Chapter 30

Pulling it all together: a concluding case study

This book has covered a lot of ground. This final chapter is designed to provide you with an opportunity to review what you have read and to think about how the many theories, models, techniques and tools can be applied to the management of a single case. You can do this on your own or with others.

After reading the case study below, reflect on the content of the whole book (or those parts of the book you are familiar with) and identify the concepts, theories and tools you feel would be most helpful if you were invited to advise the manager of the Urology Department about how best to manage the situation.

If you undertake this assignment with others, follow these three steps:

1. Working in small groups, identify the *three* concepts or theories you feel are most relevant to this case.
2. Share your views in a plenary session with members of the other groups and justify your selection.
3. Working in small groups, taking account of the views expressed by other groups in the plenary discussion:
   - formulate the advice you would give to the Urology Department manager
   - explain how this advice is informed by theory.

Case study **30.1** *Managing change in the Urology Department of a hospital in England*

The Department of Urology in an NHS hospital in England is struggling to respond to external pressures for change. The manager responsible for the department has approached you for advice on how to manage the situation.

For many years, the department has operated with five consultant surgeons, a number of middle-grade and junior doctors and a full complement of nurses and other clinical staff. In terms of infrastructure, it has two 18-bed wards and access to two operating theatres. Several departments within the hospital provide support services for diagnostic investigations and other essential supporting functions, for example anaesthesia, medical records, pharmacy and so on.

The immediate trigger for change was the combined impact of a financial crisis and new European Commission regulations limiting the number of hours medical staff are allowed to work.

Factors contributing to the financial crisis

In 1997, the UK government introduced new regulations that required all NHS hospitals to treat non-emergency patients within 18 weeks. Financial penalties were introduced for failing to comply with the 18-week referral-to-treatment target. The Urology Department was unable to meet this target with its in-house resources and responded by subcontracting some treatments to a private hospital. Initially, this was a cost-effective solution but, over a period of time, costs increased to the point where the Urology Department was losing money on every patient it sent to the private hospital. Most members of staff were unaware of this. It

was not until managers called an emergency meeting that staff, including the five consultant surgeons, realized there was a problem. Managers were criticized for not sharing this information earlier.

Factors contributing to the shortage of medical staff

In October 1998, the European Working Time Directive (EWTD) was incorporated into UK law but full implementation was delayed. An interim target was that all junior doctors would work a maximum 56-hour week by 2007. Full implementation was set for August 2009, when a 48-hour week was introduced. The 48-hour week led to staffing problems that have significantly compromised the department's ability to provide quality and continuity of patient care. It also undermined the quality of the training given to junior doctors; for example, junior doctors working night shifts do not have the opportunity to assist surgeons undertaking complex operations or to practise operating procedures under their supervision. The situation has deteriorated to the point where the external body responsible for validating the training has threatened to withdraw its validation.

Managing the crisis: the story so far

Members of the executive team, which includes the five consultant surgeons, senior nurses and senior managers, have agreed there is an urgent need to bring the work currently being performed at the private hospital back into the Urology Department, and provide an EWTD-compliant rota for junior and middle-grade medical staff that does not compromise patient care or training. They have also agreed that this will require the department to expand its physical resources (number of beds and operating theatres) and recruit more staff. However, they have failed to produce an agreed plan to meet these challenges. Members of staff who are not part of the executive team do not appear to appreciate the seriousness of the problem.

These are some of the reasons why the situation is proving difficult to manage:

- *A tension between managers and clinicians:* Some doctors and nurses perceive managers as being motivated by financial and other concerns not directly related to patient care. They believe that managers also lack specialist knowledge about patients' needs. Managers, on the other hand, believe that many clinicians fail to appreciate that efficiency improving and cost-cutting measures can be achieved without undermining the quality and safety of patient care, and that often more efficient ways of working can deliver improved clinical outcomes.
- *A failure to agree about extra beds, operating theatre efficiency and staff capacity that will be required to treat all patients in-house:* Some members of the executive team believe that better utilization of existing beds could reduce the number of extra beds required. There is also a view (again not shared by everyone) that steps could be taken to improve the efficiency of the operating theatres and make better use of staff time.
- *Information overload:* Emails are regularly cascaded from the senior executive team to all staff about a wide range of matters. This has led some staff to ignore messages, with the result that important information is not always disseminated effectively.
- *The slow response of those who have been asked to investigate problems and provide the executive team with data for decision making:* For example, a departmental theatre efficiency group was formed to improve operating theatre efficiency, but the results of a survey of six months' activity are still not available, despite being crucial to determining the potential throughput of patients.
- *The poor quality of data collected by department members on a regular basis as part of their normal work:* For example, medical procedures are often wrongly coded, making it difficult to forecast future income. This had also resulted in a loss of income in the past, thereby contributing to the department's financial problem.
- *Plans to increase the numbers of medical and nursing staff have been frustrated by disagreements about the number and grades required:* There are two conflicting views. Managers concerned about the department's financial position and the need to stop subcontracting work out to the private hospital are leading the argument in favour of recruiting more consultant surgeons. This is being resisted by others who believe that a more pressing problem has to be addressed first. They argue that middle-grade and junior doctors are unable to support the current level of activity generated by the existing five consultant surgeons, and so the first priority should be to recruit three or four new junior doctors. They argue that this will also help to ensure that the work rotas for sub-consultant-grade doctors will be EWTD-compliant, will provide more time for training, and could improve existing consultants' productivity by enabling them to run larger outpatient clinics.

Info gathering approach

Create budget of contracted spending and factor in to new staff, beds etc.