completed initiatives to generate paired measures. At the time of writing, Stage 2 data capture is active but incomplete; this paper therefore reports Stage 1 baseline results and a detailed, pre-specified plan for Stage 2 evaluation and ongoing implementation measurement.

Results

Reach and outputs

Workforce respondents: n = 949; Consumer respondents: n = 150. Thematic coding produced ~5,800 discrete coded items and an 865-item Good Ideas Database. Directorate-level synthesis produced 53 Key Insight Reports including one MSH-wide summary report and one Consumer report.

Thematic findings

Across the three themes, a number of actionable sub-themes emerged (approximate distribution of coded items):

1. Tasks that no longer add value (~38%) — high-volume, low-value communications (eg, email overload); duplicate documentation and data entry across systems; excessive approvals; unnecessary meetings. Suggested local actions included email etiquette/segmentation, form simplification, reduction of duplicate entry and meeting guidelines.
2. Physical and digital workspaces (~32%) — overcrowded workstations, inconsistent supply placement, inadequate storage and quiet spaces; digital fragmentation (multiple logins, slow systems) and network reliability problems. Suggested actions included 5S-style workspace audits, standardising supply locations, and prioritising single sign-on (SSO) and lightweight digital fixes (surge IT digital checks) alongside longer-term IT projects.
3. Cognitive and emotional overload (~30%) — workload pressure, interruptions during critical tasks, role ambiguity and onboarding gaps. Staff linked operational micro-frictions directly to stress and reduced capacity for patient-centred care. Suggested interventions included protected focus time, role clarity, improved onboarding and psychosocial safety training for line managers.

Exemplar anonymised quotes

Nurse, ED: "I spend at least 30 minutes every shift logging the same details into three different systems, time that could be spent with patients."

Allied health, community: "Supplies are stored in different rooms across the unit; it takes too long to find basic items and interrupts workflows."

Doctor, inpatient ward: "I get over 100 emails a day, and it's impossible to know what requires action and what can be ignored."

Consumer: "We waited while staff looked for paper notes and different forms, felt like the system was not organised for care."

MSH-wide summary signals and system-level priorities

Synthesis across directorates identified recurring system-level signals that informed Tier-1 priority setting while preserving local Tier-3 momentum. High-frequency signals included: inbox overload with inconsistent expectations and distribution lists; inefficient digital workflows with duplicate data entry across iEMR, Auslab and local systems; overcrowded workspaces and storage limitations; intermittent network and system performance issues; and workforce wellbeing pressures linked to operational micro-frictions. Organisational responses in planning or early implementation included an IT roadmap (SSO and integration projects), pilots for robotic process automation for low-value administrative tasks, targeted network upgrades, 5S workspace audits, and capability-building in psychosocial safety and change management.

Early implementation and actionability

Many Good Ideas were low-cost, high-feasibility 'pebbles' such as relocating commonly used supplies, standardising naming conventions in shared drives and implementing local email etiquette. Early local implementations included workspace reorganisations that reduced interruptions during medication rounds and form simplification projects that removed duplicate data entry. Tier-2 pilots (Integrated Huddles) were trialled across MSH-wide functions to coordinate cross-functional escalation and sharing of what new initiatives are coming in the pipeline; early learning suggested improved clarity of escalation pathways but formal evaluation is pending. The SharePoint hub was actively used as the central resource for Key Insight Reports, toolkits, reporting dashboard and the Good Ideas Database and supported practical Clear the Clutter ways to make practical improvements for local teams.

Tables

Table 1. MSH context and program overview

Item	Detail
Metro South Health (MSH) profile	Large Queensland public health service; >20,000 staff; multiple hospitals and community services
Program name	Clear the Clutter

Program aim	Restore joy in work by "clearing the clutter" to improve ways of working, wellbeing and time for care
Survey period	12 Aug - 5 Sep 2025
Workforce respondents	n = 949
Consumer respondents	n = 150
Key Insight Reports	51 directorate/division reports + 1 MSH-wide + 1 consumer report
Good Ideas Database	865 discrete ideas (searchable on SharePoint)
Baseline clutter impact	Mean 6.74 / 10
Program stage	Stage 3: Implement & Improve (executive resourcing; local enablement)

