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National report from The Netherlands

Company case study 3: Care3

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Co-funded by the
European Union

Care3

1. Company characteristics and innovation

Care3 provides long-term care and elderly care in the Province of South Holland, the Netherlands. They manage six locations for intramural care (nursing homes) and provide homecare in the region. Care3 has Protestant Christian backgrounds and is a private, not-for-profit company.

Several innovation processes are going on in the organisation. A first, recent example, is the introduction of 'smart sensors', a digital monitor to check if inhabitants of nursing homes fall or get out of their beds. There are also bed mats that raise an alarm when the patient sits on the edge of the bed. This has led to some efficiency in labour saving, e.g. on the night shift, where 1 person is enough to check the patients with support of the cameras and alarm systems, while in the past 2 persons were needed during the night. Some employees have difficulties in trusting these new technologies that ask them to change their behaviour and to do the opposite of what they learned at school, namely '*always to check things yourself*' (interviews WC, IT). Some workers are concerned that their mistakes in doing their tasks will be monitored, and that they will be directly dismissed for that reason. The IT manager: '*then we start a conversation about it to explain that technology is not meant for that … that IT is meant to make life easier for you instead of more difficult*' (interview IT).

Another example some years ago was the introduction of 'life circles', areas where residents are allowed to be. Residents wear a wristband or transmitter and in the building there are sensors (beacons) that recognise these channels. As soon as a resident is too far from his or her safe area, the system reacts to this and doors that are normally open to everyone remain closed. The life circle is larger or smaller depending on the personal situation of the resident. Thanks to this innovation, residents can move much more freely. As a result, they feel more comfortable and they are also calmer. Interestingly, at Care3, a broadly composed group of employees chose the system and the supplier. These involved employees turned out to be very interested in the possibilities of technological innovations (Actiz, 2019: 51). Nevertheless, the chair of the works council says that there has been not enough time for implementation by the care workers who were not part of this project group. It needed extra training in technology and in its tailored application to individual residents: *'after all, some are allowed to move more freely than others, so they need other transmitters, and residents are not allowed to give their own transmitter to someone else*' (interview IT). Implementation of new ideas and new technology always turns out to be a barrier.

Care3 has formulated a new 'Innovation Agenda 2025', including topics like digitisation. The business operations manager sees that the AI innovations in the organisation have just started. For a sector that suffers from scarcity in the labour market, a main consideration is whether new technology can lead to labour saving. According to all three respondents, direct labour saving rarely happens in practice. The chair of the works council says: '*If it's a 5 percent improvement, that's already great…the approach of innovation is more to prevent the need for more employees'.* Another consideration is whether technology can increase the quality of care provision. A third consideration concerns job quality, such as workloads. Lowering the physical and mental workloads of employees, and occupational health and safety in general, are high priorities for the works council when assessing new

technologies. A general barrier in the care sector is that technological innovation is very expensive and seldom leads to a sufficient return on investment. Practical and privacy factors also play a role when discussing new technology. An example is given in a recent discussion about 'voice reporting' with the help of AI. This can speed things up nicely for doing administrative tasks, but not all employees speak fluent Dutch. And patient information needs to be very well protected in such AI systems, and employees speaking to the computer must not be heard by other patients.

2. Workforce characteristics and labour relations

Care3 employs in total around 1200 people, mostly women (90 percent). The number of employees has grown in recent years, and it is expected that the organisation will grow further in terms of numbers of workers and locations in the coming years. The organisation's structure includes a Supervisory Board, 1 director, 4 top managers, 1 manager per location/establishment, around 10 team leaders, and then directly, without further hierarchy, the employees at the workplace (including 10 'innovation experts'). The staff can be categorised into 6 educational levels with academic personnel at level 6. Level 2 of '*verzorgende*' with maximum level MBO-3 Nursing (vocational college) is the predominant staff group. Care3 employs many workers with migrant backgrounds, so communication and cultural differences are challenging factors. The organisation provides internal training and basic education in Dutch language acquisition. Furthermore, a general challenge in the whole care sector is that care workers have low digital skills (interview IT), the more so among older workers than younger workers. Another generational inequality is that older workers often need more hierarchy, guidance and appreciation from their manager or team leader.

Care3 is covered by the sectoral collective agreements for nursing homes and homecare ('*VVT-CAO')* and is a member of the employers' association ActiZ, the main collective bargaining party on the employers' side. The general trade unions FNV and CNV, together with smaller professional unions, are the collective bargaining parties on the workers' side. A remarkable innovation in the sector agreement was the introduction of a chapter called 'A good conversation' ('*Een goed gesprek'*), aiming to promote and support better worker participation practices in nursing homes and homecare organisations. An important background for this new set of regulations is the growing shortages in the labour market in the care sector. Through the recommended conversations between managers and workers, employees are given more attention, aiming for greater employee engagement and prevention of workers leaving the care organisations.

