Chapter 7 Case study

The development of lean production in a public sector context: problems and issues

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In 2013 a management consultancy firm, 'Leaner-and-Cleaner', comprising a number of prominent former academics obtained a contract from a local public hospital that indicated that it was seeking to improve its daily health care delivery. According to documents, the consultancy brief was to reduce costs, including 'waste' (examples cited were of clinical staff spending too much time on non-frontline activities), increase productivity, and change the hospital's working culture.

The consultancy firm stated that their agenda promoting lean organizational development would see the hospital successfully delivering, what their sales pitch titled, 'Better Health Care Delivered by a Lean and Agile Hospital'. They concluded the changes would allow '... better health for all at reduced cost, better quality and greater staff efficiency. In short, we will deliver extra productivity with increased staff performance, with doctors and nurses (clinicians) working smarter not harder'. The consultancy reported that these objectives (reduced cost; increased productivity; new working culture) could be delivered by increasing the content of skill sets. Further improvements were promised by, among other changes, assigning one person, usually a doctor, to lead teams and report on deliverables; introduce team briefings led by an appointed other clinician (doctor or senior nurse); introduce quality performance criteria; establish at team meetings continuous patient care improvement programmes. The consultancy report argued that this range of measures would enable more to be achieved at lower cost, mostly through staff rationalization. This would follow where nurses and doctors were given more responsibilities to do more jobs in a more rational way.

The only problem, as the consultancy firm was soon to discover, was that front line health care workers were entirely unaware that any problems existed. They operated *self-managed teams of mixed-skill sets* performing pretty much at maximum capacity, with little waste and superb clinical outcomes including very low hospital acquired infections. These self-managed teams would rotate the lead person responsible for ensuring reporting of procedures and process. Both clinical groups (doctors and nursing staff of all grades) making up the clinical care teams were especially surprised given the frequent praise received from existing and former patients. Indeed, the hospital was often cited in the press and more widely as an example of what good public medicine can offer. Moreover, medical staff often spent much of their free time on days off administering primary health care (as unpaid volunteers at sporting and other functions in the local community) and attending a range of public events at institutions, including schools, promoting preventive medicine. While time consuming, this was outside their brief in the strict sense that their employer, Health-Care-We-Trust (HCWT), would have preferred them to spend more time promoting these activities both as a requirement of their paid time *and* in situ at the hospital itself. Management argued that staff should undertake these extracurricular activities within their normal working time. As one manager was overheard saying to her senior officer, 'we paid to train them, why should

others get the benefits of our trained staff gratis? And anyway, it would help us a bit more if doctors and nursing staff did this in-house so that we could charge a fee'.

When the medical staff were informed by HCWT that they would now be prohibited from these voluntary activities and that they must as a matter of contract perform these formerly free activities as part of a new contract agreement, both doctors and nurses protested. They had three main objections. First, they argued that their highly regarded record in delivering what was a social good in their own time would be undermined because now they would have to undertake their former voluntary work as part of their regular contract. In addition, their relationship with the community would become more inflexible and formalized. Second, not everyone did this work in the community and the proposed new contract meant that everyone would now have to promote preventative health care in addition to their regular jobs. This would involve staff having to go around schools and clubs while undertaking their normal weekly hospital based clinical duties. Third, what was sold as an enhanced job would be effectively a new job with more onerous, compulsory aspects and for the same remuneration.

Inevitably, staff groups were disgruntled but more than this was the impact of the organizational changes on clinical care and patient responses to these. Increasingly, staff had to take sick leave; especially direct nursing and auxiliary care workers began reporting repetitive strain and other musculoskeletal injuries. Nurses reported that it was 'almost impossible' to undertake the new assignments while giving patients the kind of care they, the nurses, had valued as part of their emotional labour process. They liked their patients and while enjoying their craft were beginning to feel that it was not possible to care for them as they had in the past while also having to be concerned with cost (reducing so-called 'waste') which from what they could see, was obtained essentially by reducing staff numbers and thus getting those remaining to do more. Furthermore, what they were often expected to do made them feel that they were now working beyond their trained competence. In a union sponsored survey most staff said that they were just 'very tired a great deal of the time' and 'found it hard to keep up with what was expected of them'. This applied equally to doctors and nursing staff of all grades.

Many of their new organizational activities – for example, team briefings and continuous improvement meetings - were essentially measures they felt were more about surveillance and conforming to box ticking. Prior to the changes, organisational practices depended upon collegial self -managed working arrangements. Some people had minor managerial responsibilities, besides those related to their clinical practice, but now they were being required formally to undertake managerial tasks such as checking on colleagues' performance and time and task management. They felt this was a form of snooping and that it led to less trust between people who, though different in grade and authority, had previously worked together on the basis of a collegiality sustained by mutual respect. This had been seen to sustain a degree of rough-and-ready equalitarianism. Perhaps what was particularly galling for the clinicians was that standards of cleanliness began to deteriorate subsequent to the outsourcing of cleaning duties. There were now half as many cleaners as before the changes. The new cleaners were employed on temporary contracts with company, as opposed to national sector, pay rates while a number of them were employed on zero hours contracts. All clinicians involved believed that far from the system allowing people to 'work smarter not harder' they were being driven to work by leaner and meaner working methods. And according to one auxiliary nurse, staff also felt the hospital 'certainly was not cleaner'.

Perhaps it was inevitable that the following linked outcomes were reported:

1 What had been a hitherto pleasant and supportive working environment was transformed into one where trust, as one doctor put it 'went out the window'. Industrial relations and formal and informal workplace conflict, which few had discussed previously, became a matter of concern to all, including the local media.
2 Standards of nursing care deteriorated with many clinicians taking time off due to a range of physical injuries and stress related ailments.
3 Hospital acquired infections increased to such an extent that the government sent in a task force to 'sort things out', as a government spokesman put it.
4 The trade unions, which until the change in management strategy had enjoyed good relations with hospital management, was shunned by management, much to the consternation of doctors and nursing staff.

Questions

1 Why did management want to change what clinicians and public alike regarded as a perfectly sound and efficient system of health care provision?
2 How would you describe the new working practices? What did they consist of? In what ways were staff upset by these?
3 Why do you think management pushed the unions out into the cold?
4 What were the differences between collegial ways of working and the new 'lean' ways?
5 How would you change the situation to improve health care while increasing staff satisfaction to its previous 'healthy' state?
6 Is there a difference between the idea of, in this case, the management of health care as social good and the management of health care as if it were a source of profit? Consider the extent to which the methods and practices (lean production) originating in capitalist markets are inappropriate for social goods such as health and social care?