University of Portsmouth

GERO Gerontological Economic Research Organization

PhD in Strategy and Business Systems

Quality Management at European Hospitals

Staff Perceptions of Content, Implementation and Effects in Elderly-Related, Acute Stroke Care in England and Germany

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The thesis is submitted in partial fulfilment of the requirements for the award of the degree of Doctor of Philosophy of the University of Portsmouth and was sponsored in the context of the GERO academic support programme.

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PORTSMOUTH BUSINESS SCHOOL

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Author:	Alina Halank
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Quality Management at European Hospitals

Staff Perceptions of Content, Implementation and Effects in Elderly-Related, Acute Stroke Care in England and Germany

by

Alina Halank

Abstract

The aim of this research was to analyse and compare clinical governance and quality management initiatives at hospitals in England and Germany in terms of content, implementation and effects as perceived by managerial, clinical and non-clinical staff working in elderly-related, acute stroke care in order to identify 'valued' practice approaches and develop recommendations for overall improvement.

The research applied a comparative case-study design to address this aim. Documentary analysis prepared the site visits. Interviews with 83 representatives of different staff groups were conducted at a pilot-case and eight elderly-related, acute stroke care units, four of which were located in England and four in Germany. The findings from the cross-case analysis were compared to the views of 17 experts from England, Germany and Florida.

The research contributes to knowledge by widening the scope of previous research in two senses. First, the researcher applied a qualitative research design and interviewed a wider spread of different professions, including managers, consultants, nurses, therapists and support staff, than has been done in previous research. Secondly, the interview questions focused not only on the quality understanding or quality implementation issues, but also extended the areas of discussion to include 'valued' practice and suggested improvements.

The findings of the case-study analysis highlight six emerging themes, which confirm general issues from the quality management literature, such as an unclear impact on efficiency or the 'them versus us' phenomenon, for the hospitals.

Moreover, these themes and the general findings from the research confirm and develop in greater detail the hospital specific issues of quality management and clinical governance. Examples include the contentious role of consultants, the need for more partnerships in healthcare and scarcity of resources. Most importantly, staff confirmed that clinical governance and quality management resulted in safer, more consistent care to better meet patient needs.

Based on these findings, recommendations were developed for four areas, i.e. organisation-wide concerns, staff-specific issues, political and systems aspects, as well as further research.

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Secondly, this research project would not have been possible without the financial support of GERO and the willing and enthusiastic sharing of knowledge by many individuals across England, Germany and Florida.

Last but not least, the most special thanks go to my family and friends for always believing in me and making sure I don't get too lonely on the ivory tower.

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Glossary of Abbreviations[1]

AARP	American Association of Retired Persons
ACA	Affordable Care Act
AHCA	Agency for Health Care Administration
AHRQ	Agency for Healthcare Research and Quality
BÄK	Bundesärztekammer (Federal Physicians' Chamber)
BMG	Bundesministerium für Gesundheit und Soziale Sicherung (Federal Ministry of Health)
BQS	Bundesgeschäftsstelle Qualitätssicherung (Federal Office for Quality Assurance)
C	Consultants
CC	Cultural Changes
CG	Clinical Governance
CP	Customer Priority
CPD	Continuous Professional Development
CQC	Care Quality Commission
D	Germany

[1] The translations of the organisations, committees and laws are mostly taken or adapted from Busse and Riesberg (2005, pp. 263-268).

DoH	Department of Health
DRG	Diagnosis-Related Group
E	England
EFQM	European Foundation for Quality Management
EPA	Europäisches Praxisassessment (European Surgery Assessment)
FL	Florida
G-BA	Gemeinsamer Bundesausschuss (Federal Joint Committee)
GDP	Gross Domestic Product
GF	Geschäftsführung (General Management Team)
GG	Grundgesetz für die Bundesrepublik Deutschland (Constitution of the Federal Republic of Germany)
GP	General Practitioner
HC	Healthcare
HMO	Health Maintenance Organisation
HR	Human Resources
HRG	Health-Related Groups

ICT	Information and Communications Technology
IMP	Improvement
INV	Involvement
ISO	International Standards Organisation
JC	Joint Commission
KIS	Krankenhausinformationssystem (Hospital Information System)
KTQ	Kooperation für Transparenz und Qualität im Gesundheitswesen (Cooperation for Transparency and Quality in the Healthcare System)
LS	Leadership
M	Management
MARQuIS	Methods for Assessing Response to Quality Improvement Strategies
N	Nursing Staff
NCQA	National Committee for Quality Assurance
NICE	National Institute for Health and Clinical Excellence
NGC	National Guideline Clearing House
NHS	National Health System

OECD	Organisation for Economic Cooperation and Development
PAF	Patient Advocate Foundation
PE	Perceived Effects
PI	Perceived Issues
PS	Partnerships
QM	Quality Management
S	Support Staff
SGB I, V	Sozialgesetzbuch, Erstes, Fünftes Buch (Social Code, First, Fifth Book)
SHA	Strategic Health Authority
SHI	Social Health Insurance (GKV – Gesetzliche Krankenversicherung)
SI	Suggested Improvements
SPC	Statistical Process Control
SQM / TQM	Strategic / Total Quality Management
SVR	Sachverständigenrat zur Begutachtung der Entwicklung im Gesundheitswesen (Advisory Council on the Assessment of Developments in the Healthcare System)

T	Therapists
U	Staff Understanding
VP	‘Valued’ Practice
TW	Teamwork including Partnerships
UoP	University of Portsmouth
WCC	World Class Commissioning
WHO	World Health Organisation

1 Introduction

1.1 Context

Hospitals face the challenge of finding *"more efficient ways of doing business"* (Huq and Martin, 2000, p. 80). This challenge results from the scarcity of resources in healthcare that requires organisations to operate effectively and efficiently aiming at improvement and sophistication of medical care whilst also controlling costs (Cauchick Miguel, 2006, pp. 626-627). In the light of growing healthcare costs, the control of operational costs at the hospitals becomes ever more important. Current trends that result in higher costs (Brandeau *et al.,* 2004, p. 6; Busse & Riesberg, 2005, p. 13; Rachold, 2000, pp. 19-25) include a general increase in health awareness of the citizens, demographic changes towards an aging and, thus, sicker and multi-morbid[2] society (Kayser & Schwefing, 1998, p. 34; Rachold, 2000, p. 19) as well as medical and technical progress.

In addition to these cost concerns, the acknowledgement of medical or systems errors has led to the introduction of legal obligations for quality management in healthcare (Cauchick Miguel, 2006, pp. 626-627). However, the world health report 2000 (WHO, 2000, p. xiv) *"finds that many countries are falling far short of their potential".* A more recent report (WHO, 2008, p. xi) still maintains that *"health systems […] are clearly not performing as well as they could and as they should"*. Additionally, it highlights four approaches to reforming health systems for improvement as depicted in Figure 1 below.

The introduction of clinical governance[3] in England and of legal obligations for quality management in Germany falls into this context of reforms to improve service delivery and make health systems more people-centred in terms of both staff and customers.

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[2] Multi-morbid patients suffer from several diseases (Kayser & Schwefing, 1998, p.34).
[3] Clinical governance in the English NHS corresponds to quality management in German healthcare provision – the components are comparable, as further discussed in Sections 1.4 and 3.3.2.

Figure 1: Four Types of Healthcare Reform

Source: World Health Organisation (2008, p. xvi)

Even though the positive impact of quality management and clinical governance initiatives on financial performance and efficiency remains unclear[4], they aim per definition at improvements for safer service provision and more efficient use of resources. For quality management and clinical governance initiatives to have any of these desired effects, they have to be properly implemented and embraced by all employees (Huq & Martin, 2000, p. 80; Hendricks & Singhal, 2001, p. 359; OECD, 2009a, p. 60). Therefore, this project looks at various aspects of quality management and clinical governance implementation, maintenance and improvements perceived by staff and managers in England and Germany as well as experts in England, Germany and Florida.

These current challenges in healthcare provision call for a multidisciplinary approach to researching not only the biomedical and technical aspects, but also the issues around improving the organisation and delivery of health services (Fulop *et al.*, 2001, pp. 1-2). This is supported by Green

[4] See Section 2.2.1.

and Thorogood (2004, p. 4) who more pointedly state: *"the problems of public health are increasingly those of human behaviour, rather than the development of new technical interventions".*

In this context, Bowling (1997, cited by Fulop *et al.*, 2001, pp. 2-3) defines the aim of such health services research as *"to produce reliable and valid research data on which to base appropriate, effective, cost-effective, efficient and acceptable health services".* Researchers can choose from a variety of methods to achieve this aim. Thus, it is crucial to be aware of which methods are best suited to answer which type of research question with the most robust result (Adamson, 2005, p. 242) – especially because health services research involves various disciplines ranging from, for instance, economics to sociology and political sciences. These disciplines themselves tend to have their own preferences in terms of research methods (Fulop *et al.*, 2001, pp. 2-3). Green and Thorogood (2004, p. 11) agree with this: *"the different disciplinary traditions generate different legitimate research questions and different ways of convincingly answering them".*

Researchers consciously ask themselves questions of **what** and **how** to research. The researchers' underlying assumptions about the world around them, however, significantly influence the formulation of and the answers to these questions (Saunders *et al.*, 2007, p.101). They also have an impact on the motives of the research (Holden & Lynch, 2004, p. 397). This set of assumptions, i.e. the research philosophy, forms the foundation of the overall research strategy including the methods to be used (Saunders *et al.*, 2007, p.101).

Therefore, researchers should be aware of their particular research philosophy before engaging in any type of research. This awareness helps the researcher to remain open to other research approaches and can, accordingly, lead to a further development of research skills. Furthermore, it can also provide confidence in the appropriateness of the selected

research methodology and, thus, increase the reliability[5] of the results (Holden & Lynch, 2004, p. 406).

The inter-related concepts of ontology, epistemology and human nature determine the research philosophy. *"Ontology […] is concerned with the nature of reality"* (Saunders *et al.*, 2007, p.108), with the question of *"what can be known"* (Fulop *et al.,* 2001, p. 4). Epistemology can be defined as the research attitude regarding the concern of "*what constitutes acceptable knowledge*" (Saunders *et al.*, 2007, p.102). This includes *"ideas about how we come to know the world, and have faith in the truth, or validity, of that knowledge"* (Green & Thorogood, 2004, p. 10). Finally, the assumptions around human nature encompass whether humankind is perceived as being in control or as being controlled (Holden & Lynch, 2004, p. 400).

In general, two extreme approaches to research and science are differentiated in the literature (Holden & Lynch, 2004, p. 399): the objectivist approach (alternatively also quantitative, positivist, scientific, experimentalist, traditionalist or functionalist) and the subjectivist approach (also referred to as qualitative, phenomenological, social constructionist, humanistic or interpretivist). Appendix 1 gives an overview of the continuum of these two philosophical stances and their implications for the underlying assumptions about ontology, epistemology and human nature.

Briefly summarised, the objectivist point of view assumes a stable reality that exists independently of being researched and of being understood (Green and Thorogood, 2004, p. 12). A natural scientist, observing reality and understanding it in terms of law-like generalisations, personifies this view (Saunders *et al.*, 2007, p.102).

The subjectivist standpoint, in turn, reduces the significance given to such laws in a complex world, which needs to be understood in terms of subjectively motivated interactions between social actors – a subjective

[5] Reliability: Another researcher would come to similar results when repeating the study (Saunders *et al.*, 2007, p. 149).

reality (Saunders *et al.*, 2007, pp.106-109). These social actors are seen to be complex and unpredictable human beings, whose behaviour does not follow such laws. Accordingly, this behaviour should be understood rather than explained by law-like generalisations (Green & Thorogood, 2004, p. 12). This point of view denies the pre-existence of a stable reality and advocates the social construction of reality through *"historical, social and political processes"* (Green & Thorogood, 2004, p. 13). Appendix 2 summarises how the underlying research philosophy directly influences several aspects of a research project.

Mainly quantitative approaches to research, which directly measure variables and analyse them statistically (Bailey, 1991, p. 90) according to *"scientifically rigorous procedures"* (Bowling, 2005, p. 190), have brought forward the development of medical-technical innovations. The issues in healthcare provision, however, are increasingly shifting towards soft issues around human behaviour. Apart from this, the quantitative, positivistic view insists on value-free research, which is independent of society, *"objective, rational and neutral"* (Green & Thorogood, 2004, p. 12). Considering the political and social nature of healthcare, this appears to be an unrealistic assumption for health services research.

Qualitative approaches, which collect data to generate *"narrative or non-numeric information"* (Carter & Henderson, 2005, p. 215), gain importance in research *"to enhance understanding […] and to improve the management and provision of health services"* (Green & Thorogood, 2004, p. 4). In addition to quantitative methods, they enable the researcher to discover *"a different type of truth"* (Dieppe, 2005, p. 7), to achieve a more holistic insight into healthcare that also includes underlying behaviours, attitudes, perceptions, and culture – the **how**- and **why**-details behind the **what**-facts (Ulin *et al.,* 2005, p. xiii). Therefore, this research adopts a qualitative approach to research. This addresses a significant gap in previous research, as further discussed in Section 2.3.3.

1.2 Aim and Research Questions

The aim of this research was to analyse and compare clinical governance and quality management initiatives at hospitals in England and Germany[6] in terms of content, effects and implementation issues as perceived by managerial, clinical and non-clinical staff working in elderly-related and acute stroke care in order to identify 'valued' practice approaches and develop recommendations for overall improvement. This aim was planned to be achieved by investigating the following research questions:

1. What are the main differences and similarities between and within approaches to clinical governance and quality management in elderly-related, acute stroke care as implemented at the hospitals in England and Germany?
2. What do clinical governance and quality management mean for staff working on elderly-related, acute stroke care wards at the hospitals in England and Germany?
3. How do staff perceive the implementation of clinical governance and quality management requirements in terms of their effects and issues in their day-to-day activities in elderly-related, acute stroke care at the hospitals in England and Germany?
4. Which 'valued' practice[7] and lessons-learned do staff at the hospitals in England and Germany identify to approach clinical governance and quality management in elderly-related, acute stroke care and how can these approaches be further improved?

The research intended to make a contribution to knowledge by applying a qualitative research design to address the gaps in and widen the scope of previous research[8]. Further, the research findings were expected to confirm general issues from the quality management literature and to develop in greater detail the hospital specific issues of quality management and clinical governance.

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[6] The specific context for quality management and clinical governance at the hospitals in these two countries is developed in the academic, political and economic background (see Chapters 2 and 3).

[7] 'Valued' practice refers to good practices with regard to clinical governance and quality management, as experienced by the participants.

[8] See Section 2.3.3.

The research questions were mainly addressed by interviewing members of different staff groups from a managerial, clinical and non-clinical background working in elderly-related, acute stroke care at one pilot organisation in Germany, four case-study hospitals in both England and Germany as well as international experts. Schreyögg *et al.* (2005, p. 2) state *"that health services can no longer be regarded as operating in isolation from other EU member states."* This implicitly suggests the need for an increase in cooperation between the health services of different member states – comparative research, as this project, forms part of it.

The choice of the two countries for this research was made on both theoretical and practical grounds. On the one hand, the two healthcare systems exemplify the two main system structures existing in Europe (Busse, 2006, p. 10)[9]. On the other hand, the author could rely on a good network of contacts in both countries thanks to previous research[10] to facilitate gaining access.

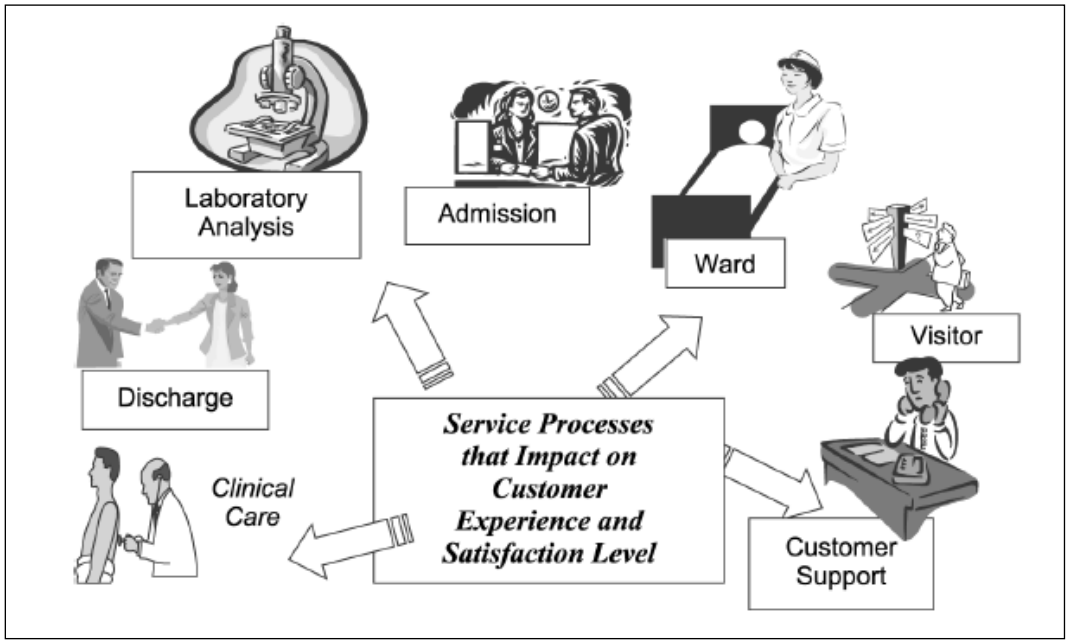
Resulting from the increasingly different structures of the NHS in the four constituent parts of the United Kingdom (Davies, 2007, p.8; Nolte, McKnee and Wait, 2005, p. 12), there could also be differences in approaching clinical governance and other influencing factors. Therefore, the author decided to focus on NHS organisations in England, also taking into account questions of access[11]. Finally, the international experts came from England, Germany and Florida – the latter were included to provide a non-European view on quality management based on experiences in a privately oriented healthcare system. These experiences were particularly relevant, since the percentage of elderly citizens in Florida is higher than in any other part of the US (Statemaster, 2010) and stroke is one of the four leading causes of death (Florida Hospital Association, 2009).

The focus on elderly-related, acute stroke care was derived from the trend towards an aging society discussed above – stroke is one of the primary causes of death and disability worldwide (Brandeau *et al.,* 2004, p. 3;

[9] See Section 3.1.2.
[10] See Section 1.3.
[11] See Chapters 1 and 4.

Cramer, 2010, p. 1). Accordingly, internationally comparable services[12] are provided in stroke units. Further, the author had already gained experiences in this field during undergraduate research (Halank, 2006).

Figure 2: Critical Medical and Non-Medical Services



Source: Lee *et al.* (2006, p. 568)

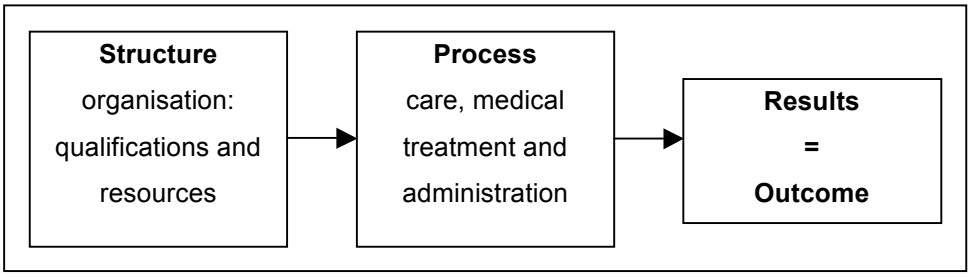
Figure 2 above illustrates the different service elements of hospital care that require the cooperation of different professional groups. Therefore, the perceptions of representatives from different managerial, clinical and non-clinical staff groups were included in this research – quality management has to be properly implemented across all these different functions to potentially impact on service and financial performance[13].

Questions of patient satisfaction are addressed in research and politics (OECD, 2003b, p. 21; OECD, 2004, p. 70). Further, the OECD Healthcare Quality Indicators Project (Arah *et al.*, 2006) develops a set of performance indicators for the international comparison of healthcare quality. Accordingly, this research mainly looked at structure and administrative process aspects of quality management. Donabedian's quality model, depicted in Figure 3 below, further illustrates this. The

[12] See Section 2.3.2.
[13] See above and Section 2.2.1.

model forms the basis for the hospital quality management model of the Joint Commission[14] (Luce *et al.*, 1994, p. 264) and is widely used in similar research (e.g. Mühlbauer, 2002, p. 2; Hudelson *et al.*, 2008, p. 35; Hearld *et al.*, 2007).

Figure 3: Donabedian's Quality Model



Source: Amelung and Schumacher (2004, p. 247)

First, the structural quality results from the resources, qualifications and general organisational structures in place for the medical service provision. Secondly, the process quality refers to how care and medical treatment are delivered and how administrative tasks are accomplished. Thirdly, the results or outcome quality describes the success of the medical service provision (Donabedian, 1980, pp. 79-128; Amelung & Schumacher, 2004, p. 247). Donabedian (1980, pp. 95-97) further splits the outcome dimension into client- and practitioner-related outcomes. The practitioner-related outcomes of satisfaction with the appropriateness of the working environment – especially with regard to technical management, management of the interpersonal process and continuity – were an important basis for this research. The respondents contributed their perceptions about quality management at their organisation (or in general – for the expert interviews) and in doing so reflected their degree of satisfaction in this regard. Based on this, 'valued' practice and recommendations for improvement of quality management structures and administrative processes were developed.

[14] See Section 3.3.2.

1.3 Research Background

The research presented in this thesis builds on the author's previous experiences with healthcare-related, academic projects (Halank, 2006, 2007a & b, 2008) during undergraduate and postgraduate studies. The undergraduate dissertation (Halank, 2006) dealt with integrated care structures for stroke in a rural region in Germany. The author gained practical knowledge about stroke care and healthcare delivery from this. During the MSc in Strategic Quality Management and as part of assignment projects (Halank, 2007a & b), the author developed more specific knowledge around content of and change management for the implementation of an enterprise resource planning system at a chain of rehabilitation hospitals.

The dissertation for the MSc played the most important part in preparing this thesis. Its aim was *"to analyse and recommend how a Strategic Quality Management (SQM) approach at the national level could help to overcome the external challenges and internal difficulties confronting the German healthcare system"* (Halank, 2008, p. 2). The guiding objectives are attached in Appendix 3, together with the conclusions and recommendations chapter. The latter suggested how the author could carry out part of the recommendations herself:

"The author intends to conduct part of this research by analysing and comparing quality initiatives in the English and the German healthcare system in terms of content and implementation. Firstly, an overview of these healthcare systems will be elaborated. Secondly, the status quo of quality aspects in English and German healthcare will be assessed and compared based on the triangulation of:

a. *A literature review of academic and political publications.*
b. *Expert interviews with (quality) specialists in one or both systems such as medical practitioners with managerial insight, national and EU politicians, affiliates with the WHO.*
c. *Four to five case-study organisations per country ideally from different regions.*

Thirdly, expert interviews and literature regarding general national culture as well as specific national traditions in healthcare will help to suggest potential reasons for differences and similarities found in the research. Finally, possible recommendations for improvement of quality aspects in both systems will be derived from the comparisons in the intended research and input from the free-market orientation in the US-American healthcare system assessed through expert interviews and (documentary) analysis of BNQP[15] Award winners in healthcare" (Halank, 2008, pp. 73-74).

These suggestions informed the development of the aim and the research questions, as outlined in the previous chapter. Discussions with supervisors, peer researchers and PhD-specific research methods training enabled the author to clarify the purpose, design and implementation of this research. They also made her realise the need to more clearly define the scope of the project. Accordingly, the research focused on elderly-related and acute stroke care. Due to access issues, the expert interviews involved fewer politicians than initially planned, and no affiliates with the WHO. Cost and time represented important constraints for the US-American part of the data collection. Therefore, the scope had to be reduced to expert interviews in Florida.

Parts of the academic, political and economic background, as presented in the following chapters, are based upon and further developed from the author's MSc dissertation. Therefore, some references might occasionally appear to be slightly dated. Sources from the late 1990s are still relevant, since more recent literature confirms that the problems and structures basically still follow the same or at least very similar patterns as before. Examples of these more recent sources include Busse and Riesberg (2005), Specke (2005) as well as Oberender, Hebborn and Zerth (2006).

[15] BNQP stands for Baldrige National Quality Program, the main US-American model for general business excellence. The Joint Commission model of continuous improvement was designed specifically for healthcare organisations and is very popular among US health service providers, as discussed in more detail in Chapter 3.

The knowledge gained through the dissertation project influenced the research design of the PhD research. Relatively imprecise initial ideas were confirmed and further detailed, taking into account the additional findings from the extended literature review for the PhD. Subsequently, the PhD-specific research methods training and internal conferences at the Portsmouth Business School supported the author's preparation for the actual implementation of the research and the analysis of the data.

1.4 Differentiation of Terminology

The definition of the aim and objectives of this research in the previous sections alludes to a key linguistic problem that runs through the entire project: different people in different countries use different terms for the same thing independently of whether they speak the same language or not. Accordingly, this research adapted the use of terminology to the different parts of the research. More detailed definitions of the concepts and comparisons of the related contents are provided in Sections 2.2.1 and 3.3.2. In the academic environment, Strategic and Total Quality Management (SQM / TQM) are often used. At the hospitals, however, staff are not familiar with these terms – in England the most commonly understood term is clinical governance and in Germany staff refer to the same concept when speaking about quality management. Finally, the experts in Florida interchangeably use quality management and continuous improvement.

1.5 Thesis Structure

According to Ferlie (2001, pp. 28-29), good quality research should be clearly connected to theory. Further, Yin (2003, p. 28) advises that, for case-study research, *"theory development as part of the design phase is essential"*. It also provides *"strong guidance in determining what data to collect and the strategies for analysing the data"* (Yin, 2003, p. 29).

Taking this into account, the literature review lays out the conceptual framework, the theoretical foundations of this piece of research and is divided into two parts.

Chapter 2, the academic background, academically defines the foundations of this research around quality and its strategic management in healthcare to support the interview questions and analytical categories applied by this research. The research context leads to the identification of the contribution to knowledge intended by this research.

Chapter 3 prepares the analysis with a political and economic background about health services provision in England, Germany and Florida, while also comparing how clinical governance and quality management are generally approached at the hospitals.

In these two background chapters, an in-depth review of the literature supports the development of the research methodology, the analysis and the recommendations for improvement in the later chapters. The sources include mainly academic literature, while also incorporating government reports, health-related laws and statistics. This reliance on different types of sources helps to reduce potential bias of the academic and political authors. It is minimised by contrasting different academic and political standpoints with one another.

The thesis combines both deductive and inductive approaches to research (Saunders *et al.*, 2007, pp. 117-121; Fulop *et al.,* 2001, p. 8). This appears to be usual practice for most research (Pope *et al.,* 2006, p. 67). Theory-driven deduction *"involves the development of a theory that is subjected to a rigorous test"* (Saunders *et al.*, 2007, p. 117). Data-driven induction occurs when rich data is gathered and analysed to formulate a theory (Saunders *et al.*, 2007, p. 118). Appendix 4 provides a more detailed comparison of these two approaches.

The thesis starts to deduce general themes from the literature in Chapters 2 and 3. The academic, political and economic background develops the conceptual framework, which informs the methodology for the practical part of the thesis.

Chapter 4 builds this methodological foundation of the research for the field research and the data analysis. Questions of research quality, rigour and limitations are discussed before the chapter concludes with an appreciation of the ethical issues arising from the research.

Chapter 5 presents the results from the case-study research in Germany.

Chapter 6 presents the results from the case-study research in England.

Chapter 7 discusses the findings from the cross-case analysis and links these to the literature.

