Sweat the small stuff

. . . minor problems, rapid fixes, major gains . . .

*Cranfield Healthcare Management Group*

*Research Briefing 17*

How do they manage?
a study of the realities of middle and front line management work in healthcare

Ciara Moore, January 2012
Following interviews with Consultants in Clearview hospital an initiative was set up to explore the potential benefits to patients, staff, and overall organizational performance, of addressing minor problems in an acute health care setting. These problems might include unanswered emails, or equipment orders not fulfilled. Such issues can be overlooked in a context where major change is at a premium. However, a small-scale initiative designed to fix these problems revealed the potential to generate savings, increase staff morale, improve quality of patient care, expose underlying issues, and strengthen clinical-managerial relationships. The success of this initiative set the foundation for further improvements, in this and other services, suggesting that classifying change on a continuum from ‘fine tuning’ to ‘transformational’ (Stace and Dunphy, 2001; Kotter, 2008) may be misleading.

‘When the computer on the ward was bust, I said to the ward manager, we need a new one, and she said we needed to ask the operations manager. When I asked the operations manager, she said the ward manager could do it. So it takes ages to just sort out the computer. It’s this inefficiency which is irksome.’

At Clearview, to explore medical-managerial relationships, pilot interviews were conducted with seven consultants - senior doctors who were leading specialists with international reputations in their respective fields of medicine. Contrary to expectations, and to traditional stereotypes (McCarthy et al., 1993), these doctors welcomed and recognized the value of management support (Moore, 2011). However, they also noted that management workload pressures meant that small problems were often not resolved. For example, one consultant had waited eight months for a connection to allow a colleague to share the printer in his office. A source of daily frustration for those affected, such problems contributed to a perceived lack of management action, and damaged managerial credibility.

The aims of this initiative, therefore, were to identify the small problems in one clinical service, to understand why these had not been tackled, to fix these quickly, to establish the benefits, and to assess the applicability of this initiative to other clinical services.

This initiative, *Sweat the small stuff*, was implemented by a three-person team including the project lead who managed and coordinated the initiative, a consultant ‘champion’, and an administrative lead in the ‘who knows who knows what’ role (Katz and Lazer, 2003, p.20). A project charter was agreed by the team, and approved by the medicine division’s budget holder and associate director. The team designed a five-day process. Could minor problems be identified, explored, and resolved in such a short time? Why had those small issues not been fixed previously? And what impact would solving these issues have on the staff concerned and patient care?

One of the key themes emerging from the pilot interviews concerned customer service.

Hospital staff who place orders or requests through internal systems expect a response similar to that which they receive when shopping online at home with Amazon and Tesco. The team wanted to emulate the customer services aspect to ensure that the responses from the project team were rapid, and that the staff were kept up to date with regard to progress on the issues they raised. Those staff members were seen as clients, and the aim was to treat them as such, by giving them one, three and five day progress updates concerning fixes for their problem.

Five problems were identified, and were fixed within the five days, for a total cost of only £89.
## The small stuff that was sweated

<table>
<thead>
<tr>
<th>problem</th>
<th>why was this not fixed?</th>
<th>the fix</th>
<th>cost of fix</th>
<th>benefits of fix</th>
</tr>
</thead>
<tbody>
<tr>
<td>patient pathways</td>
<td>obvious solution - a dedicated liaison person - not possible due to staff shortage and budget restrictions</td>
<td>a manual of visual process maps to explain pathways to endoscopy clinic and administrative staff; built up gradually and presented at weekly meetings</td>
<td>none</td>
<td>less consultant time wasted</td>
</tr>
<tr>
<td>coding (1)</td>
<td>code had been set up, but directorate manager overlooked email due to pressure of other work</td>
<td>short conversation with specialist nurse who would run the clinic to agree clinic times and patient numbers</td>
<td>none</td>
<td>patients spared further hospital visit £47,000 consultants’ time</td>
</tr>
<tr>
<td>coding (2)</td>
<td>senior commissioning management advice that a code was not required</td>
<td>information services manager gives different advice, code is set up</td>
<td>none</td>
<td>£20,000 new annual revenue</td>
</tr>
<tr>
<td>scanner</td>
<td>spare barcode scanner in another department did not work; assumed no budget for replacement</td>
<td>new scanner costed and acquired in five days (plus one day’s delay in the ‘goods inward’ department)</td>
<td>£89.00</td>
<td>157 FTE secretarial hours saved pa (cost of lost time over five years was over £11,000) £2,500 secretarial time per annum</td>
</tr>
<tr>
<td>patient safety</td>
<td>mechanism in place, but not used consistently due to poor understanding</td>
<td>issue brought daily to medicine division morning report, where patients are reallocated to correct clinical team following on call admission</td>
<td>none</td>
<td>reduced time spent on administration £11,000 consultants’ time</td>
</tr>
</tbody>
</table>

It is significant that the failure to have fixed these issues previously was not attributed directly either to lack of finance or staff (although workload may be affected by staffing numbers). Only one fix involved some minor expenditure.

Informal feedback from the staff involved in this initiative was positive. The opportunity to be involved in solving those issues was welcomed, although two gastroenterology managers, the operational team leader, and the ‘who knows who knows what’ person, did most of the work. A log of calls and time spent fixing the issues was kept by the operational lead which indicated that, to resolve those issues, she had spent 40 minutes in conversations over five days.
Although it is managers who often leave those small issues unresolved, they typically have a better understanding of how to fix them. Clinical and medical staff often lack (and may have little time or desire to develop) the networks and the organizational knowledge that contributed to the success of this initiative. Administrative teams and secretarial staff are a valuable source of potentially untapped knowledge, particularly with regard to negotiating the bureaucracy and finding appropriate and effective short cuts. The ‘soft’ benefits from this small-scale initiative may contribute in significant ways to the implementation and success of the more radical, transformational, disruptive change agenda facing healthcare. This initiative also helped to cement the mutual interprofessional trust, respect, and collaboration on which those larger-scale challenges are likely to depend.

Key success factors included (a) a receptive context in which a high performing team were frustrated with slow progress on some issues, (b) problem ownership by the team members themselves, not change imposed from outside, and (c) an effective team which moved quickly to ‘navigate the system’, identify the blockages, acquire the resources where necessary, and put quick fixes in place. This combination of factors is not difficult to replicate in other areas, and the aim is to roll out this initiative to other clinical services at Clearview.

If you have a view on any these issues, please let us know.


The research

This study is based on interviews and focus groups with middle and senior managers at six acute trusts and one primary care trust. The final stages of the project include a management survey, debriefing groups, and case studies exploring how changes are managed in the aftermath of serious incidents.

Participating trusts

Bedford Hospital NHS Trust
Cambridge University Hospitals NHS Foundation Trust
Northampton General Hospital NHS Trust
Whipps Cross University Hospital NHS Trust

NHS Bedfordshire Primary Care Trust
Gloucestershire Hospitals NHS Foundation Trust
North Bristol NHS Trust

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