Table 2. Engagement summary

Metric	Value
Workforce respondents	949
Consumer respondents	150
Directorate/Unit Insight Reports	51
MSH-wide report	1
Consumer report	1
Good Ideas Database items	865
Approx. coded items analysed	~5,800
Channels	Leadership cascades, emails, roadshows, SharePoint, intranet, Clear the Clutter Connect sessions

Table 3. Thematic findings (domain, key sub-themes, suggested improvements)

Domain	Key sub-themes (examples)	Suggested improvements
Tasks that no longer add value	High-volume low-value emails; duplicate documentation; excessive approvals	Email etiquette and segmentation ; form simplification; reduce duplicate entry;
Physical & digital workspaces	Overcrowded workstations; fragmented systems; slow performance	5S audits; standardised supply locations; SSO and lightweight digital fixes
Cognitive & emotional overload	Interruptions; role ambiguity; onboarding gaps	Protected focus time; role clarity; onboarding improvements; psychosocial wellbeing and safety training

Discussion

This whole-of-service quality improvement initiative demonstrates that systematic capture of frontline operational burden can produce a prioritised pipeline of implementable actions across the unit-to-system spectrum. The dominant themes align with international literature linking operational inefficiency and fragmented digital systems to clinician burden and burnout.^{1,4} The pragmatic emphasis on resolving low-cost, local "pebbles" while maintaining clear escalation pathways for system-level issues balanced momentum with governance.

The integration of human-centred design, CFIR-informed implementation planning and behaviour-change mapping (ADKAR) helped structure both discovery and the early implementation planning. The Clear the Clutter approach operationalised de-implementation concepts using tools adapted from the AMA De-implementation Checklist to identify non-value tasks and to design local de-implementation pathways.⁹ Embedding these activities within WHS and wellbeing strategies (eg alignment with Safe Work Australia's Code of Practice on managing psychosocial hazards) frames clutter-reduction as a psychosocial risk mitigation strategy rather than merely an efficiency exercise.²

Strengths and limitations

Strengths: whole-of-service scale, large multidisciplinary sample, executive sponsorship, pragmatic deliverables (Key Insight Reports; Good Ideas Database; Practical Tools and Resources) designed to support prioritisation and implementation.

Limitations: voluntary response may introduce selection bias; results are early-stage with objective outcome measures pending; coding interpretation risks exist despite multiple coders and reconciliation; some suggested implementations require formal project funding and time to realise measurable benefits.

Implications for policy and practice

Future policy development within health services may benefit from considering operational clutter as a formal psychosocial hazard, potentially integrating clutter-reduction efforts into existing Work Health and Safety (WHS), staff wellbeing, and quality improvement strategies.² To sustain momentum, it is recommended that services explore ways to preserve local ownership of rapid, low-cost "pebble" improvements while maintaining clear escalation pathways for complex cross-functional (Tier-2) and system-level (Tier-1) challenges.^{3,4,6} Embedding simplified measurement tools, such as the paired staff-rated clutter scores and wellbeing

impact items captured at the point of initiative completion, may assist in demonstrating program value and sustaining long-term engagement. Shared accountability across executive oversight, operational stewardship, and corporate functions (e.g. Digital Health, People and Partnerships) is suggested to ensure these initiatives are effectively translated into sustained practice.

Sustainability and embedding

Sustainment strategies include: a central knowledge hub (SharePoint) housing Key Insight Reports and toolkits; governance via the three-tier model with executive visibility for Tier-1 decisions; capability building through train-the-trainer model; and routine measurement integration (dashboards tracking projects active/completed and time saved). Encouraging teams to record changes into BAU registers to support longer-term embedding.

Conclusion

Clear the Clutter provides a pragmatic model for surfacing and acting on frontline-identified operational inefficiencies across a large health service. Early-stage results show good engagement, a rich pipeline of feasible improvements, and emerging governance mechanisms to translate staff voice into action. Future work should focus on objective measurement of effectiveness, wellbeing, and feasibility outcomes, formal evaluation of cross-functional coordination mechanisms (eg Integrated Huddles), and assessment of long-term sustainability and diffusion across services.

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