Chapter 8 extends this discussion to the research findings from the expert interviews.

Chapter 9 concludes the findings of the research to answer the research aim and questions and develops the contribution to knowledge in the field taking into account the limitations of the research.

Chapter 10 closes the thesis by developing recommendations, based on the conclusions, to improve quality management and clinical governance approaches in healthcare for operational and political decision-makers as well as for further research activity in the field. The recommendations in combination with the conclusions lead to an induction of theory.

This chapter has defined the general context of the research as well as its aim and research questions. After an explanation of how these relate to previous research by the authors, the different terminology in the field was differentiated. The final section has laid out the structure of the thesis.

2 Literature Review I: Academic Background

This chapter sets out to review the academic literature around quality and its strategic management in healthcare to develop the specific research context and to identify gaps in previous research that enable a contribution to knowledge.

2.1 Quality in Healthcare

2.1.1 General Approaches

Quality has always been important. Maguad (2006) explains that, in primitive societies, food-gatherers and hunters had to know what was edible and how to get it. Their level of knowledge about potential food, the supporting hunting tools and the capability of effectively and efficiently using them mainly determined their survival[16]. The food-gatherers and hunters could easily define and measure quality. They were suppliers, producers and customers in one person. Accordingly, they had all the required information to do so.

In modern societies a great deal has changed. Yet, quality is still a question of survival, of organisational survival. In today's highly competitive markets with ever increasing customer demands (Dale, 2003, p. 3), quality is no longer a nice-to-have feature to defeat competitors, but has become an entry requirement to the market (UoP, 2006, slide 14)[17]. Without delivering quality products or services, an organisation loses the reason for its existence. This raises the question of what quality actually is. It is not easy to answer because of the varied understandings among academics, business people and the general public, i.e. the private end-users. Garvin (1984, cited by Moullin, 2002, p. 7) groups these different types of definitions under the following five approaches:

- Transcendent
- Product-based

[16] The better they were at building and using these tools, the higher their probability was to stay alive longer.
[17] Appendix 5 provides more detail.

- Manufacturing-based
- User-based
- Value-based

Further, Kelemen (2003, pp. 7-19) groups these approaches into managerial and critical perspectives:

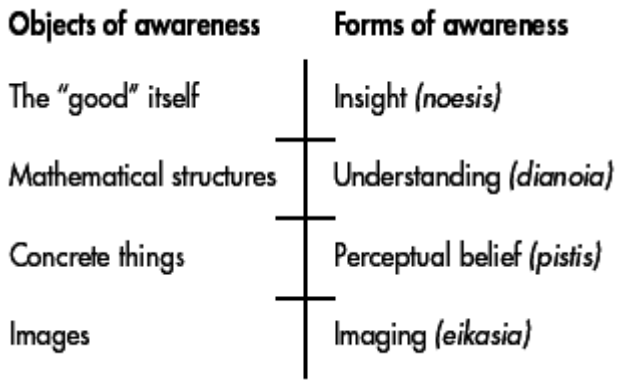
> *"Managerial perspectives view quality as a self-contained entity or process that can be planned, managed, controlled with the help of technical and managerial knowledge. Critical perspectives assert that quality is a complex and multifaceted concept which escapes a definitive definition."* (Kelemen, 2003, p. 7)

Most of Garvin's approaches reflect managerial perspectives. Only the transcendent approach to quality adopts a critical perspective. It defines quality quite intangibly as *"innate excellence"* (Bounds *et al.,* 1994, p. 45), which is timeless and enduring. Sower and Fair (2005, p. 8) claim that it is *"the least understood and least utilised of the five approaches identified by Garvin".* The transcendent approach represents a fairly subjective concept of quality that is only understandable after a series of experiences with quality products or services. *"On the one hand, quality is universally and absolutely recognisable, on the other hand, it escapes precise definitions and measurements"* (Kelemen, 2002, p. 14).

Plato's argument about beauty, which can be understood as an ancient Greek synonym for the then nonexistent word quality (Sower & Fair, 2005, p. 9), follows the same lines (Bounds *et al.,* 1994, p.45). Both quality and beauty trigger rational as well as emotional responses, i.e. pleasure, happiness and delight (Kelemen, 2003, p. 14). But it is not only these individual responses that determine beauty or quality (Sower & Fair, 2005, p. 10), rather they transcend individual subjectivities and have an external, universal existence of their own (Sower & Fair, 2005, p. 9). It is for this very reason that both concepts *"cannot be defined precisely"* (Garvin, 1984, p. 25 cited by Sower & Fair, 2005, p. 10).

When combined with Plato's idea of the divided line that contrasts objects and forms of awareness, as depicted in Figure 4 below, this fairly vague and intangible argument helps in understanding the role of the other managerial approaches to quality: a transcendent quality understanding, according to Garvin, requires insight as referred to in Plato's terminology. Only at this level of awareness does it become possible to holistically perceive and appreciate quality. Within this holistic and overarching transcendent approach to quality, which is characterised by true insight, Garvin's managerial approaches may help to operationalise the implementation of means and measures to achieve quality focusing on the product, the manufacturing process, the user or the overall value.

Figure 4: Plato's Divided Line



Source: Sower and Fair (2005, p. 11)

Knowledge of the 'good' itself represents insight – the highest form of awareness. But awareness usually evolves from the lowest form to the higher or to the highest (Sower & Fair, 2005, p. 11). The following examples regarding quality management and clinical governance awareness in healthcare illustrate this:

1. **Imaging**: Through verbal images, such as general communications about clinical governance and quality management that might employ buzz-words, most staff ought to have a certain awareness of quality management and clinical governance at their organisation.

2. **Perceptual belief**: Staff on the wards have to deal with tangible manifestations of clinical governance and quality management. Documentation and increased bureaucracy could be seen as examples of Plato's perceptual belief based on concrete things.
3. **Understanding**: This involves generalising and summarising the knowledge gained through imaging and experiencing in mathematical structures, so that solutions can be repeated to address similar problems. Members of staff may not have such a holistic understanding of clinical governance and quality management.
4. **Insight**: The highest form of awareness results in a true and all-encompassing appreciation of the 'good' itself. Insight is needed to be really creative and to bring about innovation in a field. Clinical governance and quality management are about insight to achieve innovation. Even though healthcare staff might not achieve understanding about clinical governance and quality management as such, they will understand the operational aspects of their work and can, perhaps, contribute suggestions for improvements of the integration of clinical governance and quality management into their work routines, based on their insight of working practices.

Although the managerial perspectives are less philosophical, rather *"more pragmatic, more objective and more tangible"* (Bounds *et al.,* p. 46), they can be linked to the different levels of awareness. Product-based approaches to quality equal higher quality with higher cost, as a necessary uni-dimensional consequence of definitions, such as Abbott's (1955, cited by Moullin, 2002, pp. 9-11): *"differences in quality amount to differences in the quantity of some desired ingredient or attribute."* This approach appears to be quite simple and is fairly limited in appreciating quality in different sectors. For instance, does it not necessarily increase the quality of the services provided, if many regulatory bodies duplicate documentation requirements in healthcare. Therefore, this definition could be said to reflect imaging, the lowest form of quality awareness.

Crosby's (1979) understanding of conformance to requirements represents an example of the manufacturing-based approach, making it easy to operationalise and measure quality in an objective way (Sower & Fair, 2005, p. 9). Depending on how this approach is put into practice, it relies on perceptual belief, understanding or even insight. If conformance to requirements is achieved through trial and error, perceptual belief forms the basic quality awareness. If conformance to requirements is systematically achieved by structuring the problem in mathematical ways and applying broadly accepted, 'old' solutions to common problems, understanding represents the underlying paradigm. Finally, innovative ideas based on an holistic perception of the situation lead to conformance to requirements, if insight is present. Clinical governance and quality management support staff in conforming to requirements, by clarifying these requirements – depending on how they achieve this, they expose perceptual belief, understanding or insight.

The more subjective meanings of quality, such as in the user-based approach, more directly cover patient-related aspects. According to Sower and Fair (2005, p. 9), they have a more significant impact on the commercial success of a product or service, even though they are more difficult to assess. User perception forms the core of this approach (Kang & James, 2004, p. 267), defining quality as *"meeting or exceeding customer expectations"* (Kelemen, 2003, p. 12, and Moullin, 2002, p. 11 attribute this quote to Gronroos, 1983, and Parasuraman *et al.,* 1985). Therefore, perceptual belief forms the basis of the quality definition, whereas for its implementation the same is true, as discussed above for the manufacturing-based approach.

Parasuraman *et al.* (1985) developed the SERVQUAL instrument to assess user-based quality, which is usually *"ever-changing"* (Goetsch & Davis, 2006, p. 5). This can be problematic in healthcare, because the patients cannot necessarily judge technical therapeutic or care improvements, which prevent them from, for instance, developing bed sores, while they can assess the soft quality of the services, i.e. whether staff treat them in a friendly way and with respect.

The fact, that the price of goods and services was not explicitly considered in this approach, eventually led to the development of value-based quality understandings. Feigenbaum (1991, cited by Moullin, 2002, p.13) pointedly summarises this approach:

> *"Quality does not have the popular meaning of the best in any abstract sense… It is that quality which establishes the proper balance between the cost of the product or service and the customer value it renders."*

This definition reveals at least an underlying quality awareness of understanding or even insight, depending on how implemented – as discussed above: the proper balance between cost and customer value suggests a balanced mathematical consideration of the various aspects, which determine quality, i.e. Plato's understanding. If, additionally, innovation leads to further improvement of this balance between cost and customer value, Plato's insight is present. In healthcare, cost containment is an important element of the political discussions, which staff are usually well aware of. Yet, in spite of scarce resources, the very nature of healthcare professions is to care for the patients.

Even though Garvin's work addressing the different quality approaches dates back to the 1980s, it is still relevant – many current quality textbooks and research projects rely on it (such as Kelemen, 2003, Moullin, 2002 or Sebastianelli & Tamimi, 2002). It provides a useful mindset that enables researchers and business professionals *"to capture the complexity of the quality construct"* (Sebastianelli & Tamimi, 2002, p. 442) and, thus, to appreciate the different viewpoints that have to be adopted in different sectors or in different phases of the value-chain to manage quality issues in an appropriate manner.

2.1.2 Specific Definitions

In healthcare a hybrid definition of quality, relying on user- and value-based approaches, is most commonly used. On the one hand, healthcare

takes place in a service setting, where the perceptions of customers[18] compared to their initial expectations determine the quality of a service (Dale, 2003, p. 206) – a user-based understanding. On the other hand, healthcare systems are financed by and delivered through limited resources (Oberender *et al.,* 2006, p. 31). This necessitates the consideration of value-based approaches. Nolan and Bisognano (2006, pp. 67, 72) highlight the importance of finding the right balance between quality and cost to improve the value of care. This is implicitly supported by Donabedian (1980, p. 7): *"quality costs money, but it is possible by cutting out useless services and by producing services more efficiently to obtain higher quality for the money that is now spent on care, or to have the same quality of care at a lower cost."* Accordingly, care quality cannot be judged just by monetary costs.

Therefore, Øvretveit (1992, p. 2) defines quality in health services as *"fully meeting the needs of those who need the service the most, at the lowest cost to the organisation, within limits and directives set by higher authorities and purchasers."* More recently, Moullin (2002, p.15) recommends another definition of quality in healthcare: *"meeting the requirements and expectations of service users and other stakeholders while keeping costs to a minimum."* Moreover, Vukmir (2006, pp. 8-9) clearly highlights the importance of considering *"both the technical quality stressing proper process and procedure and the service quality emphasising the interpersonal aspect of care relying on trust, communication, mutuality of goals and patient respect."*

The hard and soft aspects of TQM[19] reflect this split between technical and interpersonal aspects of care, or the science and the art of medicine, which is explained in more detail by Donabedian (1980, pp. 4-6). Further, his quality model suggests that three different dimensions of quality in healthcare have to be taken into account: quality of structure, process and outcome[20]. Finally, he cautions that *"judgements of quality are often made not about medical care in itself, but indirectly about the persons who*

[18] Section 2.2.4 discusses the issues of customer definition in healthcare.
[19] See Section 2.2.1.
[20] See Chapter 1.

provide care, and about the settings or systems within which care is provided". But, from the patient perspective, it appears rather difficult to judge the medical care itself without a professional background in this field.

2.1.3 Health and Quality of Life

In its constitution, the World Health Organisation (WHO, 1946, p. 2) defines health as *"a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."* Because of its wide approach, taking the definition literally almost everybody could be considered to be ill (Oberender *et al.,* 2006, p. 19), it has been criticised from the beginning and is still in the process of redefinition (Bok, 2004, p. 15).

However, the visionary character of this broad understanding of health has influenced the health policies and objectives in many countries. Its influence becomes manifest in the perspective of the German Federal Physicians' Chamber (Bundesärztekammer, BÄK), which interprets health as *"the physical, mental and social capability of a human being resulting from the unity of subjective well-being and individual endurance"* (cited by Schwartz *et al.,* 2003, p. 26)[21]. In England, the 'Health of the Nation' strategy started to implement this visionary WHO understanding of health in 1992 (Wanless *et al.*, 2004, p. 29).

Health combines individual and collective perspectives. As critically assessed by the Institute of History and Ethics at the University of Cologne, the WHO definition falls short on the individual's responsibility to maintain their own health and to adopt preventive measures (Specke, 2005, p. 183). In England, the initiative 'Choosing Health' (DoH, 2004) aims to support individual choices for a healthy living, e.g. reduction of smoking and increase of exercise, to address this issue, measured by *"lives saved, lengthened and improved in quality"* (DoH, 2004, p. 7). In

[21] Translated by the author. Original wording: *„die aus der Einheit von subjektivem Wohlbefinden und individueller Belastbarkeit erwachsende körperliche, seelische und soziale Leistungsfähigkeit des Menschen.*"

Germany, the SHI provides incentives for a healthier living, e.g. by funding fitness courses for patients (Zenel, Kimmel & Strippel, 2009, p. 3). However, the long and controversially discussed 'Präventionsgesetz' (prevention bill) still has to be passed (SVR, 2007, p. 823-826; BMG, 2009a).

Increasingly, evidence shows that not only the health services provided but also social position, education and professional success have a significant effect on an individual's health (Oberender *et al.,* 2006, p. 30). Even though health is generally regarded to be the most precious good a human being possesses, its value remains relative and is subjectively related to quality of life. For some, a high-quality lifestyle might include smoking or extreme sports. This, in turn, negatively influences health risks. The trade-off between too much risk and just enough fun is set individually, but impacts the collective through, potentially, reduced individual productivity and increased medical costs, financed by the Social Health Insurance (SHI) or the National Health System (NHS). Thus, health can be considered as both a private and a public good (Oberender *et al.,* 2006, pp. 21-23). In the context of scarce resources, clinical governance and quality management should help managing the public aspects of this good.

2.2 Strategic Management of Quality in Healthcare

2.2.1 Definitions and Effects

The lack of a commonly accepted definition of Total and Strategic Quality Management (TQM / SQM) represents a general problem in dealing with the subject (Kelemen, 2003, p. 100). Based on Dale (2003, p. 26), Goetsch & Davis (2006, p. 6) and Kelemen (2003, pp. 100-101) TQM means: putting the customer as highest priority, all members of the organisation and of partner organisations within the supply chain work together, effectively and efficiently, to produce quality products and services, which are continuously improved with the help of scientific quality tools and techniques to achieve customer delight.

This definition reveals the two aspects of TQM: the hard facts regarding process, product or service improvements discovered with the help of scientific methods[22], and the soft issues around leadership, employee involvement, teamwork including partnership development and the associated cultural changes to realise customer-focused operations (Kelemen, 2003, p. 100). Accordingly, TQM consists of six main components:

- Improvement
- Leadership
- Involvement
- Teamwork & Partnerships
- Cultural Changes
- Customer Priority

SQM integrates ideas of the preceding understandings of quality and its management, such as statistical process control (SPC), into a new philosophy of doing business, namely TQM[23] (Bounds *et al.,* 1994, pp. 60-62). This new philosophy permeates the entire organisation through its incorporation into strategic management to *"go beyond satisfying the customer to delighting them"* (Dale, 2003, p. 26).

Strategic quality management needs to be understood independently of and differentiated from non-strategic, rather local ways of managing quality. Organisational strategies are defined as *"approaches adopted by organisations to ensure successful performance in the marketplace"* (Goetsch & Davis, 2006, p. 82). Overall strategies can be based on cost leadership, product and, or service differentiation or focus on market-niches. They involve the interrelated activities of strategic planning and strategic execution. While the first is concerned with defining the organisational vision, mission, guiding principles, strategic objectives and

[22] Such as SPC (Statistical Process Control).
[23] In the following, TQM and SQM are used interchangeably as most of the literature uses the term TQM even when addressing its strategic issues and impact.

specific tactics, the latter implements, monitors and adjusts these strategies as necessary (Goetsch & Davis, 2006, pp. 82-83).

Kajdan (2007, p. 147) claims that *"minimisation of cost is the most attractive part of the TQM approach".* Oakland and Tanner's (2008, p. 733) positivist study shows that business excellence is positively related to organisational performance. Additionally, Kumar *et al.* (2009, p. 23) prove the positive impact of TQM on the dimensions of company performance they analyse, i.e. employee relations, operating procedures, customer satisfaction and financial results. Tarí *et al.* (2007) find, for Spanish companies with ISO 9000 certification, that quality management practices positively impact on all types of performance.

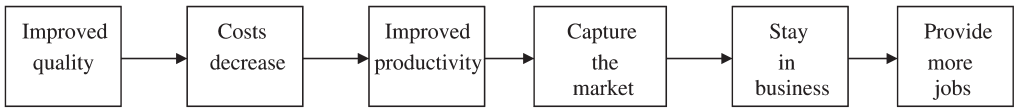
Hendricks and Singhal (2001a, p. 359) find, with a quasi-experimental study about long-term stock price performance, that *"during the post-implementation period* [quality] *award winners significantly outperform firms in the various control groups"*. Certain organisational characteristics positively influence the beneficial effects of TQM implementation. Hendricks and Singhal (2001b, p. 269) empirically confirm that smaller, more focused, less diversified and less capital-intensive firms show better effects than their larger, less focused, more diversified and more capital-intensive counterparts. Further, research in Australia shows that voluntary implementation of quality management is more likely to result in positive effects on organisational performance (Terziovski *et al.*, 2003, p. 580). Samson and Terziovski (1999, p. 393) underline the importance of leadership, management of people and customer focus as significant performance predictors.

In contrast to this evidence supporting the positive effects of TQM, York and Miree (2004, p. 291) caution that organisations showed better financial performance compared to their competitors independently of winning a quality award, i.e. both before and after receiving the award. Jacob *et al.* (2004, p. 897) support this.

Yet, Kunst and Lemmink (2000, p. 1123) maintain that *"progress in TQM and perceived service quality by customers are positively, but only to a limited degree, linked to business performance*[24]*".* Macinati (2008, p. 238) supports this for the Italian National Health Service and finds a positive relation between quality management and subjective outcome performance, such as hospital reputation or patient satisfaction, without establishing a statistically significant relationship with financial performance.

Using a Delphi expert study approach, Heras Saizarbitoria (2006, p. 792) also comes to the conclusion that quality management does exert a positive, yet not direct influence *"on company results, mainly through the improvement of operations, efficiency and the costs of companies' internal activities"*. In support of this, a study by Wayhan *et al.* (2010, p. 761) empirically tests and confirms parts of Deming's Chain Reaction Model, which theorises how improved quality indirectly affects financial performance, as depicted in Figure 5 below.

Figure 5: Deming's Chain Reaction Model



Source: Wayhan *et al.* (2010, p. 763)

Nonetheless, Wagner *et al.* (2003, p. 114) question the added value of quality management for healthcare organisations. It appears difficult to assess, because of missing information regarding the cost-effectiveness of such initiatives. Minkman *et al.* (2007, p. 90) provide a systematic literature review of studies published between 1995 and 2006 to address the evidence for quality management in healthcare. Even though they could identify a reasonable number of studies, they conclude that only very few come to significant results.

[24] In their study, business performance is measured in terms of occupation rate, financial business results and market share (Kunst & Lemmink, 2000, p. 1128).

Dey and Hariharan (2006), in turn, propose a 10-step integrated healthcare quality management model. Based on a case-study hospital in Barbados, they prove that it is possible to realise positive effects, including increased patient throughput, reduction of adverse patient outcome to zero as well as increased patient and clinical personnel satisfaction (Dey & Hariharan, 2006, p. 601). The latter effect is supported by Cauchick Miguel's (2006, pp. 634-635) findings[25] at a Brazilian hospital. The study also observes diminished absenteeism as a result of this increased satisfaction. Additionally, the organisation shows an improved financial performance with steadily increasing revenues. With regard to Portuguese elderly care homes, Antunes *et al.* (2008, p. 79) add that quality management improves productivity, while also shifting the focus from correction towards prevention, and that investments in quality impact on performance.

The findings from the MARQuIS project[26] (Suñol *et al.,* 2009, p. i62) indicate that both internal and external quality improvement strategies beneficially influence clinical, safety and patient-centeredness outputs at the hospital level. However, Donabedian (1980, p. 106) and Groene *et al.* (2009, p. i44) caution that individual health outcomes and the response to care are influenced by many factors other than medical care[27].

2.2.2 Cultural Concerns

The discussion in the previous section shows that quality management does not *"inevitably* [have to be] *a good thing"* (Green & Thorogood, 2004, p. 22) for everybody nor even be understood in the same way by different actors. This understanding is significantly influenced by culture. "*Although the acceptance of quality management does not* [seem to] *vary with* [national] *culture, the meaning that is attached to it does, i.e. quality management will have slightly different features in different* [national]

[25] Nonetheless, it has to be kept in mind that both studies are characterised by the fundamental weakness of limited generalisability, as they are only based on a single case-study organisation, which does not necessarily have to be representative of a greater collective.
[26] Section 2.3 discusses this project in more detail.
[27] Section 2.1.3 discusses this in more detail.

cultures" (Lagrosen, 2003, pp. 484-485). Daniel (1993, p. 11) adds to this: *"nowhere is sensitivity to culture more important than in health research".*
Culture is a very broad concept. It can be defined as a composition of shared values, beliefs, customs, traditions and practices, which unites a group of people and distinguishes them from others (Buchanan & Huczynski, 2004, p. 643). Accordingly, different levels of culture exist, including national culture, organisational or corporate culture as well as professional subcultures (Lagrosen, 2003, p. 473).

The corporate culture, i.e. the unique identity of an organisation, is also described as *"the way we do things around here"* or *"the collective programming of the mind"* (Buchanan & Huczynski, 2004, p. 643). Edgar Schein distinguishes between basic assumptions (which, for him, form the culture), values and surface manifestations of a culture (Buchanan & Huczynski, 2004, pp. 643-650). There exists strong dissent as to whether corporate leaders can proactively manage and influence organisational culture (Buchanan & Huczynski, 2004, p. 659) or just form part of culture-shaping (Buchanan & Huczynski, 2004, p. 656) without being able to consciously direct cultural changes (Buchanan & Huczynski, 2004, p. 663).

In a TQM culture, employees are empowered. They have the authority, responsibility as well as skills and knowledge to complete their tasks successfully, independently and innovatively (Dale, 2003, p. 217). More autonomy and discretion reduce supervision in staff decision-making (Buchanan & Huczynski, 2004, p. 267). Employee 'enlistment' goes even beyond this: input from employees in terms of innovation is not only sought actively, it is expected and they do not have a choice but to contribute to continuous improvement (Goetsch & Davis, 2006, p. 247).

Hospital management often fails to consider the workforce culture, when implementing TQM initiatives at their organisations (Huq & Martin, 2000, p. 80). Yet, the required cultural changes do not happen automatically, because these initiatives alter the division of labour between professional groups and shift the balance of power (Kirkpatrick *et al.*, 2005, p. 78). The

failure to consider and manage this aspect then becomes one of the most important obstacles to successful implementation (Huq & Martin, 2000, p. 80). Accordingly, *"there is increasing international interest in managing organisational culture"* (Mannion *et al.*, 2009, p. 153) to improve healthcare.

Morgan and Potter (1995, pp. 172-173) explain that *"professional occupational groups represent a major problem"* for managing healthcare. The professions become increasingly specialised. Doctors, nurses, therapists and other healthcare professionals are all separately represented or regulated by various professional bodies. These different groups do not necessarily share the same opinion as to what constitutes effective quality care. They form subcultures and differentiate themselves from other groups by dress code, language, professional qualifications and *"an 'us versus them' attitude to any groups outside the professions"* (Morgan & Potter, 1995, p. 173). Section 2.2.4 further discusses related issues and Table 1 below contrasts the professional with the TQM paradigm.

Table 1: Professional vs. TQM Paradigm

Professional Paradigm	TQM Paradigm
Individual responsibility	Collective Responsibility
Clinician-led	Manager-led
Autonomy	Accountability
Administrative authority	Participation
Professional authority	Managerialism
Goal expectations	Process, performance expectations
Rigid (fixed)	Flexible planning
Quality assurance	Continuous Improvement

Source: Morgan & Potter (1995, p. 183)

Based on Hofstede's (2003) dimensions of national culture, Lagrosen (2003) and Mathews *et al.* (2001) both identify low uncertainty avoidance as crucial for the successful adoption of a TQM culture. The former underlines the importance of collectivism, while the latter highlights the need for high power distance. Jung *et al.* (2008, pp. 631-631) confirm the need for high power distance. However, they come to mixed conclusions with regard to individualism – it seems to support the changes that come with TQM, while being less receptive towards the hard elements of TQM, e.g. measurement and analysis.

Contrary to Lagrosen (2003) and Mathews *et al.* (2001), Jung *et al.* (2008, p. 631) conclude that high uncertainty avoidance fosters the TQM aspects of clear rules and standardisation. This might be true for the long-term success of a TQM initiative, even though these findings are less statistically significant. But for the first implementation, low uncertainty avoidance more easily allows for the changes that such an implementation requires.

Vecchi and Brennan (2009) analyse, in more detail, how the cultural dimensions influence quality priorities, practices and performance. They conclude that different quality priorities are only marginally influenced by masculinity and uncertainty avoidance in a globalised world. Quality practices are said to vary significantly with all cultural dimensions. According to their findings, high power distance leads to more implementation of action plans, individualism discourages the involvement in quality programmes, masculine countries tend to invest more in inspection and less in external quality, high uncertainty avoidance fosters the use of inspection. In terms of quality performance, high power distance, collectivism and high uncertainty avoidance result in better performance thanks to higher levels of compliance. In addition to this, Jung *et al.* (2008, p. 631) find that masculinity has a positive impact on performance.

England, Germany and the US show a relatively medium to low score on power distance and a relatively medium to high score on masculinity. Yet,

England and the US score higher on individualism and lower on uncertainty avoidance (Hofstede, 2003). Thus, the cultural pre-disposition for adopting TQM appears to be quite similar for all three countries, even though England and the US could be at a slight advantage thanks to their lower uncertainty avoidance.

An additional debate concerns the convergence versus national specificity of quality management, i.e. the degree to which it is universally applicable (e.g. Rungtusanatham *et al.,* 2005). However, all three countries are developed, Western countries that are culturally similar to each other. Therefore, this debate does not seem to be relevant in the context of this research. Flynn and Saladin (2006, p. 598) support this view and do not question the applicability of quality management as such, but rather ask for an adaptation of European quality award criteria to account for the four cultural clusters identified in Europe, i.e. Anglo, Germanic, Latin European and Nordic.