Unionisation in Care3 is low, estimated at under 10 percent, which is lower than the sectoral average. Just a couple of works councillors are members of FNV (no other unions). According to the chairman of the works council, the dialogue with the director has improved in the last six years because the council is nowadays involved earlier in policies and decision-making processes. The council has also become more accessible for Care3's personnel. The works council has a legal right to have 15 councillors in the organisation, but the council itself chooses for fewer formal seats. This means that there is capacity left to involve employees with special expertise in specific topics relating to management's requests to the council for advice and consent. For example regarding policy reports in the domain of care quality, because nobody from that department is represented on the council. The council was just '*little by little*' involved in technological innovations like the previously mentioned

introduction of sensors, cameras and 'lifecycles' some years ago (interview WC). ' *Mostly, the council is only informed about innovation projects …. innovation processes run outside the council*' (interview WC).

3. Worker participation practices

Homecare and nursing homes in the Netherlands do have some tradition in self-management and autonomous teams (see e.g. Alders, 2015), but according to the chair of Care1's works council this has become an *outdated concept* (interview WC). Care organisations have learned that leaders and a certain level hierarchy are needed (id.). The chair of the works council is critical about Care1's structure being still too flat, with too few team leaders: a span of control of 50 workers is too large. An extra problem according to the council is that some leaders are too practically educated to be good managers: employees coming from higher professional education have learned more about management than those from vocational education.

Care3 started a process two or three years ago of introducing new leadership styles, according to the principles of 'the Rhineland leadership model'. In this model, responsibilities are set as low as possible in the organisation: '*the specialist may say it*' (interview Care3 BM). The 'Rhineland model' prescribes '*that you deliver performance together as a team'* and that initiatives for conversations comes from both sides. Before this process, Care1's organisational structure and culture was more top-down. Employees regularly sighed: '*here comes the middle management again with all those plans that we have to implement again'* (interview BM). An external consultant helped with this transformation. The management agreed not to make decisions before having heard the 'portfolio holder', someone who has a managerial position in the workplace. This 'portfolio holder' has to agree with this proposal by the management after having heard the team of workers who are involved, and having heard the other team leaders. Enjoyable work, lower workloads and a realistic time schedule for implementation are all important considerations for these dialogues (interview BM). By practising this 'Rhineland leadership model', the organisation is trying to secure the employee involvement, although the chair of the council points to the fact that this consultation culture '*does not land well with everyone because they do not understand it or too difficult words are used'* (interview WC).

Another important form of direct participation in Care1 is the regular conversations between the executives and supervisors with all the employees. This previously mentioned introduction of regulation in the sector agreement about 'A good conversation' and better worker participation have improved and intensified Care1's structure in the conversation cycles. Before 2 or 3 years ago, there were few annual appraisals with employees at Care3. The HR department has recently developed guidelines for managers and team leader to give feedback and to achieve a higher quality of individual and team conversations. Also employees are supported to give their opinions to managers and to give feedback in workers' teams. It turns out that most of the conversations address employees' problems in work-life balance, workload, sustainable employability (especially among the older workers), and training and career issues (interview BM). The works council is in favour of these talks, preferably once every six months, to monitor the arrangements agreed in the annual talks. '*We believe that care workers should become more professional and independent and should develop, but we don't really*

guide them in that' (interview WC). The regular consultations give a better supportive structure for this.

The relative well developed practices in direct worker participation in Care3 are also visible in the domain of technology, digitisation and AI. Firstly, policies and measures – also regarding the 'Innovation Agenda' – are discussed with 'portfolio holders' and team-leaders in the workplace regarding implementability (interview BM). Secondly, innovations are tried out as a pilot in a team, so that in a way the employees have some influence at an early stage before spreading it out to other teams (interview BM). Thirdly, some year ago the organisation worked with 'digi-coaches', care workers with an affinity with digitisation, to support the employees at department and team levels. This lowered the threshold among care workers in asking for help and doing a course in IT to improve their digital skills. Nevertheless, this has its limits: delivering human care comes first and care workers don't have so much time for extra training (interview IT). Nowadays the 'digi-coaches' are being replaced by professional IT-employees who work in the same workplaces than the caregivers, instead of in a separate office: '*In the past, an Information Technologist was seen as a scary person, now he or she has become a familiar face and the threshold for asking help has been lowered*' (interview IT). Finally, the IT manager has once a month consultations with managers and team leaders about the progress of how IT aspects are going in the organisation.

4. Future prospects

Care2 has developed new and interesting structures in *direct* worker participation, but does that mean that *representative* workers' participation is less needed? The works council can also adopt a more active role in companies' strategies and discuss innovative processes at earlier phases. '*I would like it if the works council were not only reactive, but also addressed major issues, such as technological developments in relation to personnel*' (Interview BM). According to the Business Operation Manager, the works council can challenge the organisation, more than it does now, with questions for the director like 'what are your plans?' and 'what are the consequences for personnel?'. The Business Operation Manager acknowledges that such social dialogue on longer-term issues is a reciprocal process. The director can also give more early information about plans or ideas to ask the works council for a response. The IT manager appreciates discussions with the works council because care workers know better what is 'good care' and these consultations engender more support for technological innovations among the staff. A condition however is that councillors need to have a good understanding of what is going on in professions, work processes, and with the employees themselves. In that respect, the works council wants to intensify the contacts with its rank and file by visiting the different locations more often with the aim of gaining more information from the workplace.

References

Actiz (2019). *Innovatie in het verpleeghuis.* Utrecht.

Quotes from 3 interviewees (checked and agreed):
- business operations manager (BM)
- chair of the works council (WC)
- head IT department (IT)