Although Hofstede's work is claimed to be the most widely cited in this field (Jones, 2007, p. 2) and has been replicated successfully by an *"impressive number"* of studies (Vecchi & Brennan, 2009, p.153), it is also criticised on several grounds. First, the methodology, including the deliberate choice of dimensions, is questioned for being based on an attitudes survey. Secondly, the sample is claimed not to be representative, as the research relies on the organisation IBM, which has a strong US-based organisational culture. Thirdly, four dimensions (or the later inclusion of a fifth) are seen to be an oversimplification of cultural differences. Fourthly, these dimensions might not be the most important differentiating factors between different cultures. Finally, some argue that the whole study is dated and that younger people from developed countries follow a cultural globalisation, leading to a convergence towards a common set of values (Gooderham & Nordhaug, 2003, pp. 139-140).

Jones (2007, pp. 5-6) supports these areas of criticism, while adding the following issues: each nation tends to include various ethnic groups. Cultures do not necessarily have the same borders as nations. Political

instabilities at the time of the original study seem to have had an influence on the inclusion or exclusion of certain countries. The statistical integrity of the analysis is questioned. Further, Blodgett *et al.* (2008, pp. 339-340) caution that Hofstede's cultural framework is not highly valid and reliable, when applied at an individual level of analysis, while also acknowledging that the *"instrument was not necessarily designed to measure culture at a more micro level".* Finally, Moulettes (2007) criticises Hofstede for basing the cultural dimensions on a survey, which exclusively includes male respondents. This would imply an equal distribution of culture between men and women, even though the masculinity-femininity dimension *"unveils a distinct perception of gender differences"* (Moulettes, 2007, p. 443).

In summary, it can be said that culture, at its various levels, is a concept, which is difficult to capture. Yet, it is indispensable for an analysis that involves different countries, as this research does. However, because of the methodological issues and limitations of previous research, this study does not aim to explain potential similarities or differences relying only on the aforementioned cultural dimensions.

2.2.3 Public and Service Sector Concerns

The definitions of health and quality of life[28] allude to a tension between private and public sector characteristics, in which healthcare oscillates. Both private-service and public sector distinctive features have to be understood to enable the application of TQM to the field of healthcare.

TQM has its origins in the private, manufacturing sector, which is, accordingly, more advanced in this regard (Gupta *et al.*, 2005, p. 391). Delivering and measuring quality in the service sector and in manufacturing environments is considerably different (Dale *et al.*, 1997, p. 246). This is due to the following characteristics, which differentiate services, including healthcare provision, from products (Dale, 2003, p. 203; Kelemen, 2003, p. 57; Ruiz & Simón, 1994, p. 536):

[28] See Section 2.1.3.

- Usually intangible, heterogeneous and perishable, not storable
- Often simultaneous production and consumption
- Customer participation, interaction between staff and customers play key roles in the service performance
- Service delivery is difficult to control and to standardise because of this high dependence on human factors

Additionally, Waldman *et al.* (2003) maintain that *"management issues in healthcare delivery are fundamentally different from those in the business world".* In spite of this, modern (quality) management tools and techniques have increasingly gained importance in public services, in general, and healthcare, in particular, after having been introduced initially in manufacturing and subsequently also in the service sector (Dey & Hariharan, 2006, pp. 583-584). This has led to a merging of philosophies and a stronger focus on service quality in terms of values and needs of the users (Kelemen, 2003, pp. 60-61).

Even though TQM has been successful in manufacturing, Chen, Yu and Chang (2005, pp. 887-890)[29] argue that its applicability to the public sector can be questioned and highlight three main difficulties:

- Essential ethos
- Customer definition
- Specific organisational characteristics

First, the public sector does not usually show an entrepreneurial business orientation. Instead of market share and profit, the focus rather lies on fairness, openness and justice (Ntungo, 2007, p. 135). Thus, the main challenge consists in balancing the potentially conflicting opposites of cost or benefit, on the one hand, and fairness and justice, on the other (Chen *et al.,* 2005, pp. 889-890).

[29] Their study deals with the Taiwanese public sector, but the cited parts are still generally applicable and are mostly backed up with studies by Western authors that they refer to.

Secondly, the concept of users is generally applied rather than the idea of a customer. *"There are relatively few public services where people are treated like customers, in other words, where people are paying for services and have a choice whether to use the service or not"* (Kelemen, 2003, p. 61). In contrast to private sector organisations, public services cannot freely define their customer target groups, but have to satisfy the needs of very diverse, pre-selected customer or stakeholder groups (Chen *et al.,* 2005, p. 890).

The example of prison services pointedly illustrates several conflicts that can occur. The customer could be the prisoner or the general public, which is being saved from the prisoner. Even though the prisoners are the immediate, literal receivers of the service, they are so unwillingly (Chen *et al.,* 2005, p. 890). To a certain degree, this complexity can also be found in healthcare, as discussed below.

Thirdly, public sector organisations traditionally follow a very bureaucratic structure, which prevents them from achieving maximum efficiency (Chen *et al.,* 2005, p. 890). This contradicts the basic ideas of TQM. Further problematic aspects under this category include *"(i) multiple, non-financial, conflicting, and ambiguous goals; (ii) lack of agreement on means and ends; (iii) environmental turbulence; (iv) immeasurable outputs; and (v) effects of management intervention being unpredictable"* (Kearsey & Varey, 1998, cited by Chen *et al.,* 2005, p. 890).

2.2.4 Healthcare-Specific Concerns

Healthcare organisations, as part of the public services sector, are usually faced with the same dilemma of defining their actual customers. Thompson (1995, p. 66) discusses labelling[30] in healthcare and sees an *"ideological shift from 'citizen-user' to 'market-consumer'",* manifesting itself in the increased use of the term 'customer' instead of 'patient'. This

[30] Labelling is defined as *"the social process by which people are classified as exhibiting certain social behaviour"* (Thompson, 1995, p. 66).

forms *"part of the process of commodifying health to take its place in the private market of goods and services"* (Thompson, 1995, p. 66).

Windrum (2008, pp. 15-17) criticises this 'consumerisation' of public services and healthcare on several grounds. The rights and responsibilities of a citizen are fundamentally different to those of a costumer. Accordingly, the relationship to the state needs to be redefined, when citizens become customers. Further, healthcare, as a knowledge-intensive service, requires that the individuals, using these services, have the relevant knowledge to make informed choices about their treatments. This customer sovereignty is difficult to realise in healthcare. The scale of commitment and the personal consequences also differ between, for instance, buying a new car or deciding about healthcare treatments and prevention. Theoretically, sovereign, empowered and informed customers in healthcare deal more responsibly with their health and change their individual usage of health services. Efficiency gains and cost savings should be the consequence. Yet, the undefined balance between individual and social responsibility[31] for health could also result in the opposite.

The definitions of quality in healthcare[32] avoid the term 'customer' by referring to service users and other stakeholders. Squires (2003a, p. 141) defines the users, providers and funders as the principal stakeholders in healthcare. Øvretveit (1992, p. 40) adds that *"the income of* [health] *service* [providers] *depends on satisfying"* the needs and expectations of:

- The direct beneficiary, i.e. the client or the patient and their families
- The carers
- The referrers, mostly GPs
- The purchasers or funding bodies, such as health insurance companies or the government

[31] See Section 2.1.3.
[32] See Section 2.1.3.

Squires (2003b, p. 205) cautions: *"each stakeholder* […] *has different, often contradictory but seldom shared expectations of quality"* in healthcare. Therefore, in this research, it may be that questions of customer definition will arise. Traditional ideas of quality improvement and organisational excellence also apply to healthcare, but they remain the ultimate aims that have to be based on patient safety as a first condition. Quality improvement and organisational excellence in healthcare cannot be achieved without patient safety (Ruiz & Simón, 2004, p. 327). No matter how the customer question is answered, quality healthcare has to meet the challenge of the healthcare value chain. A balanced coordination of payers, fiscal intermediaries, providers, purchasers and producers contributes to the delivery of quality healthcare for the service users (Pitta & Laric, 2004, p. 456).

The previous section alludes to the potentially problematic effects, which can result from the principle of *uno-actu* – the simultaneous production and consumption of a service, in general, and of health services, in particular (Oberender *et al.,* 2006, p. 24). Furthermore, the patients and their lifestyles can have a substantial impact on the success of treatments. Even the best therapies cannot necessarily guarantee quality results measured in terms of healed patients because of their co-responsibility in the therapeutic process (BMG, 2006, p. 4). Therefore, it is highly important to directly involve the patients in their healing process. In their model for quality in public services, Gaster and Squires (2003, p. 250) extend the idea of involvement to all stakeholders.

Apart from these more externally focused considerations, healthcare organisations show specific patterns in terms of internal management and service provision. Szecsenyi (2004) expands the concept of healthcare quality management to encompass five domains, as illustrated in Figure 6 below. These domains provide the basic structure of the European Surgery Assessment (EPA) and reflect TQM components[33].

[33] See Section 2.2.1.

Figure 6: Five Quality Domains

Source: Szecsenyi (2004, p. 414)

Yet, the development of administration and management often falls short in healthcare. Ruiz and Simón (2004, pp. 323-324) explain: *"traditionally the technical knowledge of medical and nursing professionals has been considered sufficient for assuring quality and safety".* Today's complex healthcare organisations also require administrative and managerial support to provide quality medical services to the patients. Accordingly, Ruiz and Simón (1994, p. 537) summarise the problem that gave rise to considering TQM in the Spanish healthcare system:

> *"Traditionally, the quality of medical services – in Spain as well as in most Western countries – was implicitly guaranteed by the practitioner's professionalism which, in turn, depends on the quality of the education delivered by the medical faculty. […] The problem resides in the apparent discrepancy between the traditional interest of the medical professionals to improve the quality of their work and the absence of norms and explicit, concrete methodologies that allow to evaluate them with their own motivated collaboration and the participation of the system's user."*

The research by François and Pomey (2005, p. 1S4), Hudelson *et al.* (2008, p. 31) as well as the author's experience with case-study organisations from other projects (Halank, 2006, 2007 a & b) suggest that professional medical prestige, coupled with a lack of the required managerial maturity, often still prevails. This represents an obstacle to adopting TQM values in this field. Gollop (2002b, cited by Buchanan & Huczynski, 2004, p. 633) supports the view that doctors are *"traditionally sceptical of management methods and suspicious of criticism"* and also identifies a potential solution to the problem. Process mapping seems to be a reasonably powerful means of *"persuading doctors* […] *to reconsider their working practices"* (Gollop, 2002b, cited by Buchanan & Huczynski, 2004, p. 633).

Table 2: Critical Dimensions for TQM in Healthcare

Dimensions	Descriptors
Cost reductions	Highly professionals labour-intensive
Customer	Major customers are the payers (government as well third part payers) Hospital service is a credence service
Dependency	Patient depends on hospital, physician, and nurses
Economic rules	Operations in the medical system are extremely costly Public opinion shows an unwillingness to accept analysis in terms of economic profitability where medical treatment of patient is concerned
Knowledge management	The relationship between medical procedures and their results is complex (process and outcomes connection) Many variables mediate and moderate and are not controlled A disparity exists between the quality of medical diagnosis and the means of treatment in accordance with the diagnosis
Measurement	Clinical outcomes research is in development stages The time frame can be long for seeing the effects of treatment
Supply chain	Community health care systems barely communicate with general hospitals
Team work	System's structure is composed of sectors, i.e. different groups (physicians, nurses, and administration) The division is most intense in the medical profession itself and between professions (specialties) within the medical world
Technology development's effects	Development in medical science's abilities have increased costs of treatment
Variation	Lack of standards for clinical outcomes Standards set for populations and not at the individual patient level Outcomes cannot be guaranteed

Source: Cauchick Miguel (2006, p. 628)

Walshe (2007, pp. 57-58) additionally highlights the problematic differences in mindsets of quality and medical professionals. Clinicians, as natural scientists, usually expect experimental evidence, that quality improvement programmes show the promised effects. But in dealing with quality a different philosophy is adopted. It aims to understand *"the complex relationship between context, content, application and outcomes"* (Walshe, 2007, p. 58) of such programmes. Waldman and Schargel (2006, p. 117) also allude to the need for a more holistic perspective, when criticising the lack of systems thinking in healthcare. Ruiz and Simón (2004, pp. 330-331) support this. They link process and systems thinking to potentially increased patient safety. Table 2 above depicts, how Cauchick Miguel (2006, p. 628) summarises some of the points discussed above.

2.3 Research Context

2.3.1 Quality Management at Hospitals

The academic community engages in comparing various aspects of health services, both throughout the world and within Europe. The more general studies focus on two main fields of research:

- General health policy development (e.g. Riesberg, Weinbrenner & Busse, 2003; Wendt, 2003)
- Quality of the healthcare service provision, mainly measured by parameters related to the patients or general cost and efficiency of the systems (e.g. Sawicki, 2005; Busse, 2006)

Recently, a European Union project has started to combine these fields in researching *"Methods for Assessing Response to Quality Improvement Strategies"* (MARQuIS; Spencer & Walshe, 2005a). In the first phase, the study provided a broad literature review, looking at different aspects of quality, related models and strategies in European healthcare. The practical research, however, takes place at a fairly general level. A survey of quality improvement policies and strategies relies on 68 key experts from 24 member states (Spencer & Walshe, 2005b, p. 2). This is the

equivalent of less than three experts per member state. The survey prepares the field tests of the second phase, where the focus lies on *"exploring the effectiveness of different quality improvement strategies for cross-border patients"* (Vallejo & Suñol, 2009, p. i1). Data was collected with a questionnaire and audit tools at 389 hospitals in eight European countries, i.e. Spain, France, Poland, Czech Republic, UK, Ireland, Belgium and Netherlands (Lombarts *et al.*, 2009, p. i28).

The MARQuIS project finds that external quality assessment is the most broadly implemented quality improvement strategy at European hospitals (Lombarts *et al.,* 2009, i28). Within the same project, Suñol *et al.* (2009, p. i57) analyse the implementation of patient safety strategies in more detail. They conclude that, even though implementation of mechanisms or activities showed greater variation, most hospitals had well developed structures and plans for safety in place. Different types of hospitals, i.e. university hospital, general hospital with and without residency training, showed similar patterns of implementation (Suñol *et al.*, 2009, p. i60).

Independently of the MARQuIS project, other quantitative surveys have been carried out to assess issues around the implementation of quality management systems at hospitals. Wagner *et al.* (2006a) analyse the views of the directors or quality coordinators of 101 hospitals in the Netherlands, 116 hospitals in Hungary and 59 hospitals in Finland. They conclude that views about issues of quality management implementation can be assessed at national and international level. Further, they suggest that specific obligations for quality management show better results than general, framework legislation.

Sangüesa *et al.* (2007) also base their analysis on the responses from hospital management teams, in order to identify the criteria to select a quality management system for the organisation; 42 out of 101 hospitals responded to their survey. Finally, Pongpirul *et al.* (2006) include a wider range of healthcare professionals, i.e. physicians, dentists, pharmacists and nurses from different departments, and surveyors to compare their opinions on problems and obstacles to the implementation of quality

management systems in Thai hospitals. Their study included 728 healthcare professionals from 39 hospitals and 41 surveyors of the national accreditation programme.

2.3.2 Perceptions, Elderly-Related and Acute Stroke Care

Previous research based on perceptions in the field is mainly quantitative and often includes a limited number of different viewpoints. Bin Saeed (1999) analyses Saudi healthcare managers' perceptions regarding the impact of costs on quality improvement initiatives in their organisations. Further, Duclos *et al.* (2008) aim to identify determinants of different perceptions, held by physicians, nurses and nursing assistants, concerning the quality of information, delivered to inpatients. Finally, both Shannon *et al.* (2002) and Hensen *et al.* (2008) compare and assess the quality of critical care and of hospital services, by including the perceptions of patients, nurses, physicians and referring physicians.

Research around elderly-related care is methodologically more diverse. Wagner *et al.* (2006b) include management and residents of Dutch nursing homes to explore quantitatively how quality management systems influence clinical outcomes. Heras *et al.* (2008a-c) use qualitative interviews, observation and a qualitative Delphi study to assess the appropriateness of (quality) management systems for Spanish nursing homes. Their studies involve top and middle managers, consultants, employees, public-sector social-service administrators, a representative from the Spanish Association for Standardisation and Certification and a UK-based academic.

Finally, research applies different methodologies to investigate various aspects of stroke care. Morris *et al.* (2007) conduct qualitative focus groups to assess patient, carers and staff experience of hospital-based stroke services. Tilley *et al.* (1997) confirm in an observational study that total quality improvement methods helped to identify critical processes, often of administrative nature, in emergency departments and to realise a reduction in time between emergency admission and treatment. Immediate treatment is very important for the survival of the patient and

reduces the risks of remaining disability. Redfern *et al.* (2006) also apply an observational study to question how risk management after stroke can be achieved by a patient-centred approach. A systematic review of observational studies by Seenan *et al.* (2007) supports the benefit of specialised, coordinated care on stroke units. This is comparable to findings from clinical trials.

Cadilhac *et al.* (2008) provide quantitative evidence that stroke units in Australia improve clinical practice in stroke care and reduce disability after stroke. Further, Rudd *et al.* (2001) research quantitatively how a national audit in England, Wales and Northern Ireland[34] has stimulated improvements in the quality of stroke care, with more patients being treated on stroke units. Stoeckle-Roberts *et al.* (2006) add that a collaborative and systematic quality improvement project has resulted in clinically and statistically significant improvements of adherence to evidence-based guidelines in stroke care at 13 Michigan hospitals. With regard to external risks, Hu *et al.* (2008) quantitatively examine the association between stroke and air pollution, income and greenness in Northwest Florida.

2.3.3 Gaps and Contribution to Knowledge

The review in the previous sections reveals the following gaps in the academic literature. The international comparisons usually take a high-level approach. With regard to different perspectives of health service delivery, the identified research mainly focuses on management and key medical personnel. Additionally, most of the research around quality management in hospitals and related perceptions is based on quantitative data. Studies of quality management in elderly care investigate mainly nursing homes, not acute care at hospitals. Research of stroke care is more concerned with quality in general, including the impact of improvement projects on quality.

[34] Section 3.2.2 explains the role of the National Sentinel Stroke Audit within the English healthcare system.

The researcher aimed to fill these gaps by innovatively combining the perceptions of different perspectives involved in the provision of elderly-related, acute stroke care at hospitals in England and Germany. The study intended to achieve a more holistic understanding based on a qualitative research approach and derive lessons to be learned for both countries. In the context of resource challenges in healthcare and the trend towards an aging society (Cauchick Miguel, 2006, pp. 626-627; Rachold, 2000, p. 19), the research is highly relevant.

Glattacker and Jäckel (2007) support this and highlight the need for qualitative research involving perceptions from different perspectives to improve the evidence for evaluating quality management initiatives and their further development. Donabedian (1980, p. 26) supports the idea of taking into account practitioner satisfaction with the organisation as an inspiring working environment: *"the organisation as [a] whole, if it is to survive and grow, must also serve the interests of practitioners. In this context, practitioner satisfaction becomes a criterion of the quality of certain features and functions of the organisation."*

The MARQuIS project encourages further research *"on the effectiveness of quality-improvement strategies and mechanisms, both for cross-border patients and for the general population"* (Vallejo & Suñol, 2009, p. i2). MARQuIS focuses strongly on the impact of quality management on performance. However, if a quality management initiative is to have a positive impact on performance, it needs to be properly implemented and embraced by all employees (Huq & Martin, 2000, p. 80; Hendricks & Singhal, 2001a, p. 359). Therefore, this piece of research assesses the implementation of quality management and clinical governance from the employees' point of view and develops suggestions for improvements, so that the initiatives can have a greater impact in the future.

Two studies have been identified that confirm the initial design ideas, which the author had developed from her MSc dissertation. Hudelson *et al.* (2008) explore in a case-study, based on semi-structured interviews at a hospital in Switzerland, which ideas about quality are held by doctors

and nurses, as opposed to quality experts. François and Pomey (2005) analyse the implementation of quality management at nine French hospitals, based on interviews with administrative staff, physicians and chief nurses.

These studies support the methodological approach of this research. In terms of scope, however, they show the same gaps, as identified above: a more limited number of different staff groups is involved and the focus lies on more general ideas around quality and its management, not so much on the way staff work with quality management.

The review of the academic literature in this chapter has looked at quality and its strategic management in healthcare. The following chapter addresses the political and economic background, before Chapter 4 uses the lessons-learned from the background chapters to develop the methodological foundations for the research, documented by this thesis.

3 Literature Review II: Political & Economic Background

This chapter provides a review of political and economic information about the healthcare systems, the healthcare service provision and funding in the three countries as well as the reforms for improvement.

3.1 Healthcare Systems

3.1.1 Definition and Constitutional or Legal Embodiment

A healthcare system can be defined as the interplay of all institutions, persons and goods that contribute to the recovery, preservation and promotion of public health (Szathmary, 1999, p. 12). The WHO (1946) constitutional definition of health was discussed in Section 2.1.3. For this chapter, its human rights aspect is of greater importance:

> *"The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition"* (WHO, 1946, p. 2).

Further, the human rights charter of the United Nations includes health as a basic right (Schwartz *et al.*, 2003, p. 24). Unsurprisingly, the constitutions governing health service provision in England and Germany build on this basic right. In order to be able to fulfil these constitutional duties, the governments had and still have to intervene legally[35].

When the NHS in England was launched in 1948, three core principles formed its basis: the service was, and still is, intended to meet the needs of everyone, be free at the point of delivery and be based on clinical need, not an individual's ability to pay (NHS, 2009). These principles implicitly reflect the right to health and the NHS is seen to be the first healthcare system to be built on such principles (Wendt, 2003, p. 120). They have guided the further development of the NHS. In 2000, a modernisation programme led to the inclusion of additional principles. These have been

[35] See Section 3.3.

further developed and refined to shape the seven guiding principles published in the NHS Constitution for England of 2010 (NHS, 2010a). The first of these principles explicitly refers to the obligation of the service to serve and respect the human rights of each individual.

In Germany, the 'Grundrechte' (basic rights) are embodied in the 'Grundgesetz' (GG) – the German constitution. The right to health can be derived from the more general rights to social security and social justice. GG § 2 grants the social security right to freely develop one's personality. This requires that the standard of living is maintained in times of illness and that recovery is achieved if, and as soon as, possible. In combination with the principle of social justice, as addressed in GG § 3, an equal right to funding of the required treatments exists for all citizens. The constitutional rights of social security and social justice are further materialised in the 'Sozialgesetzbuch' (social code). SGB I § 1 ('Sozialgesetzbuch, Erstes Buch') defines preservation, improvement and recovery of the individual's health status as the primary objective of the healthcare system.

3.1.2 Typologies

According to Busse (2006, p. 10), two basic types of healthcare system models can be distinguished in Europe. On the one hand, the Beveridge model is mainly tax-funded. Traditionally the Northern-European countries, including Ireland and the UK, use this model. In the 1980s, Southern-European countries, such as Spain, Portugal and Greece, were reformed towards this model. On the other hand, the Bismarck model is financed by a Social Health Insurance (SHI) structure. Most Central-European countries, including Germany, have traditionally been set up this way. Since the 1990s, almost all Eastern-European countries also apply this model.

Freeman (2000, pp. 36 & 53) elaborates further detail about the healthcare systems in England and Germany. Healthcare across the different parts of the UK is described as *"the prototype National Health Service* [NHS]*: tax financed and publicly managed, now combining a high degree of central*

authority with local managerial responsibility" (Freeman, 2000, p. 36). Additionally, private insurance duplicates the healthcare coverage provided by the NHS to increase choice of providers and timeliness of care (OECD, 2003b, p. 9).

Healthcare in Germany is seen as the *"archetypal social insurance system, combining elements of solidarity with independence from government"* (Freeman, 2000, p. 53). A highly regulated framework governs the financing of healthcare by independent institutions. Healthcare delivery is organised separately from its funding and carried out by a different set of independent providers (Freeman, 2000, p. 53).

Nolte *et al.* (2005, p. 15) highlight the fact that the US are unique with regard to healthcare. All the other industrialised countries have developed a system of universal health coverage. In the US, however, voluntary private health insurance is responsible for basic healthcare coverage that is provided by private (often for-profit) organisations (OECD, 2003b, pp. 9-10). Section 3.2 explains, in more detail, the structure of healthcare in all three countries.

There is no clear evidence that proves any of the above models to be "*better*" (Busse, 2006, pp. 12-13). Green *et al.* (2002) support this. In the light of rising costs for healthcare, the NHS struggles to meet patient needs (Green *et al.*, 2002, p. 488). Therefore, the authors controversially discuss whether a social insurance structure would better respond to these challenges. The case is equally made for both options. Saltman *et al.* (1998, p. viii) more generally state that complete satisfaction with methods of healthcare financing and delivery is never achieved – policy alternatives are always considered.

3.1.3 Facts and Figures

The healthcare systems in the UK, Germany and the US[36] play an important role in the national economies. They employ a large and growing part of the civilian working population; 12.4% and 12.5% of the UK and US civilian working population worked in healthcare in 2008. A slightly smaller 11.6% of the German civilian working population was employed in healthcare. Between 1995 and 2008, Germany showed the largest growth rate in healthcare employment across all three countries (OECD, 2009a, pp. 62-63). Considering the increased health awareness of the citizens, demographic changes towards an aging[37] and, thus, a sicker and 'multi-morbid'[38] society (Kayser & Schwefing, 1998, p. 34; Rachold, 2000, p. 19) as well as medical and technical progress (Saltman *et al.*, 1998, p. vii; Dieppe, 2005pp. 5-6), it can be expected that this sector is going to gain even more importance over time (Specke, 2005, p. 193).

The total expenditure on health is defined as the final consumption of healthcare goods and services including capital investment in healthcare infrastructure (OECD, 2009a, p. 158). The US dedicate by far the largest total expenditure to health with 16% of GDP (gross domestic product). Germany with 10.4% of GDP and the UK with 8.4%[39] of GDP apply more similar spending patterns (OECD, 2009a, p. 163). Between 1997 and 2007, total expenditure on health has grown far more in the UK with an annual average growth rate of 4.9%, compared to 3.4% in the US and only 1.7% in Germany (OECD, 2009a, p. 161).

The differences in growth rate between the UK and Germany result from national politics. On the one hand, the UK dedicated comparably little resources to healthcare at the beginning of the period. In the pursuit of specific policy objectives, public spending on health has increased.

[36] In order to guarantee international comparability, the statistics in this section are taken from OECD (2009a), which reports at country-level only.
[37] This trend has been most pronounced for Germany with the share of the population aged 65 and over almost doubling between 1960 and 2007 to 20.2%. The corresponding shares for the UK and the US are lower with 16% and 12.6%, but the growth trend can be observed just the same (OECD, 2009a, p. 188).
[38] Multi-morbidity occurs when a person suffers simultaneously from two or more diseases (Kayser & Schwefing, 1998, p. 34).
[39] In 1980, the German total health expenditure already was at 8.4% of GDP. The US spent more on health then, i.e. 9% of GDP, than the UK today (OECD, 2009a, p. 198).

Consequently, the growth of total expenditure on health has outpaced economic growth over the given period (OECD, 2009a, p. 160).

On the other hand, the German healthcare system has traditionally been diagnosed as suffering from a cost-explosion since the 1970s (Eichhorn & Schmidt-Rettig, 1998, p. 3). Accordingly, the levels of total expenditure on health are higher. Busse and Riesberg (2005, p. 29) claim that the growth of the healthcare system and the expenses on health, referred to as cost-explosion, resulted from a declared political strategy. Nonetheless, more recent policies have focused on cost containment in healthcare to stabilise contribution rates to the SHI (OECD, 2009a, p. 160). This explains the comparably low growth rates.

Since the 1980s, growing healthcare spending has been a concern for many countries, with the exception of the UK. The second half of 2008 has marked the beginning of a deep worldwide recession. It is expected that this will also impact on the public resources available for healthcare. As governments strive to control their budgets during or after the recession, public spending for healthcare may be affected (OECD, 2009a, pp. 9-10). It represents a high and growing part of the public budgets, as seen above. Therefore, the efficient and effective use of scarce resources becomes even more important.

The majority of healthcare spending is dedicated to hospital activities (OECD, 2009a, p. 88). Accordingly, cost-containment policies have often focused on the hospital sector. In addition to this, medical and technological progress allows for day-surgeries and reduces the need for hospitalisation. Therefore, the number of acute care hospital beds per 1000 population has decreased in most countries between 1995 and 2007. Germany still provides a comparably high capacity of 5.7 acute care hospital beds per 1000 population. This represents more than twice the capacity of the UK or the US (OECD, 2009a, pp. 94-95). Consequently, the occupancy rate of acute care hospital beds is one of the highest in the UK with 83%. Germany also shows a relatively high rate of 76%. In

contrast to this, the US occupancy rate is one of the lowest at 67% (OECD, 2009a, p. 95).

The average length of stay in hospital is often considered to reflect the efficiency of a healthcare system. *Ceteris paribus*, treatment costs decrease when patients are discharged earlier from cost intensive inpatient care to less expensive post-acute settings. This effect can, however, be reduced or nullified, if discharge happens too early. Patients may need to be re-admitted and costs increase again (OECD, 2009a, p. 98). Germany shows a slightly higher average length of stay for acute care in 2007, with 7.8 days, than the UK with 7.2 days. Hospital stays in the US are the shortest of all three countries with an average of 5.5 days (OECD, 2009a, p. 99).

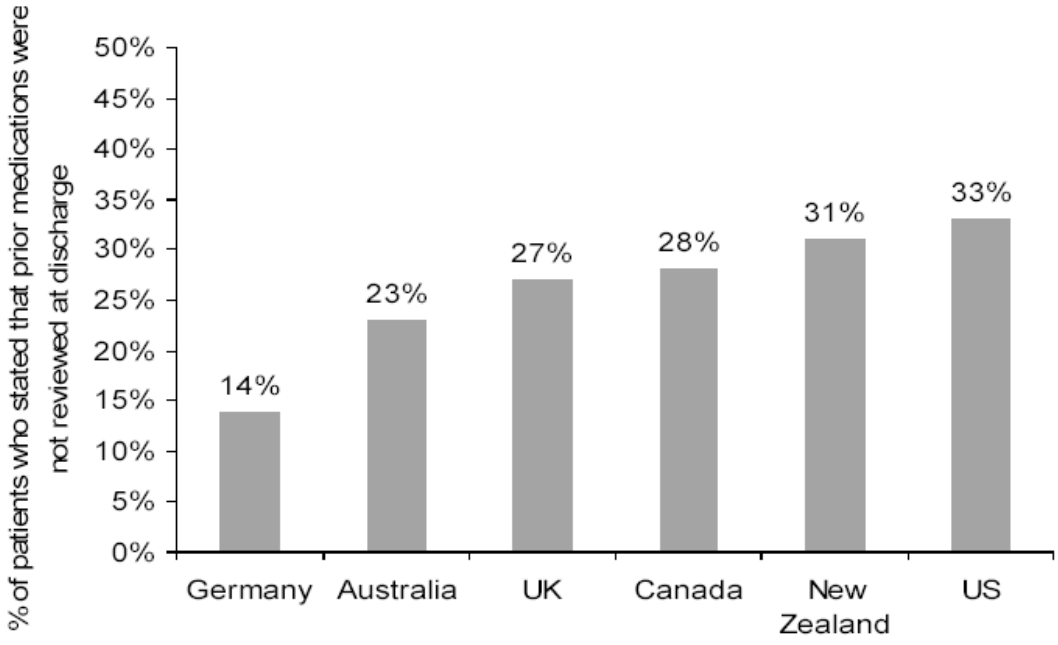
Specke (2005, pp. 128 & 195) appreciates the high quality and guaranteed supply of healthcare without waiting lists (Busse & Riesberg, 2005, p. 243) in Germany. Even though the capacity levels in UK and US healthcare are similar, only the UK faces the problem of excessive waiting times for elective surgeries. The reduction or non-existence of waiting times positively relates to per capita spending on healthcare (OECD, 2004, p. 71). If more money is spent on healthcare, patients have to wait less long for surgery. Compared to the UK, the US spend twice the amount on healthcare (OECD, 2009a, p. 163). Accordingly, the US do not encounter the problem of waiting lists (OECD, 2004, p. 71). Yet, in comparison with the US, Germany and the UK spend less on healthcare (OECD, 2009a, p. 163). The differences in waiting times in this case depend mainly on different levels of physician density (OECD, 2004, p. 71). In Germany it is twice as high as in the UK (OECD, 2009a, p. 149).

In spite of this, Specke (2005, pp. 128 & 195) states critically that this high density of physicians and high capacity of acute care hospital beds cause expensive excess-capacities in Germany. More and more doubts are raised as to whether the high healthcare expenses in Germany are justified and actually result in correspondingly high levels of quality and efficiency in the use of scarce resources (Busse & Riesberg, 2005, p.

245). In contrast to this, the political debate in the UK has started to acknowledge the need to increase funding for healthcare after years of cost containment. Yet, there is no agreement as to how these additional funds should be financed (Green *et al.*, 2002, p. 489). With regard to the current economic climate (OECD, 2009a, pp. 9-10), pressures to save costs and increase efficiency can be expected to become stronger in Germany and to stop or slow the increase of healthcare funding in the UK.

With regard to general outcome quality, the Commonwealth Fund (2005, cited by OECD, 2007, p. 28) finds that German patients experience much higher levels of medication safety than patients in the UK or the US, as depicted in Figure 7 below. However, internationally gathered data are not necessarily completely comparable due to, for instance, different methods of data tracking. Comparisons across countries should, therefore, not be over-evaluated (OECD, 2007, p. 31; Specke, 2005, p. 197).

Figure 7: Patients' Experience of Medication Safety

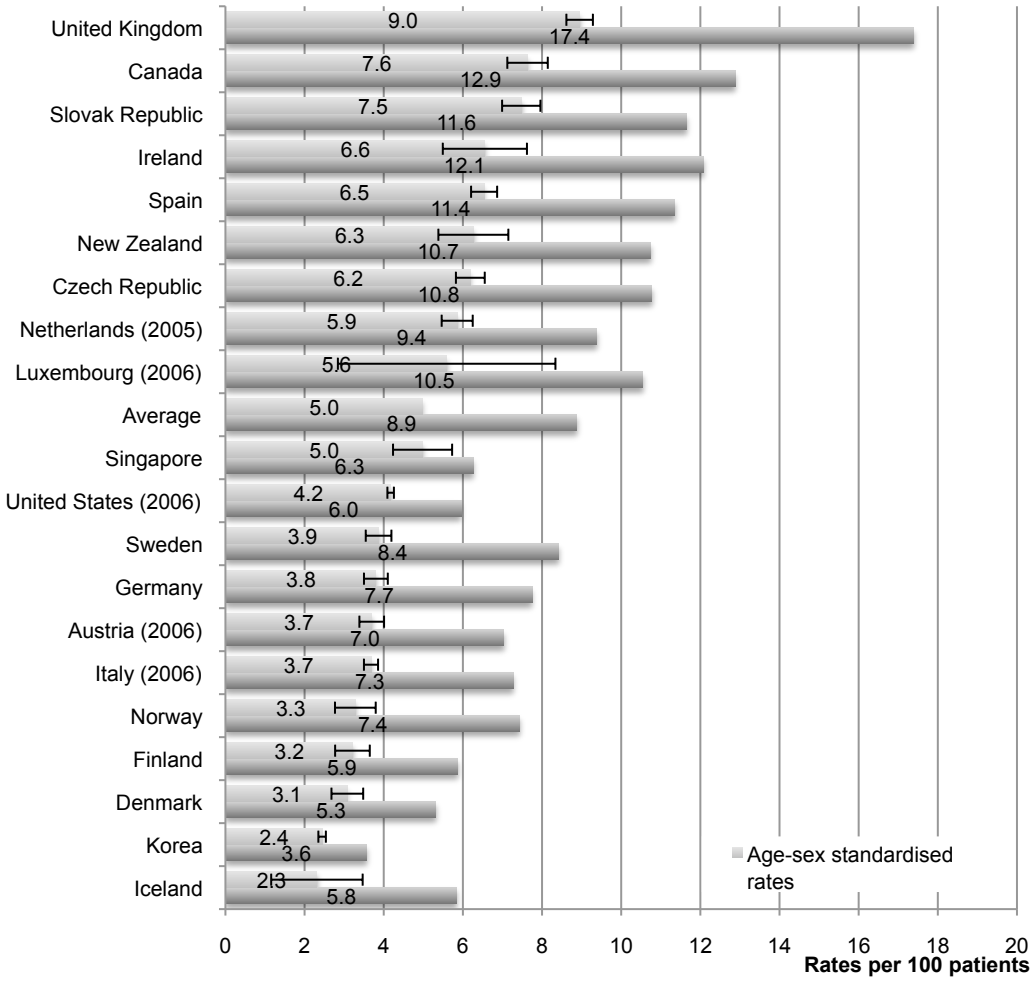


Source: Commonwealth Fund (2005, cited by OECD, 2007, p. 28)

The focus of the research reported in this thesis lies on stroke care. Together with the other cardiovascular diseases, it represents the main cause of death in most industrialised countries (OECD, 2009a, p. 22). Men

are usually more affected than women. Of the three countries considered in this thesis, stroke mortality rates are the lowest in the US and the highest in the UK. However, the stroke mortality rates of all three countries are still below OECD average (OECD, 2009a, p. 23). Death and disability define the total burden of a disease for a healthcare system. After ischemic heart disease and depression, stroke causes the third largest total disease burden (OECD, 2003a, p. 54). Resulting from this high burden, the associated costs for the healthcare system are also high ranging between an estimated 2 to 4% of total health expenditure (OECD, 2003a, p. 54).

Figure 8: In-Hospital Case-Fatality Rates (2007)



Source: OECD (2009a, p. 125)

Due to its high impact on mortality, disability and ultimately cost, stroke care has increasingly received public and political attention. Figure 8 above depicts an outcome quality measure for acute care of ischemic

stroke[40]: *"the number of people who die within 30 days of being admitted (including same day admissions) to hospital"* (OECD, 2009a, p. 124). Stroke care in Germany and the US achieves relatively low fatality rates, while more patients die during acute stroke care in the UK. Since 2002, case-fatality rates have been improving in most industrialised countries by around 15%. Accordingly, the quality of care seems to have improved (OECD, 2009a, p. 124). Seenan *et al.* (2007) review 18 studies about stroke unit outcomes. They confirm that acute care provided in stroke units reduces the odds of death and the odds of death or poor outcome within one year after stroke. In other words, patients treated in a stroke unit are more likely to *"survive, return home, and regain independence"* (Seenan *et al.*, 2007, p. 1886). Those countries that have pioneered in establishing stroke units in their hospitals tend to achieve better case-fatality rates (OECD, 2009a, p. 124).

Table 3: Public Views on Healthcare: UK, Germany and US

	UK	GER	US
Availability of Quality HC (2008)			
- Satisfied	85%	87%	81%
- Dissatisfied	14%	12%	19%
Satisfaction with HC system (2007)			
- Minor changes needed	26%	20%	16%
- Fundamental changes needed	57%	51%	48%
- Completely rebuild	15%	27%	34%

Source: OECD (2010a, 2010b)

Independent of the actual and objective outcome quality of healthcare, the population of the UK, Germany and the US form subjectively motivated opinions about healthcare in general and their personal experiences with it. These are summarised in Table 3 above. Even though most individuals across the three countries do not report any personal problems in accessing quality healthcare services, the majority sees the need for fundamental changes or a complete rebuild of the healthcare systems. This contrast is also found in other countries (OECD, 2004, p. 70). The

[40] Ischemic stroke is the most common type of stroke present in around 85% of cases (OECD, 2009a, p. 124).

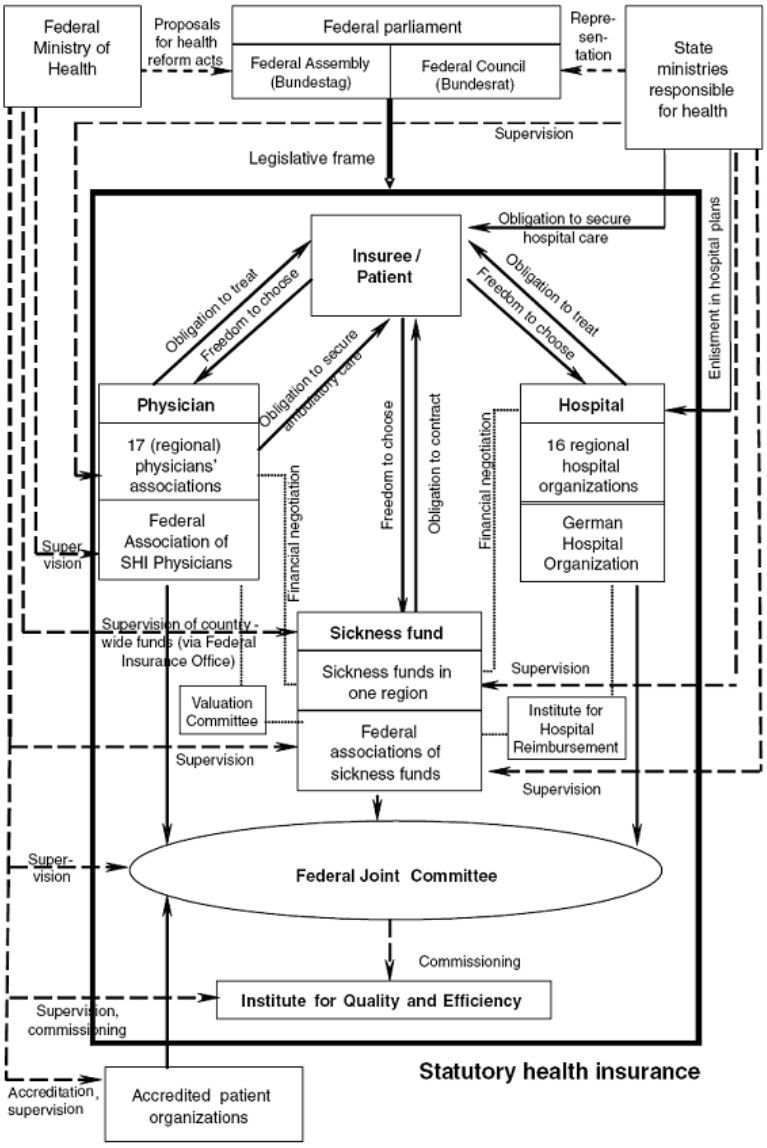
reforms and approaches to clinical governance and quality management (see Section 3.3) form part of government efforts to face these challenges and to improve healthcare towards meeting consumer and patient expectations and preferences.

3.2 Healthcare Service Provision and Funding

3.2.1 Germany

Figure 9 below depicts the structure of healthcare service provision and funding within the SHI in Germany.

Figure 9: Healthcare Service Provision and Funding in Germany



Source: OECD (2009b)

The government sets the legal framework for healthcare, mainly in social code book V (SGB V). SGB V, Chapter 2 deals with the obligation or the choice to be insured within the SHI[41]. In summary, the following groups have to belong to the SHI (Oberender *et al.,* 2006, pp. 43-44)

- employees with a gross annual income below the 'Versicherungspflichtgrenze' (compulsory insurance limit) – for 2006 this limit was 47,250 Euro,
- pensioners, students and unemployed people,

while these groups can choose to be privately or SHI insured

- employees with a gross annual income above the compulsory insurance limit,
- farmers, artists and other self-employed people.

Accordingly, almost 90% of the population are SHI insured and only a minority of the population relies on private, instead of social, health insurance for basic healthcare coverage (OECD, 2009a). Further, private health insurance also offers supplementary[42] and complementary[43] policies for the population, covered by the SHI (OECD, 2003b, p.9).

Healthcare service provision in Germany is based on the principle of 'Selbstverwaltung' (self-administration). Accordingly, the SHI self-administration of the health service providers and funders within the system organise and deliver healthcare. Members of the SHI self-administration include doctors, hospitals, health insurers and their respective organisations (Specke, 2005, p. 192; Busse & Riesberg, 2005, p. 35):

- 'Kassenärztliche / kassenzahnärztliche Vereinigungen' (KV, Associations of SHI Physicians / Dentists)

[41] Spouses and children of SHI members are automatically insured in the same organisation as the main-member but are exempt from contributions (Oberender *et al.,* 2006, pp. 43-44).
[42] *"To fill gaps in the benefit packages"* (OECD, 2003b, p. 9).
[43] To *"absorb out-of-pocket payments"* (OECD, 2003b, p. 9).

- 'Deutsche Krankenhausgesellschaft' (German Hospital Organisation)
- 'Verbände der Krankenkassen' (Federal Associations of Sickness Funds)

These organisations cooperate and agree contracts to define the health services to be delivered within and funded by the SHI, their prices and quality standards (Busse & Riesberg, 2005, pp. 35-36). The patients can freely choose their health insurers, doctors and hospitals. In turn, these are obliged to provide their services to all patients that form part of the SHI (Busse & Riesberg, 2005. p. 37). This obligation is independent of the ownership of the hospital – 49% of the acute care beds are provided by publicly owned hospitals, 36% by not-for-profit privately owned and 15% by for-profit privately owned (OECD, 2009a, p. 192). The government positively appreciates the increase in privately owned for-profit hospitals, as a consequence of increased competition, which offers opportunities for quality improvement in the hospital sector. This trend is expected to continue (Deutscher Bundestag, 2009).

SGB V §§ 2 and 12, in part, allude to issues of quality and efficiency in the medical service provision. More explicitly, SGB V § 70 states:

> *"The health insurers and service providers have to guarantee a demand-oriented and regular healthcare provision that corresponds to the generally accepted body of medical knowledge. The healthcare service has to be sufficient and effective, must not exceed the present needs and has to be provided within adequate levels of quality and efficiency[44]."*

The healthcare reform of 2004 established the 'Gemeinsamer Bundesausschuss' (G-BA), the federal joint committee, to foster quality

[44] Translated by the author. Original wording: *"Die Krankenkassen und die Leistungserbringer haben eine bedarfsgerechte und gleichmäßige, dem allgemein anerkannten Stand der medizinischen Erkenntnisse entsprechende Versorgung der Versicherten zu gewährleisten. Die Versorgung der Versicherten muß ausreichend und zweckmäßig sein, darf das Maß des Notwendigen nicht überschreiten und muß in der fachlich gebotenen Qualität sowie wirtschaftlich erbracht werden."*

and efficiency in the healthcare system. According to SGB V § 91 the G-BA consists of:

- A neutral chairperson and two additional neutral members
- Four representatives of the Federal Association of SHI Physicians
- One representatives of the Federal Association of SHI Dentists
- Four representatives of the German Hospital Organisation
- Nine representatives of the sickness funds

The G-BA decides all issues relevant to the medical service provision, informs the patients (Specke, 2005, pp. 168-169) and publishes directives regarding quality management and efficiency. A list of possible topics for directives, as defined by law, can be found in Appendix 6. This committee also intends to help increase transparency and responsibility of the self-administration towards the public, a lack of which has been identified in the past (Busse & Riesberg, 2005, p. 63).

According to SGB V § 139a, the G-BA founded the Institute for Quality and Efficiency in the Healthcare System ('Institut für Qualität und Wirtschaftlichkeit im Gesundheitswesen'). This independent institute provides the academic research that is the basis of the G-BA directives; Appendix 7 lists the main fields of research. Based on this academic research and the G-BA directives, the members of the SHI self-administration regulate healthcare service provision in Germany. The sickness funds negotiate the respective prices, quantities and measures for quality assurance directly with the service providers (Zahn, Gothe & Häussler, 2005, pp. 604-605).

The German Hospital Organisation, the Federal Associations of Sickness Funds and the Federal Association of SHI Physicians commission the BQS Institute for Quality and Patient Safety ('BQS-Institut für Qualität und Patientensicherheit') to collect data about and compare the outcome quality of German hospitals (BQS, 2010a). This is referred to as external quality assurance. In compliance with SGB V § 137, the corresponding results are publicly available on the website of the BQS Institute (BQS,

2010b). SGB V § 137 further obliges all SHI hospitals to publish a structured quality report every other year. According to a G-BA agreement (2007, p. 3), these reports have to be made publicly available on the Internet[45]. They contain information about internal measures for quality assurance and quality management.

The office of the Federal Government Commissioner for Patients' Affairs ('Beauftragter der Bundesregierung für die Belange der Patientinnen und Patienten') establishes a link between improving healthcare services and involving the service users. It acts as an independent advisor to the patients and deals with patient complaints about SHI service providers. In doing so, it further develops and strengthens the implementation of patient rights (Patientenbeauftragter, 2010).

In order to improve the healthcare system and the health of the population, the government develops national health objectives ('nationale Gesundheitsziele'). At the federal level, stroke is not included as one of these (BMG, 2010a). Only one federal state, namely Rhineland-Palatinate ('Rheinland-Pfalz'), explicitly refers to stroke as a regional focus for health development (GVG, 2009). However, the Federal Ministry of Health ('Bundesministerium für Gesundheit', BMG) has identified the demographic changes towards on aging society as the most important challenge for the healthcare system (BMG, 2008). Accordingly, a new topic has been selected for becoming a national health objective in 2008: growing old in good health ('gesund älter werden'). The detailed content of the objective is still being developed (BMG, 2010a). In terms of disease patterns, the burden of stroke – next to cancer, diabetes, osteoporosis and dementia – increases with age (BMG, 2008). As an unhealthy life-style is one of the risk factors for stroke (DoH, 2005, p. 4), this national health objective can be expected to have an impact on stroke amongst the elderly population.

More stroke-specific, the BMG has recently commissioned a research project on primary prevention for women in this regard. This focus is

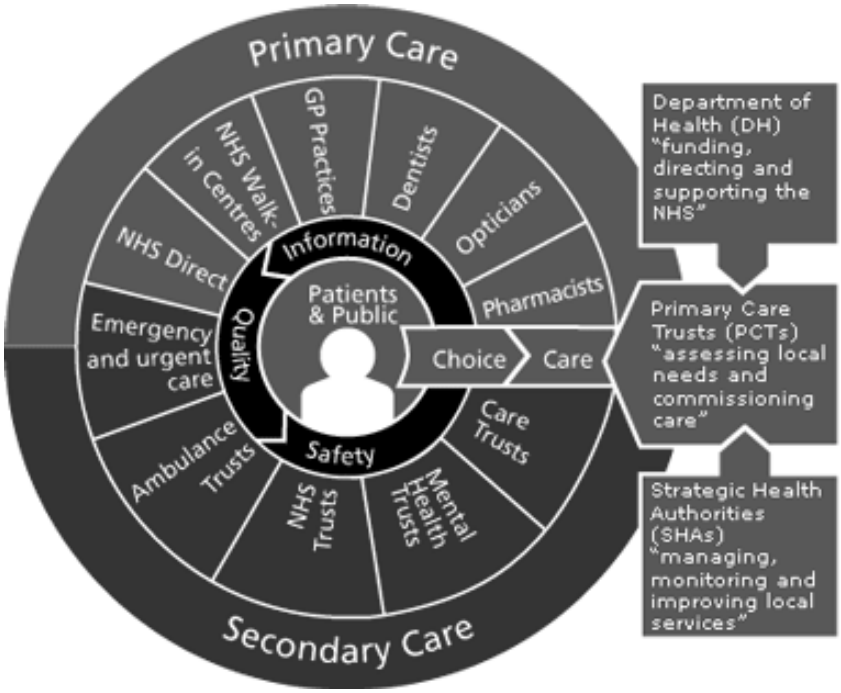
[45] See http://www.qualitätsbericht.de/.

justified by the different disease pattern and impact on women. Twice as many women die of stroke. They are usually older, when having a stroke. Therefore, they frequently suffer from additional medical conditions and often have to be admitted into special care homes, if they survive the stroke (BMG, 2010b).

3.2.2 England

Figure 10 below depicts the structure of the NHS in England. The government is responsible for the funding and the general functioning of the NHS (Davies, 2007, p. 11). Ten strategic health authorities (SHAs) have the responsibility for the efficient operation of their local health systems. Their main functions are of strategic nature (Davies, 2007, p. 17). They form the link between national policy and local service provision to improve the quality of healthcare (Newdick, 2005, p. 77) and to ensure high-quality standards (Baggott, 2004, p. 163).

Figure 10: Healthcare Service Provision and Funding in England



Source: NHS (2010b)

The local health systems are split between primary and secondary care. Primary Care Trusts are responsible for commissioning health services

according to the needs of their local population (Davies, 2007, p. 19). Patients register with a local general practitioner (GP). Access to Accident and Emergency services is direct, but GP referral is needed to access specialists (Freeman, 2000, p. 36).

The focus of this research lies on elderly-related, acute stroke care provided at NHS Trust hospitals. They have to fulfil the legally defined duty of breaking-even financially and adhering to minimum quality standards. In spite of the performance management through SHAs, NHS Trusts are largely self-governing (Davies, 2007, p. 23). Further, they are also the most important provider of secondary care services; 96% of the acute care beds available in the UK were provided by publicly owned hospitals in 2008/2009 (OECD, 2009a, p. 192).

The Health and Social Care (Community Health and Standards) Act 2003 has introduced NHS Foundation Trust hospitals to *"encourage competition between hospitals as an incentive to improve services to patients"* (Newdick, 2005, p. 81). NHS organisations receive greater financial and operational freedom (Baggott, 2004, p. 164) under the independent regulation of Monitor[46]. The service provision is less nationally controlled. NHS organisations are locally accountable for planning and delivery of their services, while still being subjected to national standards and inspection (Davies, 2007, p. 24). Several national bodies are responsible for these standards and inspection, such as:

- NICE (National Institute for Health and Clinical Excellence)
- NHS Institute for Innovation and Improvement
- Care Quality Commission
- Ombudsman

NICE *"provides guidance, sets quality standards and manages a national database to improve people's health and prevent and treat ill health"* (NICE, 2010). Patients, the public and health professionals can suggest

[46] Monitor is independent of the Department of Health but accountable to Parliament (Davies, 2007, p. 24).

specific topics that the government then commissions to be examined by NICE (Davies, 2007, p. 87). Further, the NHS Institute for Innovation and Improvement *"supports the NHS to transform healthcare for patients and the public by rapidly developing and spreading new ways of working, new technology and world class leadership"* (NHS Institute for Innovation and Improvement, 2010).

The spread of these new ideas is supported by practical guidance for safe, local implementation (Davies, 2007, p. 128). This guidance currently focuses on making *"High Quality Care for All a reality"* (NHS Institute for Innovation and Improvement, 2010) in response to the Darzi report about the NHS next stage review (Lord Darzi, 2008). This report develops three areas to advance quality in the NHS: high quality care for patients and the public to improve the patient experience, quality at the heart of the NHS to measure outcome improvements resulting from raised standards of care, and working in partnership with staff to address change fatigue in the NHS (Lord Darzi, 2008, pp. 3-8).

In contrast to the organisations discussed above, the following two bodies are independent from the government. The Care Quality Commission (CQC) regulates health and adult social care services in England. In order to improve the quality of care, the CQC registers service providers, as well as monitors, inspects and enforces the meeting of essential standards of safety and quality (CQC, 2009, pp. 3-4). On its website[47], CQC provides quality reports about the registered service providers.

The Department of Health (DoH), Monitor, CQC and NHS East of England have worked in partnership for a yearlong period to develop the form and content of quality accounts. All providers of acute care, mental health, learning disability and ambulance services have to compile quality accounts from April 2010 onwards (DoH, 2010a). A quality account aims to increase accountability to the public (DoH, 2010a) and is defined as *"an annual report to the public from providers of NHS healthcare services*

[47] See http://healthdirectory.cqc.org.uk/findcareservices/informationabouthealthcare services/summaryinformation.cfm.

about the quality of their services" (DoH, 2010b). Providers of acute national health services are the first group of providers to publish their quality accounts on NHS Choices (DoH, 2010b).

Further, the office of the Parliamentary and Health Service Ombudsman establishes a link between improving public services and involving the service users. It investigates complaints about the NHS in England, as well as Government departments and other public bodies (Davies, 2007, p. 100). The Ombudsman office evaluates these complaints based on six basic principles that should be adopted by the organisations *"to deliver good administrative and customer service, including offering remedy when things go wrong"* (Parliamentary and Health Service Ombudsman, 2008, p. 5):

- Getting it right
- Being customer focused
- Being open and accountable
- Acting fairly and proportionately
- Putting things right
- Seeking continuous improvement

These principles mirror the ideas behind the models[48], applied at the hospitals included in this research, to implement quality management and clinical governance.

Because of the impact of stroke on the nation's health and economy, the Department of Health has developed a 'National Stroke Strategy' to improve the quality of stroke prevention, treatment, care and support (DoH, 2007, p. 5). The strategy is based on a ten-point plan for action to increase public awareness about stroke, on the one hand, and the quality of healthcare services for stroke patients, on the other (DoH, 2007, pp. 7-8). In order to react correctly and as soon as possible, the public needs to

[48] See Section 3.3.

know about sings that indicate a stroke. The Stroke – Act F.A.S.T.[49] initiative (NHS, 2010c) informs the public via different media channels about stroke symptoms, the urgency to recognise them as early as possible and seek medical emergency help. This medical emergency care provided by a stroke-unit is the most important factor in improving patients' outcomes after stroke (DoH, 2007, p. 7). The Royal College of Physicians carries out the National Sentinel Stroke Audit (Hoffman *et al.*, 2009) to compare and suggest improvements for the quality of stroke-units across the NHS in England, Wales and Northern Ireland.

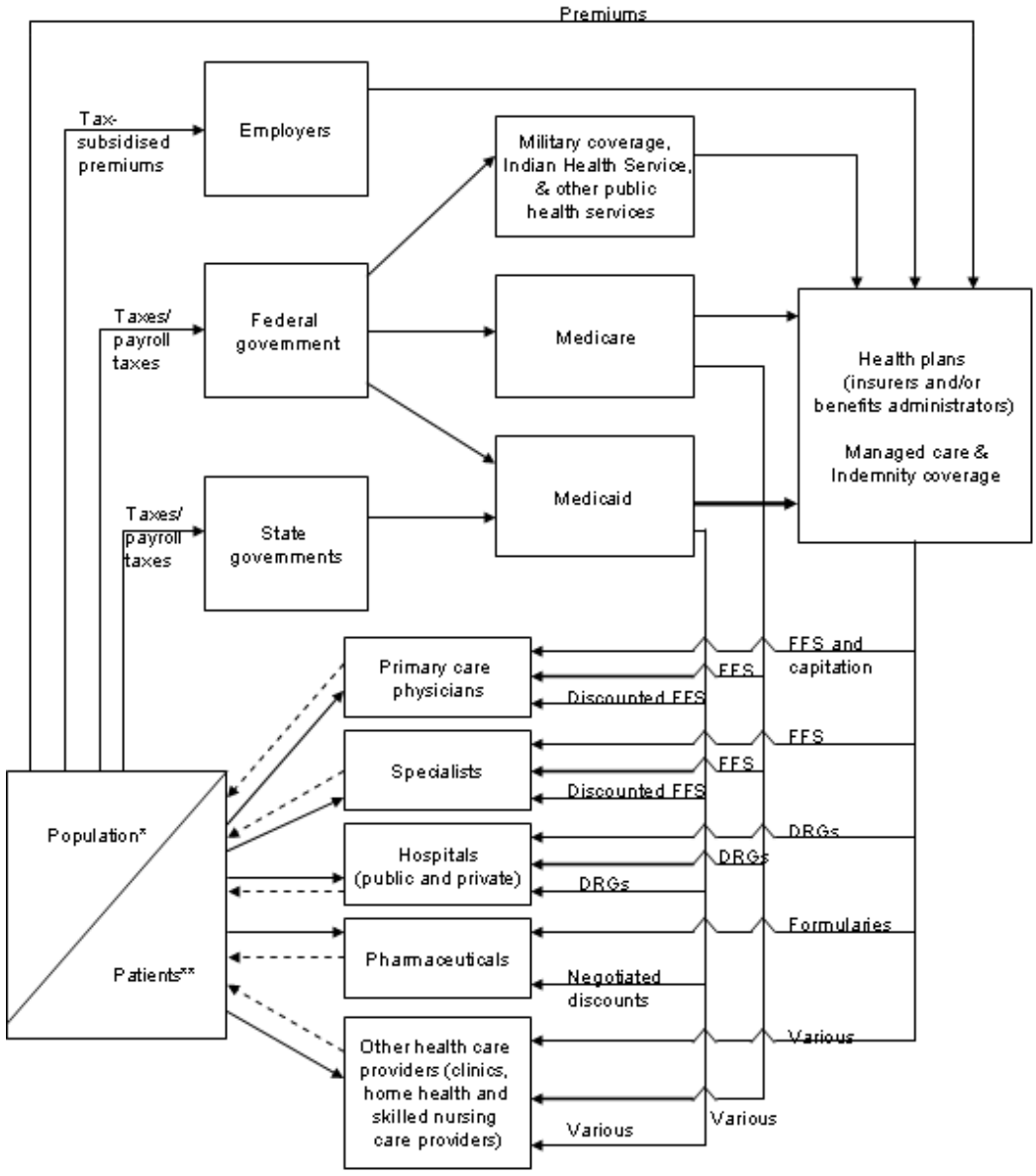
3.2.3 Florida

Figure 11 below depicts the structure of healthcare service provision and funding in Florida. The federal government regulates healthcare with general legal requirements (Güssow, 2007, p. 164). Under certain conditions, it also offers health plans for the elderly under Medicare (US Government, 2010) and for the poor under Medicaid (US Department of Health and Human Services, 2010a), in addition to federally funded programmes, for instance for the armed forces, for veterans and for Native Americans (Nolte *et al.*, 2005, p. 12). Yet the majority of the population, i.e. 66%, relies on private health insurance. Almost 15% of the population are not covered by any health insurance (OECD, 2009a).

In Florida, only a minority of hospital services is delivered by public organisations – 10% of the hospitals are in public ownership and these hospitals provide 14% of the beds available for acute and rehabilitation care (Florida Hospital Association, 2009). Medicare, Medicaid and Commercial HMOs[50] provide 18% of the healthcare (Florida Hospital Association, 2009). These organisations offer health plans that coordinate the care of the insured patients with the providers (Medicare HMO, 2010). The majority of the healthcare services, however, are negotiated under and provided for commercial health plans (Florida Hospital Association, 2009).

[49] The acronym stands for: Face, Arms, Speech, Time to call 999 (NHS, 2010c).
[50] HMO stands for health maintenance organisation.

Figure 11: Healthcare Service Provision and Funding in Florida



NOTE: FFS is fee-for-service payment. DRGs are case-based payments to hospitals based on a diagnosis-related group system.

*Health care for the 14% of the population lacking health insurance coverage is financed by publicly subsidised charity care and patients' out-of-pocket payments to health care providers.

**Patient cost-sharing arrangements vary widely by type of coverage. Indemnity coverage generally includes deductibles and co-insurance. Managed care plans often require co-payments for certain services.

Source: OECD (2009c)

The Agency for Health Care Administration (AHCA) is the health policy and planning entity for the state of Florida. Its main areas of responsibility cover the state's Medicaid programme, the licensing of the 41,000 healthcare facilities and the sharing of healthcare data (AHCA, 2010a). The Florida Center for Health Information and Policy Analysis within AHCA

performs the latter activity. The centre publishes detailed reports on healthcare trends and outcomes, which also aim to inform the consumers (AHCA, 2010b). Further, the Division of Health Quality Assurance within AHCA oversees the regulation of hospitals and other healthcare providers (AHCA, 2010c).

Various organisations deal with quality issues in healthcare at the federal level. Within the US Department of Health and Human Services, the Agency for Healthcare Research and Quality (AHRQ) aims to advance excellence in healthcare. Its mission consists in improving *"quality, safety, efficiency, and effectiveness of healthcare for all Americans"* (AHRQ, 2010). One of the initiatives of AHRQ, the National Guideline Clearinghouse (NGC), publishes evidence-based clinical practice guidelines (NGC, 2010).

Other than these official bodies, private not-for-profit[51] organisations and foundations also foster quality in US healthcare. The National Committee for Quality Assurance (NCQA) aims to improve the quality of healthcare by accrediting health insurance plans. The accredited plans cover *"70.5% of all Americans enrolled in health plans"* (NCQA, 2010). Further, the Patient Advocate Foundation (PAF) supports patients with problems around accessing healthcare insurance or overcoming a medical debt crisis (PAF, 2010).

Every ten years, the US Department of Health and Human Services renews the national health objectives, summarised under Healthy People, in order to improve health service provision, promote health and prevent disease (US Department of Health and Human Services, 2010b). Several objectives around stroke are proposed for Healthy People 2020, i.e. reducing stroke deaths and incidence rates, increasing public awareness of stroke symptoms, increasing 30-day survival rates as well as reducing the recurrence rates (US Department of Health and Human Services, 2010c). Being the third leading cause of death in Florida, stroke is also

[51] The related websites interchangeably refer to not-for-profit and non-profit. For consistency in this thesis, the author decided to use not-for-profit.

high on the state Department of Health agenda (Florida Department of Health, 2010).

3.3 Healthcare Reforms for Improvement

3.3.1 General Approaches

The issues around healthcare quality, cost and scarcity of resources[52] have instigated reforms in healthcare across Europe. These reforms have focused on patient empowerment through patient rights and choice (Saltman *et al.*, 1998, p. 5), direct control of healthcare spending, increased managerial functions for payers and providers, more explicit quality norms and standards (Freeman, 2000, p. 72). The latter are discussed in more detail below. Since the 1980s, healthcare reforms, especially in England and Germany, have mainly aimed to introduce more elements of competition, in order to increase efficiency and improve patient choice (Wendt, 2003, p. 293).

In the early 1990s, the NHS saw a policy change towards the creation of an internal market in order to increase competition and decentralise management responsibility. Some of the reform ideas were inspired by the US experience of increasing cost-effectiveness by promoting competition (Baggott, 2004, p. 105). In England, competition was created by *"separating purchasers (or commissioners), from providers of care"* (Newdick, 2005, p. 59). The market mechanisms, however, were weak and they were met by *"significant opposition from both patients and providers"* (OECD, 2003b, pp. 37-38).

The effects of the internal market are controversially discussed in the literature (Baggott, 2004, pp. 113-118). In summary, efficiency indicators showed only minor improvements, waiting lists did not improve and improvements in clinical quality of care, health outcomes, as well as patient satisfaction were not measurable. Some evidence even suggests that the internal market had a negative impact on quality, measured by

[52] See Section 3.1.3.

death rates at hospitals where competition was strongest (OECD, 2003b, pp. 38-39). Further, it is controversially discussed whether the internal market increased inequities of access to care (Baggott, 2004, pp. 117-118).

Even though the original internal market only lasted until 1997, some of its underlying elements still persist in the form of commissioning services in the NHS (OECD, 2003b, p. 39). The DoH and the NHS cooperated to develop World Class Commissioning (WCC) – a national programme that was launched in December 2007 to improve commissioning of services (DoH, 2009, p. 2). WCC is expected to deliver *"better health and well-being for all, better care for all and better value for all"* (DoH, 2009, p. 3). The role of Foundation Trusts and the related competition in improving healthcare is discussed in Section 3.2.2 above.

In Germany, competitive elements have mainly been implemented for the insurers, as a response to growing healthcare costs (OECD, 2003b, p. 40). The healthcare reform of 2007 has started to foster competition in both the SHI and the private health insurance market by increasing consumer choice in terms of policy coverage (BMG, 2007). The government has commissioned the federal ministry of health ('Bundesgesundheitsministerium', BMG) to develop the legal foundations for the next reform to increase competition even further (BMG, 2010c). A recent report supports that these policies of strengthening competitive elements improve quality and efficiency of healthcare (BMG, 2009b).

Experience from the US, however, suggests that the introduction of competitive elements can cause long-term problems. Health insurance seems to become more segmented. This reduces risk sharing across the population and can cause certain high-risk, high-cost segments to collapse (OECD, 2003b, p. 42). Himmelstein and Woolhandler (2008, p. 407) further argue that *"the poor performance of US health care is directly attributable to reliance on market mechanisms and for-profit firms, and should warn other nations from this path"*. Moreover, the Institute of Medicine (2009) highlights the need to address the issues arising from the

fact that a growing part of the US population is not covered by any health insurance.

This trend is driven by drastic growth in healthcare costs and insurance premiums, which outpaces the growth of individual family income and of the economy as a whole. Florida belongs to a group of states, where the coverage is particularly low (Institute of Medicine, 2009, pp. 1-2). Research shows that, after acute ischemic stroke, *"uninsured adults are more likely than insured adults to suffer extremely poor outcomes, including neurological impairment, intracerebral hemorrhage, and death"* (Institute of Medicine, 2009, p. 3). The government intends to stop these trends with the most recent healthcare reform law, the Affordable Care Act (ACA). Its measures are also designed to improve quality and safety of patient care (Mills *et al.*, 2010, pp. 1-2).

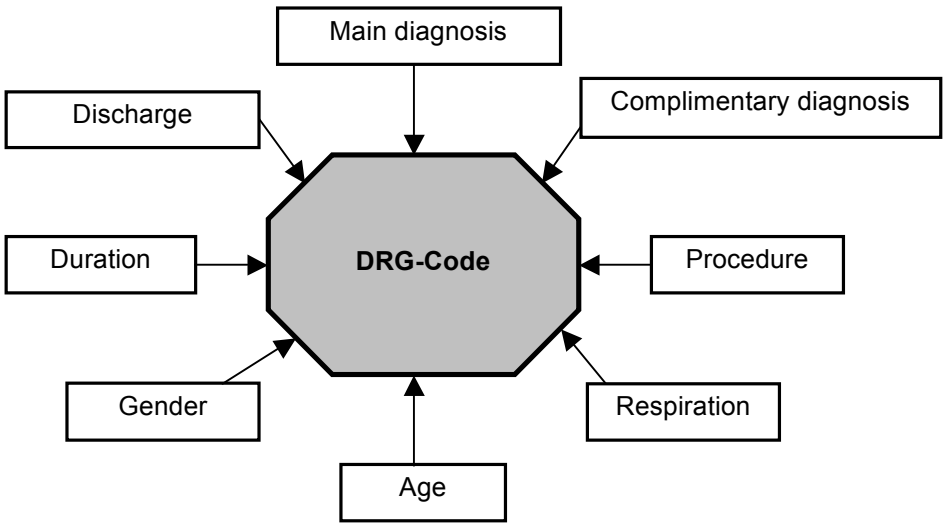
In addition to the more explicitly competitive elements discussed above, European governments have addressed other reform areas that support competition to improve efficiency, quality and safety of care. Integrated care structures, for instance, were introduced by the German healthcare reform of 2000 and have been further developed by later reforms. The SHI health insurers have the opportunity to offer integrated care structures that include general and specified practitioners, in-, out-patient, preventive and rehabilitative as well as non-medical service providers, such as physio-therapists, pharmacists or psychologists (SGB V § 140b). Patients may choose, if they want to participate and use the integrated care or the traditional service structures (SGB V § 140a). This enables the SHI health insurers to negotiate the contracts, to establish partnerships with the service providers more freely. Thus, more competition has been created between the SHI service providers.

In England, two concepts correspond to this idea of partnership across healthcare funding and provision. Within WCC, service commissioners and providers are required to build partnerships to plan and deliver high quality and integrated services (DoH, 2009, p. 4). Integrated Care Pilots (ICP) have been developed in sixteen sites across the country (DoH,

2009, p. 7). On the provider side, integrated care pathways give guidance for multidisciplinary services aimed at a specific patient group and support the evaluation of outcomes to continuously improve the service quality (Jones, 2006, p. 51).

Further, pathology-oriented payment has been implemented in England seven years ago, in Germany five years ago (Hope, 2008, p. 12). This uniform pricing structure is based on diagnosis-related groups (DRGs), known as health-related groups (HRGs) in England (Newdick, 2005, p. 62). Originally, US-American health economists developed the concept of DRGs in 1967. Medically comparable cases are organised in cost-homogenous groups. These require similar resources and, therefore, cause similar costs in the hospital (Zaiß, 2003a, pp. 6-8; Zaiß, 2003b, p. 13). Upon admission, a patient is assigned to one of these groups. The hospital receives a lump sum for the corresponding treatment (OECD, 2003b, p. 34). Figure 12 below depicts the components of a DRG-Code.

Figure 12: Components of a DRG-Code



Source: Gaa *et al.* (2005, p. 23), Hollick and Kerres (2002, p. 21)

In order to avoid undesirable provider outcomes, such as 'cream-skimming' patients, these payment systems need to be carefully adapted to national circumstances (OECD, 2003b, p. 34). If this is done properly, efficient hospitals are in a position to generate savings thanks to their

efficiency. These savings can then be used to improve facilities. Further, this mechanism represents a competitive incentive for inefficient hospitals to become more efficient (Newdick, 2005, p. 62).

Health data systems and electronic medical records have the potential to make these payment systems more accurate and also facilitate data sharing. The implementation of these elements of information and communications technology (ICT), however, remains difficult due to a lack of universally agreed standards for data collection, minimal financial incentives for healthcare providers to invest in ICT and considerable privacy concerns (OECD, 2004, p. 30). Baggott (2004, p. 222) highlights the potential of ICT to positively affect the quality of care by improving *"efficiency, planning, performance management, accountability, access to services and patient choice"*.

3.3.2 Quality Management at Hospital Level

The WHO has started to develop the concept of health promoting hospitals with its 'Global Strategy for Health for All by the Year 2000' (WHO, 1981). By 2004, a standard for health promotion at hospitals had been developed and formed the basis of the Network of Health Promoting Hospitals (WHO, 2004, p. 8). An orientation towards quality improvement represents one of the key characteristics of these hospitals (WHO, 2005, p. 109). The implementation of the 'Health Promoting Hospital Strategy' is achieved through the application of Total Quality Management[53] (TQM) models and tools (WHO, 2005, pp. 80-99).

In line with this WHO trend and independently of official reforms, TQM methods have been implemented at European hospitals since the 1990s to improve clinical quality and patient satisfaction as well as to reduce costs (Øvretveit, 2000, pp. 74 & 79). In the US, hospitals more commonly refer to continuous quality improvement. The terms TQM and continuous quality improvement can be used interchangeably (Øvretveit, 2000, p 76).

[53] The content, core values or underlying principles of TQM in general and the other, more specific models of excellence, clinical governance and quality management are compared towards the end of the section.

Koch (1991) discusses examples from different NHS organisations that show TQM application. Moeller *et al.* (2000) explains how the EFQM (European Foundation for Quality Management) excellence model, as one way of understanding TQM (Øvretveit, 2000, p. 76), was adopted at a selection of German hospitals for a three-year pilot project to demonstrate successful ways of introducing a comprehensive, internal quality management system.

Research over the past fifteen years supports the need for TQM or similar approaches and suggests that widespread quality problems in healthcare result from misuse, overuse, and underuse of services (Chassin & Galvin, 1998, p. 1000), which are *"delivered in a technically poor manner"* (OECD, 2004, p. 27). Komashie *et al.* (2007, p. 359) extend this to say that *"the quality of healthcare has been a major problem in many countries for over half a century, and its origins go back even further"*. Moreover, Newhouse (2002, p. 13) cautions: *"medical care seems to obtain less value from the resources it uses than other industries do"*. In several countries, scandals around medical errors have highlighted the need for policy intervention to improve healthcare quality. Successful efforts in this regard feature strong leadership within an interdisciplinary approach and rely heavily on measurement of data (OECD, 2004, p. 30).

In this context, the healthcare reform of 2000 extended the requirement for quality management to all medical service providers in Germany. According to SGB V § 135a, all service providers have to assure and improve the quality of their services, which have to reflect the specific medical body of knowledge and be of adequate quality. Hospitals have to implement and continuously improve an internal quality management system. The Federal Ministry of Health (BMG) defines this as the systematic effort for continuous quality improvement in an organisation; structures, processes and outcomes are regularly documented according to certain standards, checked and changed, if necessary. Quality management aims to improve both the treatment quality for the patients and staff morale (BMG, 2010d).

Even though the BMG does not prescribe a certain quality management model, most hospitals in Germany apply and are certified against the KTQ[54] model, which is depicted in Figure 13 below. The Federal Association of SHI physicians, the German Hospital Association, the Federal Association of SHI Sickness Funds and the German Care Council have cooperated in its development (KTQ, 2003, p. 2). Elements taken from the excellence, quality management and improvement models developed by the Joint Commission, ISO (International Standards Organisation) and the EFQM provided guidance for the development of the KTQ model (Flenker, 2001, p. 408).

Figure 13: KTQ Categories (Version 5.0)

Source: KTQ (2004, pp. 189-194)

Medical scandals in the 1990s have lead to the implementation of clinical governance (CG) in the NHS in England from 1998 (Baggott, 2004, pp. 225-226; Davies, 2007, p. 90). The Department of Health (DoH, 1998, p. 33) defines clinical governance as *"a framework through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish"*. This includes

[54] KTQ stands for 'Kooperation für Transparenz und Qualität im Gesundheitswesen', cooperation for transparency and quality in the healthcare system.

clear lines of responsibility and accountability for clinical care, a comprehensive programme of quality improvement, procedures for identifying and remedying poor performance, as well as clear policies for identifying and minimising risk (Baggott, 2004, p. 219). Clinical governance is intended to help *"using scarce resources cost effectively"* (Merry, 2007, p. 34). Originally, clinical governance was based on the Seven Pillars Model, as depicted in Figure 14 below. This model was later amended by the Standards for Better Health (DoH, 2006a).

Figure 14: Seven Pillars of Clinical Governance Model

Source: NHS Clinical Governance Support Team (1999)

Healthcare quality assessment and improvement has a longer history in the US (Luce *et al.*, 1994). Founded in 1951, the Joint Commission (JC) has ever since played an important role in establishing quality management at US-American hospitals. Nowadays, more than 17,000 healthcare organisations and programmes in the US are evaluated and accredited by the JC (The Joint Commission, 2009b). Since 1988, JC

accreditation and certification[55] are based on the principle of continuous quality improvement (Luce *et al.*, 1994, p. 264).

Accordingly, planning, designing, measuring, assessing and improving continuously are the strategies to achieve performance improvement. *"Performance is defined as doing the right thing and doing the right thing well"* (Price *et al.*, 1998, p. 42) and includes the dimensions of *"efficacy, appropriateness, availability, timeliness, effectiveness, continuity, safety, efficiency, respect and caring"* (Price *et al.*, 1998, p. 42).

Table 4 below summarises the comparison of the models, presented in this section. The TQM components are based on the definition, derived from the literature in Section 2.2.1. In spite of the variation in focus and specialisation of the models, they are based on similar components.

Especially leadership, employee involvement and teamwork including partnership development find similar appreciation, even though the latter is least explicit in the KTQ model. Customer focus becomes patient focus or experience under KTQ, CG and JC. This reflects the contentious definition of a healthcare customer[56]. In general, these three models use a more hospital specific language, e.g. hospital management, environment of care or patient.

[55] Accreditation refers to an entire healthcare organisation, e.g. a hospital, while certification refers to programmes or services that are based within or associated with one of these organisations, e.g. special diabetes care (The Joint Commission, 2009a)
[56] See Section 2.2.3.

Table 4: Comparison of Models

TQM	EFQM	ISO	KTQ	CG 7 Pillars	CG amended	JC
Improvement	Results Orientation; Management by Processes and Facts; Continuous Learning, Innovation and Improvement	Process Approach, Continual Improvement	Safety, Documentation and IT, Quality Management	Clinical Effectiveness, Risk Management	Safety, Clinical / Cost Effectiveness	Improving Organisational Performance, Information Management
Leadership	Leadership and Constancy of Purpose	Leadership, Factual Approach to Decision Making	Hospital Management	Leadership, Ownership, Resource / Strategic Effectiveness	Governance	Leadership
Involvement	People Development and Involvement; Continuous Learning, Innovation and Improvement	Involvement of People	Staff Focus	Communication, Learning	Care Environment / Amenities (CE/A)	HR Management
Teamwork / Partnerships	Partnership Development	Mutually Beneficial Supplier Relations	Quality Management	Patient-Professional Partnership, Teamwork	Public Health	Structures with Functions
Cultural Changes	Corporate Social Responsibility	System Approach to Management	Quality Management	Systems Awareness	Accessible / Responsive Care, CE/A	Management of Environment of Care
Customer Priority	Customer Focus	Customer Focus	Patient Focus	Patient Experience	Patient Focus	Patient Focus

Source: EFQM (2003), BSI (2005, pp. v-vi), KTQ (2004, pp. 189-194), NHS Clinical Governance Support Team (1999), DoH (2006a), The Joint Commission (2008)

The models differ slightly more with regard to continuous improvement. Not explicitly mentioning this aspect, KTQ and CG stand out the most. Yet, the two models share the explicit notion of safety, which can be grouped as a component of continuous improvement. To ensure safety, the organisation has to respond to errors and prevent them from recurring by establishing continuous improvements.

Finally, the most significant variation can be noted under cultural changes. None of the models includes cultural changes as an explicit component. Yet, the content of one of the components in each model requires or instigates cultural changes. Therefore, questions of cultural changes may arise at the case-study organisations.

The review of the literature in this chapter has compared healthcare systems aspects, service provision, funding and reform in the three countries included in this research. In combination with the review of the academic literature in the previous chapter, this prepares the development of the methodology in the following chapter.

4 Methodology

This chapter develops the research design, its implementation as well as the foundations for analysis of the data in later chapters and discusses issues around research quality, rigour, limitations and ethics.

4.1 Research Design

4.1.1 Overall Strategy

For Ferlie (2001, pp. 28-29) explicitness of method is a key criteria of good quality research: in order to avoid confusion in the explanation of how field research is carried out, the methodology and its methods have to be clearly distinguished. While the methodology relates to the overall orientation, the design or strategy of a study, the methods include the data collection techniques used within this overall methodology (Green & Thorogood, 2004, p. 39). Saunders *et al*. (2007, p. 135) identify various research strategies:

- Case-study
- Survey
- Experiment
- Action research
- Grounded theory
- Ethnography
- Archival research

In order to address the gaps in previous research, as discussed in Section 2.3.3, this thesis applied a comparative case-study design, involving a pilot case, eight elderly-related or acute stroke care units, four in England and four in Germany, as well as expert interviews in England, Germany and Florida. Saunders *et al.* (2007, p. 592) define a case study as a *"research strategy that involves the empirical investigation of a particular contemporary phenomenon within its real-life context, using multiple sources of evidence."*

Green and Thorogood (2004, p. 37) add to this that a case-study approach is very appropriate to achieve depth and accuracy in research. Yet, it might not be as strong on empirical generalisability as, for instance, a survey. The thesis aimed to more deeply understand employee perceptions of quality management in their organisation. Therefore, the case-study design was preferred to a survey. Previous research by Hudelson *et al*. (2008) as well as François and Pomey (2005) supports this design decision. The design of this thesis widened the scope of extant qualitative research, as it included an international comparison, involved more professional groups and investigated various aspects around quality management in healthcare. This represents a contribution to knowledge, as previous international comparisons in the field are of quantitative nature.

The other research strategies would have been unfeasible or unreasonable on practical or theoretical grounds. An experiment or quasi-experiment would have required the inclusion of an experimental group of hospitals, which implements quality management, compared to a control group of hospitals, which does not change anything (Saunders *et al.*, 2007, p. 136). Due to the political and legal circumstances, hospitals in both England and Germany had to implement clinical governance (CG) and quality management (QM) in 1998 and 2000. Accordingly, it would have been impossible to identify a control group without CG or QM in place.

Action research involves a close collaboration between practitioners and researchers in the management of a change (Saunders *et al.*, 2007, p. 591). The researcher is or becomes part of the organisation, which implements this change. Thus, the same argument as for experiments also applies to action research. The change has already happened, so that such a strategy does not make sense. Further, access would have been very difficult, as the author does not work at a hospital or a similar organisation.

Grounded theory and ethnography are both strongly related to the inductive approach. Data collection within these strategies is not based on an initial theoretical framework (Saunders *et al*., 2007, p. 142). Taking into account the tradition of CG and QM in hospitals and the extent of the existing literature, it would be unreasonable not to use this information as an initial theoretical framework to guide the research. Finally, archival research based on administrative records and documents (Saunders *et al*., 2007, p. 143) as the only research strategy would not be able to provide enough detail about employee perceptions of CG and QM. Yet, documents form part of the data collection within the case-studies, as further discussed below.

Apart from these practical and general theoretic considerations, previous research supports that a case-study approach is well suited to research quality and its management at hospitals (François & Pompey, 2005; Glattacker & Jäckel, 2007; Hudelson *et al.*, 2008). Ferlie (2001, p. 24) explains that healthcare is provided within large and complex systems. Further, Yin (2003, p. 2) states that *"the distinctive need for case-studies arises out of the desire to understand complex social phenomena".* Accordingly, this research strategy represents a good way of understanding the complexities of CG and QM at the hospitals, as researched by this thesis. Appendix 8 displays more detail about Yin's categorisation of relevant situations for different research strategies.

In the view of Keen (2006, p. 113), *"case-studies are most valuable where a planned change is occurring in a messy real world setting, and when it is important to understand why such interventions succeed or fail".* This applies to this research. The QM and CG initiatives can be understood as a planned change. The complexity of health service provision corresponds to a messy real world setting. Finally, it is important to understand how staff perceive and work with the initiatives to make them succeed and which areas for improvements they identify.

Various authors (e.g. Ferlie, 2001, p. 34; Saunders, 2007, p. 140; Yin, 2003, p. 19) suggest the use of multiple, as opposed to single, case-

studies in order to achieve *"a more robust outcome"* (Bailey, 1991, p. 62). This also forms part of Ferlie's (2001, pp. 28-29) criteria for good quality research built on a substantial empirical base.

Daniel (1993, p. 2) summarises the advantages of using more than one case-study: *"comparative studies can help the researcher to escape from the specificities of one case-study; the inevitable contrasts can produce answers of greater validity and generalisability."* Miles and Huberman (1994, p. 173) support this enhanced generalisability, while also adding deeper understanding of, insight into the cases and improved explanation building. Rihoux and Ragin (2009, p. xviii) agree with aspects of both generalisability and insight. However, Yin (2003, p. 47) cautions that this approach requires *"extensive resources and time".*

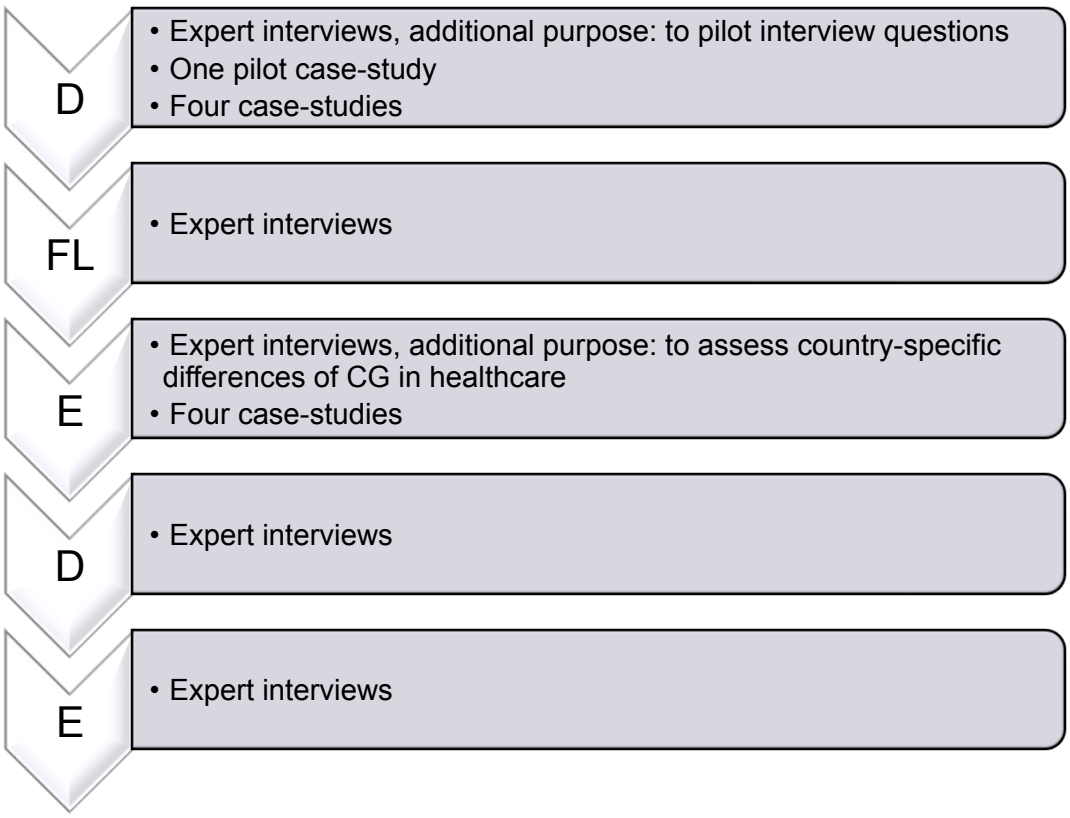
Bailey (1991, p. 139) suggests the use of a pilot study, *"to check on the feasibility of various components of the project."* Case-studies themselves can often be regarded as pilot studies, while also including parts that can be pre-tested, such as the data collection instrument (Bailey, 1991, p. 140).

Finally, Yin (2003, pp. 22-24) highlights the importance of being clear about the cases to be studied, including the specific units of analysis. For this piece of research, the cases were the CG and QM initiatives on the elderly-related, acute stroke care wards of the different hospitals. The units of analysis included the documents and the views of the interview participants involved in the various phases of the research, as detailed in the following section.

With such an embedded approach that combines various units of analysis in one case, Yin (2003, p. 45) cautions that it still remains important to also analyse the 'big picture' instead of only focussing on the subunits. In addition to the case-studies, expert interviews were conducted in Germany (D), Florida (FL) and England (E) to support the evaluation and explanation of the findings from the organisations. Figure 15 below chronologically summarises the initial research design.

After the clear definition of the cases, Green and Thorogood (2004, p. 45) underline the need to clearly justify the selection of the organisations to be researched. Keen (2006, p. 115) supports that *"site selection is important in the case-study approach".* Cases can be selected statistically at random or the selection can follow a non-probability sampling logic. The former is neither possible nor appropriate to address a topic that involves a substantial qualitative aspect in the way that this research does (Saunders *et al.,* 2007, p. 226). Nevertheless, Kemper *et al.* (2003, p. 277) state that any sampling technique can be applied for qualitative, quantitative and mixed method approaches to research. Keen (2006, p. 115) elaborates: qualitative, non-probability sampling aims to answer the question and not to achieve the statistical representation of a sample. Yin (2003, p. 47) adds that, in a case-study approach, statistical sampling logic is replaced by replication logic to theoretically select sites to confirm results found elsewhere (literal replication) or to contrast them (theoretical replication). Appendix 9 provides an overview of non-probability sampling techniques.

Figure 15: Initial Research Design



Source: the author

Based on these theoretical concerns, this study intended to apply purposive sampling from existing and newly developed contacts (Saunders *et al.*, 2007, p. 167) to select participants for the expert interviews as well as to choose comparable regions and organisations in England and Germany. Relevant general statistics, including urban as opposed to rural environments and various organisational aspects (Lutfiyya *et al.*, 2007, pp. 141-142), were planned to form the foundation of these choices. Especially for the less centralised healthcare service provision in Germany, the degree of quality management experience had to be taken into account.

Finally, research can be designed for three purposes. According to Saunders *et al.* (2007, pp. 132-134), it can set out to:

a) explore new fields (**exploratory studies**),
b) describe certain persons, events or situations in detail (**descriptive studies**) or
c) explain a situation, a problem by identifying the causal relationship between the involved variables (**explanatory studies**).

This research more strongly relies on qualitative methods. Therefore, the purpose of this research cannot be of general explanatory nature. This would require a more quantitatively influenced approach to look at causal relationships (Green & Thorogood, 2004, p. 6). According to Bailey (1991, p. 61), case-study research is generally often associated with exploration. Yin (2003, p. 3), however, contradicts this view by stating that any research design could be used for exploratory, descriptive and explanatory purposes. Resulting from its underlying philosophical assumption, this research could explore new fields and describe certain situations in detail (Green & Thorogood, 2004, p. 6).

Based on the gaps identified in previous research, this piece of research mainly sets out to explore how staff on elderly-related, acute stroke care wards view QM and CG in their daily working routines and how they would improve the local approaches. This is achieved by a detailed description of

the related perceptions. Further, the expert interviews and links to the academic literature start to explain the findings.

4.1.2 Data Collection

Certain research strategies are more commonly combined with a certain set of methods for data collection. Surveys and experiments, for instance, tend to be associated with quantitative, case-studies with qualitative methods (Bailey, 1991, pp. 60-61). Yet, this is not mandatory. Both quantitative and qualitative ways of collecting data can be brought together under any methodological umbrella (Green & Thorogood, 2004, p. 39).

In general, a quantitative researcher tends to prefer experimentation-based research techniques (Fulop *et al.,* 2005, p. 8). Health services research could hardly be isolated in any meaningful way in an experimental, laboratory setting in order to investigate in the way of a traditional, natural scientist. Accordingly, surveys are seen to be the most common quantitative means of data collection in this field; these are mostly based on questionnaires. Documents or direct observations can also be used for statistical analysis (Bowling, 2005, p. 190).

In contrast to this, a qualitative researcher concentrates on techniques to observe and describe the interactions in social surroundings, the experiences of individual actors and the associated meanings (Fulop *et al.,* 2005, p. 8). Data, relating to this, can be captured by textual or narrative sources (Carter & Henderson, 2005, p. 215; Patton, 2002, p. 4). Patton (2002, p. 145) explains that for focusing on quality-related issues, as this piece of research does, the application of qualitative methods appears to be intrinsically appropriate.

Each case-study can include a set of various quantitative or qualitative data collection techniques, such as (e.g. Bailey, 1991, p. 61; Green & Thorogood, 2004, p. 37; Saunders, 2007, p. 139):

- Documentary analysis

- Observation
- Interviews
- Questionnaires
- Combinations of quantitative and qualitative methods

Appendix 10 provides a more detailed account of the different techniques including the associated strengths and weaknesses. Further, Donovan and Sanders (2005, pp. 516-517) highlight the limitations of just relying on one type of data collection technique. Keen (2006, p. 113) supports this by stating that *"a distinctive feature of case-study research is the use of multiple methods and sources of evidence with the aim of ensuring comprehensiveness of findings".* In order to achieve this comprehensiveness, different parts of the present study were designed to rely on different types of data from different sources, as depicted in Table 5 below.

Table 5: Data Types and Sources

	Statistics (quantitative)	Documents (quant. & qualit.)	Interviews (qualitative)
Expert Interviews			
- Selection - Data Collection		✓ (qualit.)	✓
Case-Study Organisations			
- Selection - Data Collection	✓	✓ (quant.) ✓ (qualit.)	✓

Source: the author

The participants for the expert interviews and the case-study organisations were planned to be selected, based on publicly available information from the Internet. Initially, it was planned to involve a total of 15 experts, five each of England, Germany and Florida. At each organisation, the researcher intended to interview 10 participants, i.e. two representatives from the five professional groups of management, consultants, nurses,

therapists and support services. Across one pilot study in addition to the four case-studies conducted in Germany and England, this would equal to 90 participants. The researcher planned to conduct 105 interviews in total.

After the selection of the hospitals, documentary analysis preceded the site-visits. This analysis looked at quantitative and qualitative data, extracted from:

- Official rankings
- Patient satisfaction surveys
- General media coverage of the organisation
- Publicly accessible information provided by or about the organisation including quality reports as well as vision and mission statements

In addition to these documentary sources, the views of the experts and the participants at the hospitals could have been assessed through interviews, observations or survey questionnaires. Donovan and Sanders (2005, pp. 516-517) perceive interviews and observation to be the most relevant means of qualitative data collection in healthcare. Observations involve a *"considerable time commitment"* (Donovan & Sanders, 2005, p. 517), more than interviews do. This time commitment would have been unfeasible for the number of cases under study and the available resources for the research. The author also doubted, whether access would have been granted for this type of research, considering the previously experienced complexity of gaining access to healthcare organisations for other research, as discussed below.

Saunders *et al.* (2007, p. 318) provide a checklist to assist the choice between semi-structured interviews and surveys. The design decision of this research, to use interviews for the experts and the participants at the case-study organisations, reflected three points from this checklist. First, personal contact was expected to help gaining access to participants. This judgement was based on experiences during previous research. It was very difficult to realise meaningful response rates to a survey, which the

author conducted as part of her undergraduate dissertation (Halank, 2006). Participants explained this with the sheer number of survey invitations they received – even if they had wanted to, they would not have had enough time to deal with all of these. Secondly, the different background of the participants was expected to require an adaptation of the order and the logic of the questioning, to account for varying degrees of understanding and experience with CG and QM. Thirdly, the researcher also anticipated the need to probe interviewees' responses to develop further explanations of the findings.

Yin (2003, p. 86) explains the strengths and weaknesses of interviews. On the one hand, interviews focus directly on the case-study topic and provide perceived causal inferences. On the other hand, interviews can contain various types of bias, can be inaccurate due to poor recall and the interviewee could just be saying what they think the interviewer wants to hear. Saunders *et al.* (2007, pp. 317-319) agree with these strengths and weaknesses. Further, Eriksson and Kovalainen (2008, p. 86) summarise the issues of interviews as *"problems of memory, attention, and perception"* on the side of the participants.

The research evaluation below discusses in more detail, which concrete design weaknesses have been identified for this thesis and how they have been mitigated as much as possible. Peters and Austin (1985, p. 71) conclude: *"the real problem is that perception is all there is. There is no reality as such."* The quality management and business excellence models, compared in the political and economic background, contain employee involvement as a key element. If a quality management initiative is to have a positive impact on performance, it needs to be properly implemented and embraced by all employees (Huq & Martin, 2000, p. 80; Hendricks & Singhal, 2001a, p. 359). Therefore, employee perceptions are seen as one possible source to identify effects, issues, 'valued' practice and suggestions for improvements with regard to CG and QM.

Even though various authors (e.g. Keen, 2006, p. 113; Donovan & Sanders, 2005, pp. 516-517) suggest the use of more than one data

collection technique, academic dissent involves the question of how to best combine these different techniques. Triangulation represents one of the most popular reasons for combining different methods (Adamson, 2005, p. 233). Flick (2004, pp. 178-179) defines triangulation as the use of several sources of data to validate, justify and underpin findings. Patton (2002, p. 247) cites Denzin (1978) to distinguish four types of triangulation:

- **Data triangulation**: Different sources are used.
- **Methodological triangulation**: Different methods are employed to study the same issue.
- **Investigator triangulation**: Different researchers investigate the same issue.
- **Theory triangulation**: Different theories are used to interpret the same sources.

The design of this research mainly involved data and methodological triangulation. Documents and research participants represented different sources, from which data was collected with different methods, i.e. documentary analysis and interviews. Investigator triangulation happened to a lesser extent with the application of an analysis control group. This group of academic peer researchers coded parts of the data, collected by the author, in order to triangulate the findings. Section 4.3.1 provides more detail in this regard. Theory triangulation does not fully apply to this research. The literature review in the academic, political and economic background does not reveal any rival theories, but various theories complement each other to address different areas within the specific field of this research. Accordingly, a combination of theories was used to interpret the data.

Triangulation, however, is also criticised. First, an inflation in its use has rendered it almost meaningless in certain academic circles, because of the different meanings attached to the term (Pope *et al.,* 2007, p. 179). Secondly, if used in the sense defined above, Morgan (1998, cited by Adamson, 2005, p. 233) questions, if it is affordable, to simply duplicate the same findings by using different methods. Thirdly, Pope *et al.* (2007, p.

180) express their doubt as to *"why different methods should produce the same answer, or, indeed, necessarily be capable of focusing on the same phenomena"*. This concern is supported by several sources cited by Adamson (2005, p. 233).

To address these issues around terminology, O'Cathain and Thomas (2006, p. 107) prefer crystallisation to triangulation. This crystallisation aims to refine the research results by exploring the convergence, divergence or contradiction of the data collected quantitatively and qualitatively. Erzberger and Kelle (2003, p.466) agree with this. A new definition of triangulation should acknowledge that the use of different data collection techniques sheds light on different aspects of the researched phenomena and, therefore, provides a more complete picture. Therefore, this research relies on different data collection techniques, as discussed above.

Yet, Adamson (2005, p. 233) states critically that this definition is more commonly associated with complementarity. Pope *et al.* (2007, p. 178) support this and further explain: *"the basic idea behind this […] is that the whole can equate to more than simply the sum of the parts if the different sources are used creatively."* Morgan (1998, cited by Adamson, 2005, p. 233) adds that the strengths of the methods mutually reinforce each other, if applied correctly.

Finally, O'Cathain and Thomas (2006, p. 107) identify *"development"* as a third way of combining different methods in one research setting. In this approach, the methods are mostly used sequentially. The results revealed by the first method prepare the realisation of the second, as applied by this research. Adamson (2005, p. 233) includes this idea of development in the definition of complementarity: some researchers restrict qualitative approaches to the exploration and piloting of the investigations. Yet, others eliminate such hierarchical categories to be able to select *"the method that is best for the task at hand"* (Adamson, 2005, p. 233). Baum (1995) is cited by Adamson (2005, p. 233) to support this idea of an

enlarged public health research toolbox or toolkit, which can also be found in Ulin *et al.* (2005, p. xiii).

4.1.3 Data Analysis

Green and Thorogood (2004, p. 194) state that *"comparison is what drives qualitative analysis"*. Data is compared to discover patterns, exceptions, contextual meaning and to build theory, which is further refined and amended by comparisons with new data and, finally, the findings are compared to the results of other research in the field. Rihoux and Ragin (2009, p. xvii) push this to an even further extreme. In their view, *"comparison lies at the heart of human reasoning and is always there in the observation of the world […], we know that apples are not pears because we have compared the two."*

The literature provides a wide spectrum of *"approaches to data analysis"* (Donovan & Sanders, 2005, p. 518) to make sense of the qualitative data, collected for this research through documents and interviews. To achieve good quality research results, especially in health services research, Green and Thorogood (2004, p. 176) as well as Donovan and Sanders (2005, p. 525) suggest that not only several data collection techniques should be applied, but also various approaches to data analysis. Pope *et al.* (2006, p.65-67) add that data collection and analysis usually take place simultaneously as a fluid and non-linear process throughout the research project. Saunders *et al.* (2007, p. 484) argue that analysis also continues afterwards. Donovan and Sanders (2005, p. 525) support this view by stating: *"qualitative research requires a cyclical and iterative process of analysis followed by data collection driven by the findings of analysis, and then further analysis."*

The research design of this research combined template with cross-case and elements of discourse analysis. The former provided the initial framework, within which the latter two were applied. King (2004, p. 257) supports this choice by arguing that template analysis is strong at comparing *"the perspectives of different groups of staff within a specific context"*, as done by this research. A template is a list of categories,

including hierarchically structured lower level codes, which can be descriptive, interpretative or pattern-related (Miles & Huberman, 1994, p. 57); the analysis uses these in both deductive and inductive ways (Saunders *et al.,* 2007, p. 496). To take both approaches into account, an initial template was developed from the literature and was revised continuously, after the analysis had started, taking into account the following strategies (King, 2004, pp. 259-263):

- **Insertion**: When the data reveals an issue that does not fit into any of the existing categories or codes, a new one has to be created.
- **Deletion**: When a category or code shows substantial overlap with another or in case it does not find any corresponding data, it should be deleted.
- **Change of Scope**: During data analysis, a category or code might turn out to be more or less important, which then requires a change in its hierarchical position and in the breadth of its definition.
- **Reclassification**: A lower level code that initially forms part of a high-level category has to be reattached to another high-level category, if the data suggest this.

Section 4.2.3 describes the initial template for this research and explains how it was changed in the course of the analysis, using the strategies of insertion, change of scope and reclassification. This continuous, inductive revision of codes and categories resembles the process of constant comparison, used within grounded theory. Glaser and Strauss (1967, pp. 101-115) initially developed this theory. The researcher moves cyclically between data collection, analysis and theory building until saturation is achieved (Green & Thorogood, 2004, pp. 180-181). Both approaches share the difficulty of balancing openness towards themes, emerging from the data, with selectiveness, regarding the most important issues, to focus the research, impose structure on it and to decide, when the point of saturation is reached (King, 2004, pp. 263+266-269). Yet, the grounded theory approach does not use a theoretical framework, as initial guidance for data collection (Pope *et al.,* 2006, p. 70).

Language in the form of talk, i.e. interviews, and text, i.e. documents, played an important part in this research. Even though the deconstruction *"of hidden meanings"* (Donovan & Sanders, 2005, p. 521) within talk and text can involve time-consuming discourse analysis, Saunders *et al.* (2007, pp. 503-504) encourage researchers not to take their findings *"at face value"*. Language is not necessarily employed to reveal social phenomena as such; individuals rather construct, reproduce and change the world around them by the way they make use of language (Phillips & Hardy, 2002, cited by Saunders *et al.,* 2007, p. 502). Donovan and Sanders (2005, p. 521) refer to this as the *"socially constructed nature of language"*. To uncover individual identities as well as relationships and ideological systems within a given social context expressed by talk and text, Dick (2004, p. 205) suggests analysing the following three dimensions, which are mainly based on Fairclough (1992); Section 4.2.3 explains that the last dimension was the most important for this piece of research:

- **Text or talk**: Which aim is followed (e.g. to assert, persuade, justify, accuse, defend or explain) and how is it achieved?
- **Discursive practice**: What is the context of the text or talk production?
- **Social practice**: Which propositions are taken for granted, challenged or defended?

Finally, Yin (2003, pp. 133-137) suggests that the results of multiple case-study research should be brought together in a cross-case synthesis. Initially, each case should be analysed separately, before the analysis can be aggregated at national and cross-national level. The present research implemented this analysis strategy, as further detailed below.

4.2 Research Implementation

4.2.1 Lessons Learned from Pilot Study

In response to the experience from the pilot study, the researcher had to change two aspects of the data collection. The interview questions had to

be more focused and tape-recording of the interviews turned out to be unfeasible.

Dick (2004, p. 208) explains: *"structured and semi-structured interviews are more useful where the researcher is interested in examining a specific issue […]. However, it is important to account for the discourses used by the researcher to construct the interview questions."* Accordingly, the researcher used the literature review in the academic, political and economic background to develop three sets of interview questions for the different groups of participants. The most general and most flexible set of questions was prepared for the expert interviews in Germany, Florida and England. Another more specific set of questions was designed for managerial staff at the hospitals, dealing with CG and QM, in England and Germany. A shorter version of this set was adapted for staff on the wards who incorporated CG and QM into their daily routines.

The interview questions for the experts worked well. They confirmed the relevance of the research. The author added only minor amendments in the interview questions to probe for certain aspects, if the respondents did not refer to them, so that comparisons would be possible. The questions for the interviewees at the case-study organisations required more changes. Initially, the researcher had prepared an extensive list of questions. This list turned out to be too long as well as not focussed and structured enough. A considerable number of the questions looked more at **what** was done under the umbrella of QM and CG, instead of focusing on **how** from the employees' perspective.

Table 6 below summarises the main concepts from the three final sets of interview questions, the reason for their inclusion and links them to the literature, as reviewed in the academic, political and economic background. The abbreviations QM and CG are used interchangeably.

Table 6: Interview Questions and the Literature

Concept	Reason	Sources
Definition of QM	Lack of a commonly accepted definition	Kelemen (2003, p. 100)
Strategic nature of QM	General trend to manage quality strategically	Bounds *et al.* (1994, pp. 60-62)
Model for QM	There are various to chose from	See Table 4, Section 3.3.2, p. 75
Role of management consultants	Experiences with management consultants to facilitate change during previous research in Germany	Halank (2006, 2007a&b)
Role of ICT	Research supports the usefulness of ICT within QM	OECD (2004, p. 30), Baggott (2004, p. 222)
Needed vs. done before	QM in healthcare has changed to include administrative and managerial support in addition to the technical knowledge of clinical staff	Ruiz and Simón (2004, pp. 323-324)
Expectations / actual impact on:	Overall mixed evidence for and against QM	Wagner *et al*. (2003, p. 114)
a) customers	Customer or patient focus is an important feature across all the models for QM, compared in Table 4, Section 3.3.2, p. 75, patient safety and satisfaction were important reasons to introduce QM	EFQM (2003), BSI (2005, pp. v-vi), KTQ (2004, pp. 189-194), NHS Clinical Governance Support Team (1999), DoH (2006), The Joint Commission (2008), Øvretveit (2000, pp. 74 & 79)
b) partnerships	Partnerships are important features in general QM models, but only included implicitly in most healthcare specific models	See under a) customers
c) employees	QM influences employee relations and staff support is needed for QM to succeed	Kumar *et al.* (2009, p. 23), Samson and Terziovski (1999, p. 393)
d) finances, efficiency	Reduction of costs was an important reason to introduce QM	Øvretveit (2000, pp. 74 & 79)
Barriers and problems	Different mindsets between quality and medical professionals create barriers to QM implementation	Walshe (2007, pp. 57-58)
Suggested improvements	Improvements are an important element of QM	Dale (2003, p. 26), Goetsch and Davis (2006, p. 6)

Source: the author

In spite of the discussion around the applicability of the customer concept to healthcare in Section 2.2.4, the author consciously used the term to assess whether the participants agreed with the theoretical concerns. In addition to the theoretically motivated concepts, the interviewees were also asked about their background and role in CG or QM to frame their responses. At the end of the interview, the researcher gave the participants the opportunity to make a final summarising comment of the key points, if they still had enough time for this.

The experts were asked similar questions, which had to be slightly adapted according to the national context and the specific area of expertise. The overall structure included these elements:

- What is your background and how does it relate to QM / CG?
- What is your understanding of QM / CG?
- How is QM / CG approached strategically?
- Which models do you deem most appropriate to apply QM / CG to hospitals?
- What do you think about management consultants supporting the implementation of QM / CG?
- What is the role of ICT within QM / CG?
- Do you think that formalised approaches to QM / CG are needed or have their components been there before?
- Which impact / effect / improvement do you see for:
    - Customers, in particular patients,
    - Employees (probe for views on involvement, training, teamwork, if not mentioned),
    - Finances, efficiency,
    - Other?
- Which problems and barriers do you see to the implementation of QM / CG and how should they be addressed?
- Which improvements do you suggest in order to more effectively and efficiently approach QM / CG, taking into account your national and international experiences?

The questions, addressed to managers responsible for CG and QM, followed a similar structure, as the expert interviews. The aim was to get an overview of the local approaches to CG and QM as well as corresponding issues. The language and the use of terminology were adapted to the national context:

- What is your role in QM / CG and what is your professional background?
- When and why has QM / CG been implemented at your organisation?
- How has QM / CG been implemented at your organisation – did you rely on a specific model?
- Which role did or does ICT play within QM / CG at your organisation?
- What was expected of implementing QM / CG and which impact has it actually had on:
    - Customers, in particular patients,
    - Cooperation with other providers (probe for Benchmarking)
    - Employees (probe for involvement, training, teamwork),
    - Finances, efficiency,
    - Other?
- Which problems / barriers have you encountered during implementation and how have you solved them?
- How would you improve QM / CG?

The questions for clinical and non-clinical staff on the wards focused on their views of QM and CG. The language and the use of terminology were also adapted to the national context:

- What is your professional / educational background?
- Who do you think is the customer of your work?
- What is your understanding or definition of QM / CG?
- Is QM / CG needed and which effects do you attribute to it with regard to:

  - Your customer,
  - Your workload (probe for involvement, training),
  - Other (probe for teamwork, efficiency)?
- How could QM / CG be improved?

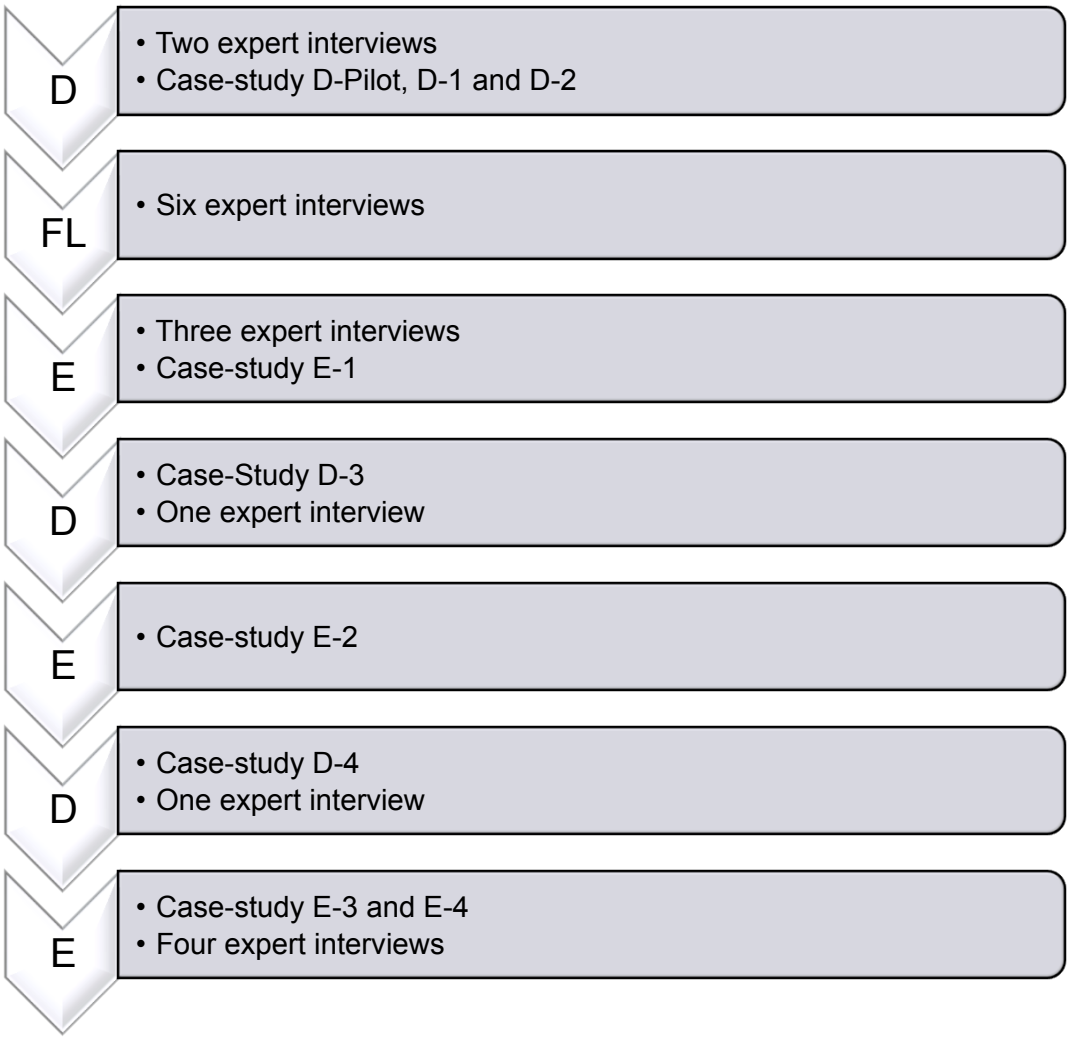
Initially, the researcher planned to tape-record the interviews. Oliver (2003, p. 45) explains the related advantages: *"note-taking cannot ensure the same degree of accuracy of recording the actual words spoken, let alone such often important matters as emphasis and pauses between utterances. The first thing to be said about tape recording is that the informed consent of the participant should be obtained."* But this latter aspect turned out to be a problem for this study. Most participants in Germany would not have agreed to be interviewed, if the interviews had been tape-recorded. This was particularly true for staff working on the wards. Their explanation of this was that they were not used to participating in research and would feel even less comfortable, if the interviews were to be tape-recorded. Saunders *et al.* (2007, p. 334) confirm this problem. They add that tape-recording an interview may negatively influence the relationship between the interviewer and the interviewee, in the sense that the focus changes to the audio-recorder. Further, there could be a technical problem with the recorder, so that the data might get lost, and transcribing the records involves a considerable amount of time.

The researcher decided not to tape-record, in order to achieve comparable data quality across the interviews. Participant checking ensured the quality of the field notes. The researcher randomly selected one participant at each case-study organisation. During their interviews, these participants were asked and agreed to check the interview protocols afterwards. All of the selected participants confirmed the content of the protocols. Appendix 11 displays an example of the emails, exchanged in the course of participant checking.

4.2.2 Data Collection

Gaining access to potential participants for both expert interviews and case-study research was more difficult and time consuming than initially expected. Therefore, the researcher also had to rely on snowball effects in order to find approachable participants. These snowball effects helped to develop new contacts through existing ones (Saunders *et al.*, 2007, p. 167). The researcher achieved this through personal networks in Germany, Florida and England in addition to university contacts in England.

Figure 16: Actual Research Implementation



Source: the author

Figure 16 above displays how the data for this research were actually collected over a period of 18 months. Access to the experts in Germany and Florida, as s well as to the first case-study organisations in Germany,

was slightly easier because of previous research activities and work experience of the author. Accordingly, the data collection could start earlier in these two countries.

Table 7 below summarises, grouped under country and nature of expertise, how many expert interviews were conducted. In total, the researcher interviewed two more experts than planned, but due to access issues the number of experts varied between the countries. In preparation for the interviews, the researcher conducted a Google search about the experts to understand the nature and origin of their expertise. Two academics contributed their expertise in the UK, based on extensive experience as practitioners. As their expertise is more practically than academically oriented and the academic viewpoints can be assessed through the literature, no other academic experts in the field were contacted in the other countries. In addition to the academic literature, a large number of political documents are publicly available for healthcare. Accordingly, only one political expert from each country was selected. All of them fulfilled comparable roles. The main focus was on practitioners, i.e. management consultants and senior executives, to support or further develop the findings from the case-study organisations.

Table 7: Overview of Expert Interviews

	Practitioners	Academics	Politics	TOTAL
Germany	3	0	1	4
Florida	5	0	1	6
England	4	2	1	7
TOTAL	12	2	3	17

Source: the author

The researcher applied four criteria for the purposive selection of the case-study organisations. Table 8 below maps the hospitals against the selection criteria. Due to confidentiality reasons, additional details about the case-study organisations could not be published. Lutfiyya *et al.* (2007, pp. 141-142) compare quality of care indicators between urban and rural hospitals finding differences mostly in favour of the urban hospitals,

resulting from both organisational and patient characteristics. Further, urban areas show a higher concentration of specialised services (OECD, 2009a, p. 148), such as acute stroke care. Accordingly, the case-study organisations selected for this research are all located in urban areas.

Table 8: Hospital Selection Criteria

	D-Pilot	D-1	D-2	D-3	D-4	E-1	E-2	E-3	E-4
Urban	✓	✓	✓	✓	✓	✓	✓	✓	✓
Stroke-Unit	✓		✓		✓	✓	✓	✓	✓
QM / CG Experience	✓	✓	✓	✓	✓	✓	✓	✓	✓
Ownership									
- NHS						✓	✓	✓	✓
- public			✓						
- private not-for-profit	✓	✓							
- private for-profit				✓	✓				

Source: the author

Seenan *et al.* (2007) agree with Cadilhac *et al.* (2008) that patients benefit most from coordinated, standardised services provided by a stroke-unit, because of improved clinical practice and a reduced probability of remaining disabled after stroke. All the organisations, included in this research, provide specialised stroke services. Due to access difficulties in Germany, however, two clinics had to be selected, which do not have a specialised, certified stroke unit, but take care of stroke patients within their acute elderly care ward. Similar to the other organisations, they treat around 300 stroke patients per year.

Due to differences in the healthcare system, the selection of case-study organisations had to consider QM or CG experience in different ways: all organisations selected from England performed well to very well in the ranking published as part of the National Sentinel Stroke Audit 2008 (Hoffman *et al.*, 2009) as well as in the Care Quality Commission reports and performance rating. As QM or CG certifications are less common in England and all the organisations form part of the NHS, focussing on the outcome quality appeared to be the most viable way to select

organisations with relevant CG experience, from which lessons could be learned. Antunes (2008), Cauchick Miguel (2006) as well as Dey and Hariharan (2006) confirm that successfully implemented initiatives result in good quality outcomes of care.

The selection of the case studies from the less centralised healthcare system in Germany had to take into account the degree of QM experience more directly measured by certification against KTQ. Hospital D-4 was not certified against KTQ, but against an internal model. The group of hospitals, this organisation belongs to, has developed this model to suit the structures of the group. The adaptation of the model for the whole healthcare system of Switzerland suggests that the model is as established as KTQ. The homogeneity with regard to these selection criteria demonstrates Rihoux' and Ragin's (2009, p. 20) view that in meaningful case-study research *"cases must parallel each other sufficiently and* […] *share enough background characteristics"*.

In the case of the hospitals selected from England, there is no need to account for ownership issues. They all form part of the NHS. For the SHI hospitals selected from Germany, however, different ownership structures ('Trägerschaft') could make a difference also in terms of quality management. Therefore, organisations in public, private not-for-profit[57] and private for-profit ownership were included.

The documentary analysis for the case-study organisations was performed immediately after selection. The researcher achieved the first contact with the organisations via the respective quality management representative ('Qualitätsmanagementbeauftragter', QMB) in Germany. Due to the ethical review processes in England, as discussed below, the first contact was established with the local R&D managers for organisational approval. Subsequently, the researcher contacted the clinical governance managers who then forwarded an invitation to participate in the study to clinical and

[57] The hospitals in private not-for-profit ownership are related to the church. This is very common in Germany.

non-clinical staff working on the stroke units. Table 9 below provides an overview of the interviews, conducted at the hospitals.

Table 9: Overview of Staff Interviews

	D-Pilot	D-1	D-2	D-3	D-4	E-1	E-2	E-3	E-4
Management	✓	✓	✓	✓	✓	✓	✓	✓	✓
Consultants		✓	✓	✓	✓	✓	✓	✓	✓
Nurses	✓	✓	✓	✓	✓	✓	✓	✓	✓
Therapists	✓	✓	✓	✓	✓	✓	✓	✓	✓
Support Services	✓	✓	✓	✓	✓	✓	✓		✓
TOTAL	5	7	11	10	10	10	9	10	11
TOTAL (per country)	43					40			
TOTAL (overall)	83								

Source: the author

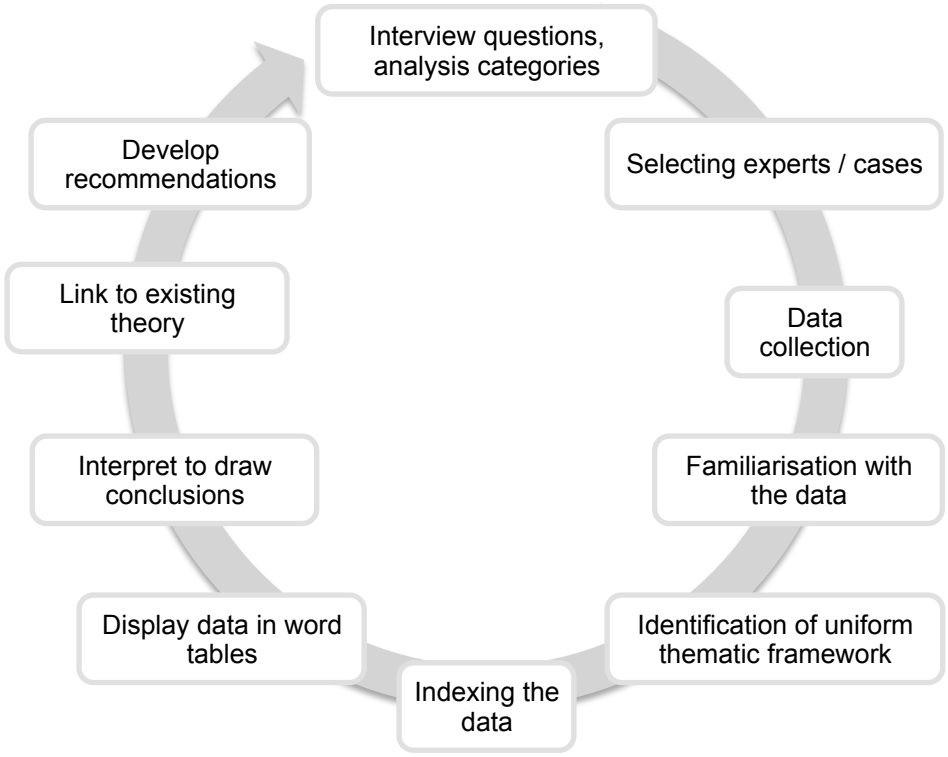
The number of interviews, which could actually be conducted, deviated slightly from the plan. Out of the 90 interviews planned at the hospitals 83 were actually conducted. Together with the expert interviews, this equals to a total of 100 interviews as opposed to 105 that were initially planned. As questions of patient satisfaction are addressed in research and politics (OECD, 2003b, p. 21; OECD, 2004, p. 70), this thesis did not include participants from this stakeholder group.

4.2.3 Data Analysis

In general, *"qualitative analysis seeks to develop analytic categories to describe and explain social phenomena"* (Pope *et al.*, 2006, p. 67). Figure 17 below depicts the cyclical nature of data collection and analysis that applied to this research. The analytic categories can be defined *a priori,* based on the literature review, or *a posteriori,* emerging from the present research (Bailey, 1991, p. 99). The former corresponds to a deductive, the latter to an inductive approach (Pope *et al.,* 2006, p. 67). *A priori* categories derive their names from academic literature and existing theory (Saunders *et al.,* 2007, pp. 480+487). According to Corbin and Strauss (2008, p. 160), *a posteriori* categories emerge from the data analysis

(*"researcher-denoted concepts"*) or are directly taken from the participants' use of terminology (*"in-vivo codes"*).

Figure 17: Research and Analysis Steps



Sources: Yin (2003, pp. 133-137), Ritchie and Spencer (1993, cited by Pope *et al.*, 2000, p. 116), Eisenhardt (1989, p. 533)

Yin (2003, p. 29) argues that building research upon *a priori* categories provides *"strong guidance in determining what data to collect and the strategies for analysing"* it. Yet, Bryman (1988, p. 81) cautions that this possibly introduces a *"premature closure on the issues to be investigated".* Finally, Saunders *et al.* (2007, pp. 488-489) suggest always starting with a theoretical perspective to highlight links to previous research and to provide an initial analytical framework. This also corresponds to one of Ferlie's (2001, pp. 28-29) criteria for good quality research, the connection to theory.

Therefore, this research started with a set of *a priori* categories, which was developed with the interview questions. Table 10 below makes the link between the initial set of categories and interview questions, while also highlighting, which categories or aspects within a category were added to account for findings from the data, e.g. the importance of personal interest

to become involved in quality management and clinical governance. A more detailed version of the coding guidance with definitions and examples for each category is attached in Appendix 12.

Table 10: Coding Guidance and Interview Concepts

Coding Guidance	Interview Concept	New from Data
1 QM or CG Initiative and Project – Content and Timeline		
1a general overview	model for QM, role of management consultants	
1b strategic importance	strategic nature of QM	
1c expectations and actual impact on staff, patients, finances, other	expectations / actual impact on customers, employees, finances, efficiency	impact on other, e.g. transparency and accountability
1d ICT	role of ICT	
1e Benchmarking, comparisons, cooperation	expectations / actual impact on partnerships	
2 Issues and Areas for Improvement		
2a customer definition	impact on customers	
2b definition, awareness, understanding of QM/CG, them versus us	definition of QM/CG	awareness, them versus us
2c needed or done before	needed vs. done before	
2d personal interest		completely new
2e involvement (communication, training including university or ward-based initial training)	expectations for employees	communication, training including university or ward-based initial training
2f inter-staff group conflicts, teamwork		completely new
2g leadership issues		completely new
2h resistance to change	barriers and problems	
2i implementation issues (time, resources, context)		completely new
2j humanity, focus on relationships, special characteristics of elderly care		completely new
3 'valued' practice	needed vs. done before, impact on customers, employees, finances, efficiency	
4 suggested improvements	suggested improvements	

Source: the author

Initially, each case was analysed separately and by staff group, before the analysis was aggregated at national and cross-national level. Ritchie and Spencer (1993, cited by Pope *et al.*, 2000, p. 116) clarify this initial

analysis by breaking it down into three stages: familiarisation with the data, identification of a uniform thematic framework of the data using *a priori* categories and also adding new where applicable, indexing the data by highlighting which parts belong to which category. The initial uniform framework corresponds to the categories displayed in Table 10 above. Apart from the researcher-denoted category of leadership issues, the names for the newly developed categories were derived from the interviewees' use of terminology. In terms of discursive analysis of social practice, as alluded to in Section 4.1.3, the category of 'them versus us' was most revealing. Ward staff linguistically differentiated themselves from the CG/QM department with statements, such as *"I don't understand what they do"* or *"let them solve the problem and tell me what to change"*.

The researcher applied the coding guidance to the interview notes. For the analysis, the categories were regrouped using the strategies of reclassification and change of scope[58]. Apart from the organisational context, all the groups of analytical categories were subdivided using the six elements of the TQM definition[59]:

- Improvement (IMP)
- Leadership (LS)
- Involvement (INV)
- Teamwork & Partnerships (TW)
- Cultural Changes (CC)
- Customer Priority (CP)

Table 11 below displays the final analytical categories. Both Yin (2003, pp. 133-137) and Ritchie and Spencer (1993, cited by Pope *et al.*, 2000, p. 116) advise to display the data in word tables following a uniform framework to facilitate cross-case conclusions. Accordingly, the researcher inserted the coded text into six separate word tables for each case-study organisation, i.e. one for each group of analytical categories. These tables were grouped nationally and are attached in Appendix 16 to 27.

[58] See Section 4.1.3.
[59] See Section 2.2.1.

Table 11: Analytical Categories and Coding Guidance

Analytical Categories	Coding Guidance
1) Organisational Context	
Timing	1a general overview
Reason	1a general overview
Initiator	1a general overview
Implementation details	1b strategic importance, 1a general overview
Role of ICT	1d ICT
Benchmarking / Comparisons	1e Benchmarking, comparisons, cooperation
2) Staff Understanding of QM/CG	
Improvement Leadership Involvement Teamwork / Partnerships Cultural Changes Customer Priority	2b definition, awareness, understanding of QM/CG
3) Perceived Effects	
Improvement	2c needed or done before
Leadership	No separate code, as hardly found in data
Involvement	No separate code, as hardly found in data
Teamwork / Partnerships	1c expectations and actual impact on staff and other, 2j focus on relationships, humanity
Cultural Changes	No separate code, as hardly found in data
Customer Priority	1c expectations and actual impact on patients, 2i implementation issues (time, resources, context)
4) Perceived Issues	
Improvement	Not found in data
Leadership	2g leadership issues, 2d personal interest
Involvement	2e involvement (communication, training), 2b them versus us, 2d personal interest, 2e involvement (university or ward-based initial training)
Teamwork / Partnerships	2f inter-staff group conflicts, teamwork, 2j focus on relationships
Cultural Changes	2h resistance to change, 2j humanity
Customer Priority	2a customer definition, 2e involvement (university or ward-based initial training), 2j special characteristics of elderly care, 1c expectations and actual impact on finances, other
5) Perceived 'Valued' Practice and Lessons Learned	
Improvement Leadership Involvement Teamwork / Partnerships Cultural Changes Customer Priority	3 'valued' practice
6) Suggested Improvements	
Improvement Leadership Involvement Teamwork / Partnerships Cultural Changes Customer Priority	4 suggested improvements

Source: the author

The analysis was aggregated on a national and cross-national level. In order to increase readability, the following chapters discuss the findings from the case-study organisations grouped nationally. Reflecting the actual chronology of the data collection, the discussion starts with the organisations from Germany.

The findings from the documentary analysis were incorporated with the interview data about the organisational context and compared with the staff understanding of QM and CG. Mind-maps were designed to visualise the participants' understandings and definitions of QM and CG. Due to the homogeneity in responses, these mind-maps are aggregated summaries of organisational findings and not broken down to account for differences between staff groups. Based on the data displays developed by Miles and Huberman (1994), role-ordered and conceptually clustered matrices contrast the perceptions of different staff groups in the discussion of perceived effects, issues, 'valued' practice, lessons-learned and suggested improvements.

Miles and Huberman (1994, pp. 173-177) and Rihoux and Ragin (2009, pp. 6-7) distinguish two contrasting approaches for the cross-case analysis. On the one hand, qualitatively case-oriented techniques search for types or families among the cases. On the other hand, quantitatively variable-oriented techniques identify *"themes that cut across the cases"* (Miles and Huberman, 1994, p. 175). This study combined both approaches. The cross-case analysis of the case-study organisations yielded some findings, which differentiated the national families, and others, which cut across cases from both countries. Matrices, similar to those used for the case-study organisations, support the cross-case conclusions by visualising patterns and themes. The focus was placed on issues that came up at a majority of cases in at least one of the countries or that came up dispersedly across both countries.

Further, good analysis is based on a *"dialogue between cases and relevant theories"* (Rihoux & Ragin, 2009, pp. 6-7). Hartley (2004, p. 330) more pointedly states: *"the analysing of data is enhanced by reference to*

the existing literature and using this to raise questions about whether the researcher's findings are consistent with or different from extant research."
The link to the literature was integrated into the cross-case analysis to avoid repetition. In order to facilitate this integration, the researcher decided to change the structure of the discussion. After the cross-case comparison of the organisational context, the findings are discussed by analytical category, i.e. by improvement, leadership, involvement, teamwork including partnerships, cultural changes and customer priority. Finally, the expert interviews[60] were grouped nationally and compared with the other findings. Similar matrices were used again for further clarification.

4.3 Research Evaluation

4.3.1 Quality, Rigour and Limitations

There is considerable debate as to whether, and how, the quality of qualitative research – as this research – can, or should, be assessed (Mays & Pope, 2006, pp. 82-87). The traditionally quantitative measures of research quality, i.e. validity[61], reliability[62] and generalisability[63], are usually of less concern, as illustrated in Appendix 4.

Several authors (Donovan & Sanders, 2005, pp. 526-528; Ferlie, 2001, pp. 28-29; Green & Thorogood, 2004, pp. 191-199; Mays & Pope, 2006, pp. 87-99; Riege, 2003, pp. 82-84; Spencer *et al.,* 2003, p. 6) suggest the following strategies, to increase rigour and quality of qualitative or mixed-methods research:

[60] In contrast to the analysis of the case-study organisations, the analysis of the expert interviews did not involve word tables to summarise the interview notes. The researcher did not need this additional step, because the responses were more structured and there were fewer interviews to keep an overview of.
[61] Validity: The research method really measures what it was initially employed for (Saunders *et al.*, 2007, p. 614).
[62] Reliability: Another researcher would come to similar results when repeating the study (Saunders *et al.*, 2007, p. 149).
[63] Generalisability: The findings can be applied and generalised to other research settings (Saunders *et al.*, 2007, p. 151).

- **Transparency, Reliability and Dependability**: explicit and clear exposition of methodology; methods, data collection and analysis are strongly linked to existing theory, which can be retraced by fellow researchers.
- **Validity and Plausibility**: attention to deviant and disconfirming data, respondent validation where applicable or possible, enough information also about the context.
- **Comparison**: between and within cases as well as to other studies.
- **Reflexivity**: awareness about the role of the researcher including prior assumptions or experiences and how these influence the research outcomes.
- **Relevance and Generalisability**: public concern for the research topic is addressed or created, researched concepts and theories are transferable to other settings.

These strategies guided this research. In addition to an explicit and clear exposition of methodology, a control group of three fellow researchers ensured that the coding of the data was reasonable to foster **transparency, reliability and dependability** of this research. One staff interview and one manager interview were selected for each member of the control group, two of whom looked at the interviews in English and one in German. The author provided the fellow researchers with the coding guidance[64]. The table structure helped one of the fellow researchers to follow the train of thought of the coding exercise and to understand better how the author was thinking, by going through the interviews one code at a time. He[65] did not see a problem in this as he is used to working with long code lists, as in the excellence models. Another fellow researcher agreed with him that the coding made sense and was reasonable. The third fellow researcher, however, found the exercise more difficult than the others, because he was more used to quantitative research.

[64] See Appendix 12.

[65] If singular pronouns are used to refer to participants or fellow researchers, the researcher decided to opt for the masculine versions. This does not discriminate the female participants, but was intended to increase readability by avoiding s/he or a more ambiguous they.

In terms of **validity and plausibility**, one respondent per case validated the notes taken during the interview, as discussed above. The previous sections also provide information about the context of the research, both locally and nationally. **Comparisons** between and within cases as well as to other studies are developed in the following chapters.

With regard to **reflexivity**, Ferlie (2001, pp. 28-29) explains that a reflexive researcher should be independent and external, so that the impact of vested interests can be reduced or eliminated in order to increase the quality of the findings. Even though the researcher is external to the studied organisation, Mays and Pope (2006, p. 89) caution that *"personal characteristics such as age, gender, social class and professional status"* as well as *"the 'distance' between the researcher and those researched"* have a significant influence on the research. Donovan and Sanders (2005, p. 528) suggest providing biographical information about the author and discussing how this could influence the research and research participants.

Section 1.3 discusses how the author's previous academic experiences have influenced the present research. Oliver (2003, p. 91) develops more detailed dimensions of potential differences[66] between the researcher and the participants as well as among participants. Accordingly, the author is a young, female German with university or work-placement experience in France, Spain, Switzerland, Germany and Florida, currently pursuing a PhD in England. This could result in different types of bias on the side of both the author and the research participants. The author could be expected to have a more idealised academic understanding of QM and CG in hospitals than the participants, working with it on a daily basis. Dick (2004, p. 207) argues that *"the participant is likely to position the researcher according to their own personal beliefs".* One or all of the following general factors (derived from Mays & Pope, 2006, p. 89) probably shaped these personal beliefs:

[66] These dimensions include values and attitudes, social customs, religious beliefs, ethnicity, gender, language, employment patterns and education. In the context of this research, religious beliefs and ethnicity do not require special attention – the participants are not ethnically diverse, religious beliefs are not fundamentally different.

- The participant's medical or non-medical work experiences with QM or CG
- The participant's position in the professional hierarchy
- The participant's opinion about the value of research in general and non-medical, qualitative approaches in particular
- The participant's experiences with other academic studies
- The participant's age and gender

These factors have influenced the interviewees' openness towards participation, the acceptance of the researcher and, thus, the way of contributing to the research. Further, Oliver (2003, p. 94) raises *"the question of whether the researcher ought to try to amend a situation where some respondents are better able to respond to research questions than others."* In this research, managers and different members of staff on the wards inevitably had different understandings of QM and CG. When participants did not know how to reply to a question, the author had to prompt them to reply, without actually telling them what to say. Mentioning, what other participants had answered, and showing several different response options were the author's strategies to achieve this.

Gaining access to organisations and the relevant sources of information within them represents a common problem, faced by most research (Saunders *et al.,* 2007, pp. 163-164) including this study. Saunders *et al.* (2007, pp. 168-169) suggest the use of existing contacts to facilitate access and develop new contacts. This was the main strategy of the author. It could create another source of bias, resulting from previous work or research together, and could lead to focus more on only positive aspects without critically evaluating problems. None of the experts or case-study organisations had previously worked or cooperated with the researcher, so that this did not apply. Further potential bias, however, depended on, how the introductions were made, if the connection with a new contact was established via an existing one. The author asked existing contacts to make the introductions as value neutral as possible

and provided them with information about the research, extracted from the information sheet and consent forms[67].

Apart from this, it was important to ensure that subordinates did not develop any bias resulting from what they believed their managers wanted them to say. The author underlined the confidential treatment of the interview responses in order to achieve this.

In the end, some sort of bias remains inevitable (Keen, 2006, p. 118). Therefore, Green and Thorogood (2004, p. 195) advise to develop a *"reflexive awareness of the research process"*, taking into account:

- Explicit methodological awareness
- Theoretical awareness about assumptions
- Awareness of the social interactions between researcher and participants
- Awareness of the wider social context, i.e. general and organisation-specific social and political values and historical contexts that facilitate or constrain the research

Methodological awareness is created in this chapter. The background chapters develop theoretical awareness about assumptions. Most importantly, the researcher had to keep in mind during the interviews that quality management does not *"inevitably* [have to be] *a good thing"* (Green & Thorogood, 2004, p. 22) for everybody or even be understood in the same way by different actors. Further, social interactions between researcher and participants are discussed above.

In the context of this research that compares CG and QM at hospitals in England and Germany close attention had to be paid to issues of potential cultural bias resulting from the wider social context. This bias could mean, that participants might misunderstand the aims of the research in the context of historical rivalries and only reveal positive information to 'win' the competition between the nationalities. The author addressed this issue

[67] See Appendix 13.

by carefully phrasing the introduction to the interviews and highlighting the importance of mutual learning to achieve the research aim.

Further, the researcher herself might not be completely free of bias, as most of her experience with health services provision was in Germany. Oliver (2003, p. 105) advises to remain neutral during data collection and maintain objectivity during data analysis. Therefore, the researcher used neutral language during data collection and gave examples from both countries, when needed to prompt the interviewees, in order not to convey the impression of preferring any of the hospitals. The coding control group helped to maintain objectivity during data analysis. In addition to this, the researcher worked with a supervisory team, which was mixed in terms of gender, national background and research interests, to identify and reduce potential sources of bias as much as possible.

A reflexive awareness helped in dealing with the various types of bias in combination with the relatively small sample of case-study organisations. But these aspects still represent limitations to this study. Their impact has to be understood in the context of the **relevance and generalisability** of the findings. The public relevance of the research topic is unquestionable, considering the current academic, political and economic activity in the field, as discussed in the introduction as well as in the background chapters.

Because of the significantly qualitative nature of the research, generalisability has to be understood in a non-statistical, analytical sense. Accordingly, *"generalisation is about theoretical propositions not about populations"* (Hartley, 2004, p. 331). The case-study organisations are not representative samples of a wider population, to which the results can be generalised. It is more the concepts, patterns and themes found in the data that are generalised to theory. This, then, requires replication of the findings in similar settings, as is achieved by traditional scientific experiments for positivist research (Yin, 2003, pp. 10+37). Replication within the present research was achieved by contrasting the findings

between the different case-studies, and could also form part of further research, as recommended at the end of the thesis.

4.3.2 Ethics

Research ethics require that researchers behave appropriately, taking into account the rights of research participants and also of those otherwise affected. This applies to the entire research process including the formulation of the research questions, designing the research, gaining access to information and collecting, processing, storing, analysing data as well as writing up the findings (Saunders *et al.,* 2007, p. 178). Green and Thorogood (2004, pp. 51-52) enumerate the following groups of stakeholders. Researchers are responsible towards them. These responsibilities, however, frequently conflict with one another, due to the differences between these stakeholders:

- The research team and institution
- The professional organisations, a researcher might represent
- The participants
- The sponsor
- The policy-makers, that use results in their decision-making
- The groups, affected by these results and decisions
- The wider public, indirectly paying for much health-related research

This study was not carried out in a team and the researcher does not represent a professional organisation. Accordingly, the most important immediate stakeholders were the research institution, i.e. Portsmouth Business School, the participants and the sponsors, i.e. GERO and the author's family. The impact of the research on political decision-making processes and, with this, on healthcare service providers, users and the wider public will depend on an effective publication of the findings that reaches beyond the academic community. Upon completion of the analysis, the author emailed a feedback summary of the findings to the participants. After handing in the thesis, the author plans to disseminate the findings further in cooperation with her supervision team by publishing various articles about the different aspects of the research.

Every researcher has to balance the individual rights of their specific stakeholders against the wider society's need for knowledge (Barrett & Coleman, 2005, p. 555). Potential conflicts can result from financial incentives, from commitments to different bodies or organisations and from personal bias (Steneck, 2004, pp. 68-76). In order to find fair solutions to potential ethical dilemmas and to promote good research practice in general, the following key principles are suggested (Barrett & Coleman, 2005, p. 565; Green & Thorogood, 2004, p. 53; National Commission for the Protection of Human Subjects of Biomedical and Behavioural Research, 1979, pp. 4-7):

- **Autonomy and respect for persons**: acknowledging the rights of autonomous individuals and protecting those with diminished autonomy.
- **Beneficence**: doing good by maximising possible benefits and minimising possible risks.
- **Non-maleficence**: avoiding to cause harm, in close relation to beneficence.
- **Justice**: fairly distributing benefits and burdens of research.

For this study, no conflicts resulted from financial incentives or commitments to different organisations. The sponsors' aims corresponded with those of this piece of research. The research institution, in turn, had accepted these. Issues around bias are discussed in the previous section. Yet, the four key principles played an important role in several aspects of this research. **Autonomy** was an important concept for selecting, gaining access to and researching participants. In order to respect their individual rights, it is generally advised to seek informed consent (National Commission for the Protection of Human Subjects of Biomedical and Behavioural Research, 1979, p. 7) to ensure that participants understand (Green & Thorogood, 2004, p. 58; Ulin *et al.,* 2005, p. 58):

- The purpose and objectives of the research
- Information about the researcher and their funding

- Possible risks and benefits
- Voluntary participation
- Assurances of confidentiality
- How they were chosen to participate
- Data collection procedures and general handling
- Whom to contact with questions and concerns

Steneck (2004, p. 46) adds that the right to withdraw from participation at any time during data collection is closely related to the idea of informed consent. Appendix 13 provides the informed consent form, used for this study, in English for the research in England, a slightly simpler version in English for Florida and in German for the research in Germany.

When analysing the data, researchers need to make sure that they adhere to objectivity and also to the assurances given about anonymity and confidentiality in the informed consent form (Saunders *et al.,* 2007, p. 192). Goodwin (2006, p. 53) states that identity protection to guarantee anonymity can hardly ever be completely achieved by simply changing names and obscuring locations, because of the level of contextual detail required for sound case-study analysis.

Even though complete anonymity could, thus, not be guaranteed by this study, the data still had to be treated confidentially to *"safeguard against the invasion of privacy through research"* (Goodwin, 2006, p. 55). Therefore, the author used the key points contributed by the interviewees, without revealing which interviewee made which comments.

In compliance with the Data Protection Act 1998 and the corresponding European Union Directive (Saunders *et al.,* 2007, pp. 190-191), confidential and especially personal data has to be stored safely (Steneck, 2004, p. 94; Oliver, 2003, p. 50). This was achieved by locking away paper notes about the data collection process and by password protection on the computer for electronic versions. The stored data did not include the names of either interviewees or organisation. Where the participants agreed to this, interview data are stored for future reference.

For the understanding of **beneficence** and **non-maleficence**, in the context of this study, it is vital to keep in mind that harm and risks are not necessarily always of physical nature, but might as well relate to psychological, social, economic, or professional aspects, affecting the research participants (Ulin *et al.,* 2005, p. 58). Accordingly, the main risks and harms, which could result from this study for the participants, were related to confidentiality issues, as discussed above. The author aimed to adhere to good ethical research practice to ensure that the reputation of the university and the sponsor were not put at risk. With regard to the other stakeholders, the author did not perceive any major risks other than maybe having to change mindset and habits.

Furthermore, the National Commission for the Protection of Human Subjects of Biomedical and Behavioural Research (1979, pp. 11-12) establishes the link between **justice** and the selection of participants. Participants should be selected and treated fairly, trying to avoid society-wide institutionalised bias with regard to or resulting from social class, race, gender or culture. Issues around bias are discussed above. Gaining access to the hospitals was equally difficult in both countries, yet for different reasons.

Before any data collection could commence, the research had to be approved by the university-internal, ethical review process. The review form and the decision of the review committee are attached in Appendix 14. In addition to this, any research involving NHS staff in England has to be thoroughly reviewed and approved prior to data collection. This research project successfully went through the process and got formal NHS approval under the reference number 08/H0501/111. The letter of confirmation can be found in Appendix 15. Once this approval and the site approvals for each organisation were gained, access to participants was comparatively easy in most cases.

In Germany, no such approval process for qualitative research exists in healthcare settings. The researcher experienced major difficulties in gaining access to the case-study organisations. Access via personal

contacts became inevitable. The quality managers explained this with the fact that they received many research proposals, which did not meet any ethical or quality standards, and did not have the time or resources to scan these proposals for interesting research.

This chapter has laid out the methodological foundations of research design, implementation and evaluation for this thesis in order to prepare the discussion of the results in the following chapters.

5 Results: Case-Studies Germany

This chapter discusses the results from the case-study organisations in Germany and looks at the organisational context, staff understanding, perceived effects, perceived issues, perceived 'valued' practice and lessons-learned as well as suggested improvements for quality management.

5.1 Organisational Context

Prior to the site visits, the author performed documentary analysis for all the cases, using the six analytical categories of improvement (IMP), leadership (LS), involvement (INV), teamwork including partnerships (TW), cultural changes (CC) and customer priority (CP), as explained in Section 4.2.3, Table 11, p. 105. Table 12 below summarises the findings from the documentary analysis. P stands for D-pilot, 1 for D-1 etc. for the remaining organisations. A tick indicates agreement across the organisations.

Table 12: Overview Documentary Analysis (D)

	IMP	LS	INV	TW	CC	CP
Rankings - Performance - Patient Satisfaction - Referrer Satisf.	P, 1, 2			P, 1, 2		P, 1, 2
Media Coverage - Certification - Local Impact	P, 1, 2, 3					✓
Structured Quality Reports	✓	✓	✓	✓	✓	✓
Equivalent of Vision and Mission Statement	✓	✓	✓	✓	✓	✓

Source: the author

Performance and patient satisfaction rankings are not available for all areas in Germany. D-3 and D-4 were not covered by any rankings. The other rankings were retrieved from Initiativkreis Ruhrgebiet (2007). The

organisations received similarly good rankings for overall performance and performed comparably in patient and referrer satisfaction surveys.

The researcher assessed the media coverage via online searches in the archives of the local newspapers as well as in the news sections of the hospitals' websites. The media responded similarly to KTQ certifications with local features about the hospital and the certification process. D-4 is not KTQ certified. Therefore, the media could not report anything related. The general presence of the organisations in the local newspapers depended on their involvement with or impact on the local community via educational discussion rounds or construction projects. In general, the media reported about the case-study organisations in neutral ways. One of the hospitals, for instance, started a regional hygiene campaign that the local newspaper informed its readers about.

The researcher downloaded the structured quality reports for the hospitals from http://www.qualitätsbericht.de/. The hospitals published similar information about their quality management approaches. D-pilot, D-1 and D-2 published a vision and mission statement ('Leitbild') on their website. The other two hospitals referred to the same as 'Unternehmensgrundsätze' (corporate principles) or 'Strategie' (strategy).

The background information about the QM initiatives is based on the interviews with the 'Qualitätsmanagementbeauftragten' (QMB, quality management representatives). Appendix 16 contains detailed tables about the interviews. Table 13 below provides a summarised overview of the main findings.

Table 13: Overview Organisational Context (D)

	D-pilot	D-1	D-2	D-2	D-3
Timing	Around 1998				
Reason	Changes in the political landscape				
Initiator, choice of model	Management		Corporate owner		
Implementation details					
- Model:					
KTQ	✓	✓	✓	✓	
EFQM	✓	✓	✓	✓	
ISO 9000 series		✓			
Own model					✓
- Certification (KTQ)	✓	✓	✓	✓	
- Strategic importance	✓	✓	✓	✓	✓
- Management consultants	✓	✓	✓	✓	✓
- Role of ownership	No agreement on impact				
Role of ICT	Important to support QM				
Benchmarking, academic projects	✓	✓	✓	✓	✓

Source: Appendix 16, pp. 372-374

Most of the initiatives started in response to the changes in the political landscape from a conservative to a social-democratic government in 1998. In the case of D-1 and D-2, the QM projects were initiated for additional reasons. The GF (‘Geschäftsführung’, general management team) of D-1 had gained management experience with implementing the EFQM excellence model during their previous job. The owner of D-2 had participated in the development of the KTQ model.

Across all the cases, the QM projects were initiated from the top. The corporate owners initiated the projects and chose the QM model to be applied for D-2, D-3 and D-4. The GF supported by the head of nursing did the same for D-pilot and D-1. Apart from D-4, all the organisations were KTQ certified and had implemented QM, taking into account the EFQM excellence and the KTQ model. D-1 had also incorporated the basic principles of the ISO 9000 standards series.

D-4 applied its own model for quality assurance and continuous improvement that had been taken up for the entire healthcare system of Switzerland. In terms of QM certifications for the entire organisation, the QMB of D-4 held a very critical opinion: *"we don't do ticking boxes here and we are not interested in just having the QM label on our organisation"* (*"wir sind keine Papiertiger und wollen uns nicht nur das QM Schild hinhängen"*). However, the QMB admitted that the organisation pursued departmental quality and QM certifications, e.g. for the stroke unit, to facilitate comparisons with external hospitals and support continuous improvement.

The QMBs of all the hospitals agreed that QM was of strategic importance and prepared the organisation for the future. More pointedly, the QMB of D-4 aimed for the organisation to become the market leader with the help of QM. Yet, the QMB of D-pilot alluded to changing management priorities that caused fluctuation of this strategic importance. The QMB of D-2 stated more critically that the organisation officially put strategic importance to quality management for the certification. But as soon as the certification was over, he explained, other priorities took over again.

For the implementation and maintenance of QM, all the organisations relied on the help of management consultants or at least did so in the beginning, as advised by Dale (2003, p. 72). The QMB of D-pilot was very satisfied with the consultancy services to overcome initial resistance against the implementation of QM. This also applied to D-2. The QMB admitted that the organisation could not count on internal 'know-how' and, thus, needed the management consultants. Further, the QMB of D-3 summarised that management consultants helped with the implementation process, e.g. with the organisation of QM training to reduce resistance. The content of the QM project, however, was decided internally. Finally, the QMB of D-4 agreed with the latter two and added that an external perspective (*"Fremdblick"*) fostered innovation and helped to identify improvement potential.

Hospitals in Germany differ in their ownership (‘Trägerschaft’). D-pilot and D-1 were in denominational, private not-for-profit ownership; D-2 was publicly owned; D-3 and D-4 formed part of private for-profit hospital chains. There was no agreement among the QMBs, independently of the ownership of their organisation, as to whether the ownership had an impact on QM or not.

The QMB of D-pilot saw staff and customer focus as strengths of the denominational orientation. Yet, the QMB of D-1, the other denominational hospital, could not confirm this. Heringshausen (2008, p. 2) clarifies that the successful implementation of these values is not a question of the ownership, but of the actual organisational culture.

Further, the QMBs of D-2 and D-3 agreed on the following two aspects. The owner in general influenced the content and the orientation of the QM. Without the support of the owner, the QM project would be doomed to failure. The QMB of D-4 gave a slightly different connotation to the latter point that links back to their view on certification: the owner supported the quality philosophy, was interested in good results but did not care for *“paper”* (*“Papier”*, i.e. certifications). In his view, private ownership would be the future, because in his region all hospitals were in private ownership. He explained this by the fact that these organisations were more modern and offered good on the job training to be more attractive for staff.

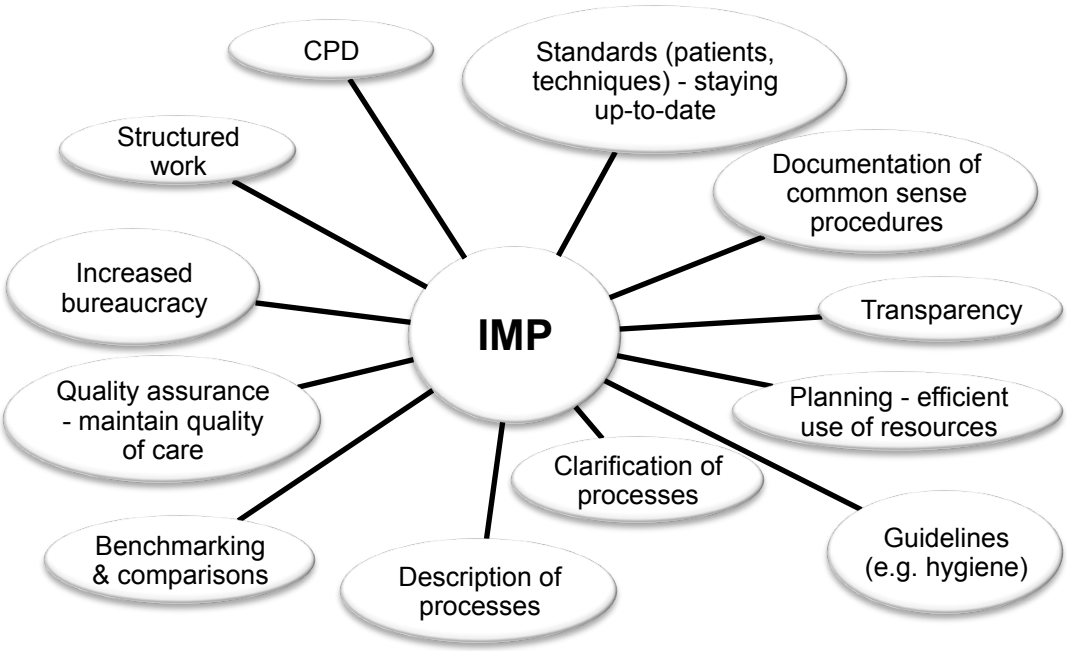
The QMB of D-4 cautioned not to overestimate the value of ICT, as it did not solve problems but helped to organise. Nonetheless, all QMBs agreed on its importance to support the implementation of QM initiatives. All the hospitals had a KIS (‘Krankenhausinformationssystem’, hospital information system) in place to provide the data needed for quality assurance. Email and intranet were seen to increase transparency, so that employees could be better informed. Apart from the QMB of D-3, all the other QMBs underlined the problematically low ICT literacy of staff, which made its efficient and effective use more difficult. All agreed that this resulted, at least in the beginning, in increased resistance and an elevated need for training.

All the organisations participated in or organised benchmarking activities, often within the corporate group or with a group of close partner hospitals. With regard to academic projects, the QMBs mentioned that their organisations had already participated in other studies, but none of the same type as this research.

5.2 Staff Understanding

The following analysis of staff understanding of QM at their organisation is based on the word tables attached in Appendix 17, which summarise the interviews with medical and non-medical staff at the case-study organisations.

Figure 18: Staff Understanding (D) – Improvement



Source: Appendix 17, pp. 375-379

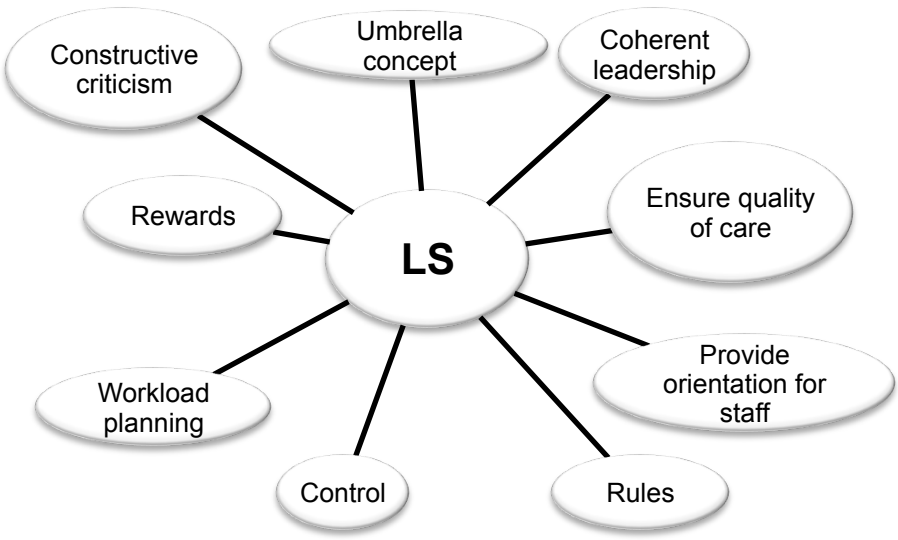
Figure 18 above depicts improvement aspects that staff attributed to quality management. Staff included quality assurance and standards referring to patients and techniques as well as guidelines (e.g. for hygiene), clarification and description of processes, documentation of common sense procedures and planning in their understanding of quality management. In their view, quality management, thus, stood for structured work and efficient use of resources. Even though they criticised the

increase in bureaucracy, they also praised the increase in transparency that resulted from quality management.

At D-pilot, staff further mentioned staying up-to-date with advances in therapy and medical care as well as Benchmarking and comparisons for organisational improvement. The ideas of Benchmarking, maintaining quality of care and continuous improvement also came up in the interviews at D-2 and D-4. Staff at D-4 additionally linked continuous professional development (CPD) of the workforce to improvement within quality management. Finally, staff at D-3 implicitly referred to improvement, when they linked good service provision, including external assessment as positive control, state of the art technology and improved competitiveness with quality management.

Figure 19 below illustrates staff understanding of leadership. Staff at D-pilot, D-1, D-2 and D-3 agreed on quality management as an umbrella concept or framework, which informed coherent leadership to ensure quality of care, *"satisfy everybody"* and provide orientation for staff. Many well-communicated rules formed part of this orientation.

Figure 19: Staff Understanding (D) – Leadership

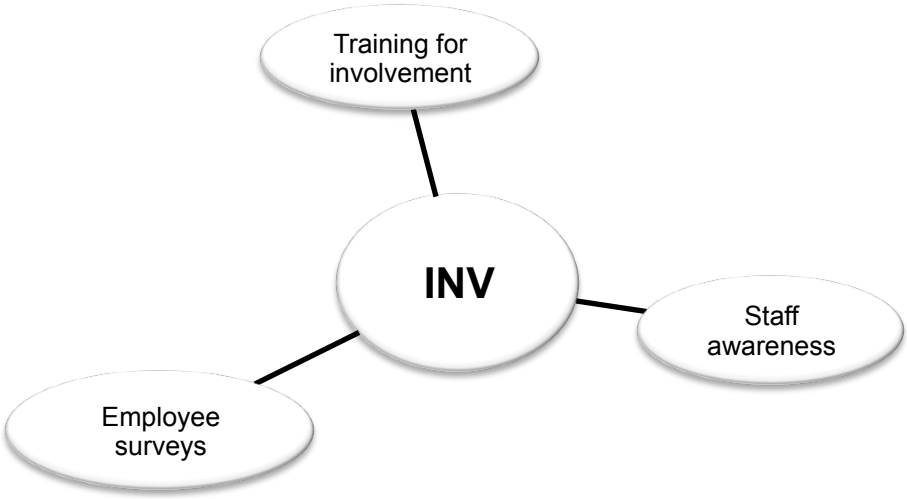


Source: Appendix 17, pp. 375-379

Staff at D-3 also revealed a slight criticism and resistance towards quality management: *"there are many, many rules that are very well publicised externally and some things are even realised."* A further point of criticism cut across all cases, apart from D-1. Quality management was seen to include control. However, staff at D-2 softened this criticism, by mentioning positive sides to leadership control, such as having an overview of the workload to plan for sufficient staffing on the wards, rewards and constructive criticism.

Not many members of staff included involvement in their understanding of quality management, as depicted in Figure 20 below. At D-pilot and D-4, staff mentioned training to involve staff in quality management. Further, staff at D-pilot also understood staff awareness and employee surveys as part of quality management.

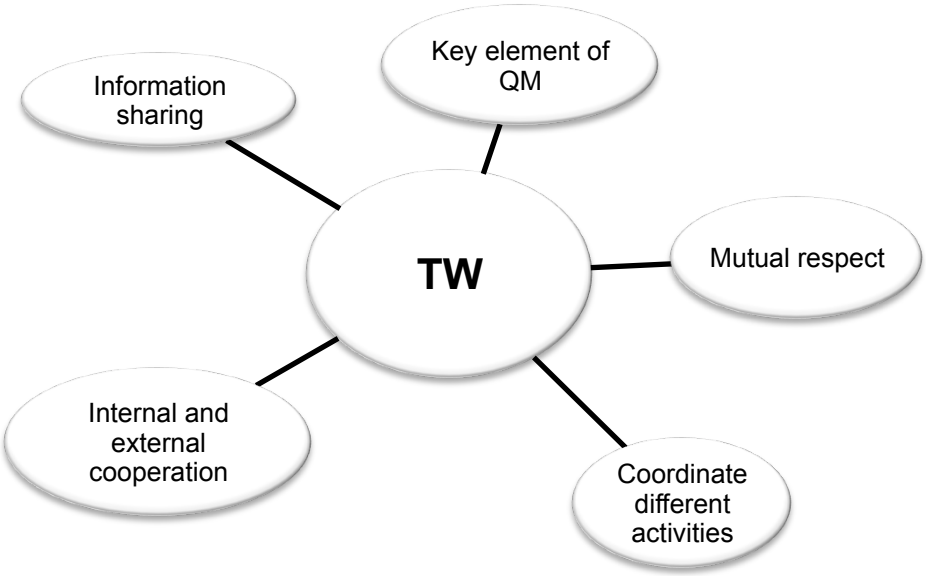
Figure 20: Staff Understanding (D) – Involvement



Source: Appendix 17, pp. 375-379

Figure 21 below illustrates staff understanding of teamwork and partnerships. Staff generally agreed on teamwork as a key element of quality management to support mutual respect between all professional groups and coordinate different activities.

Figure 21: Staff Understanding (D) – Teamwork & Partnerships

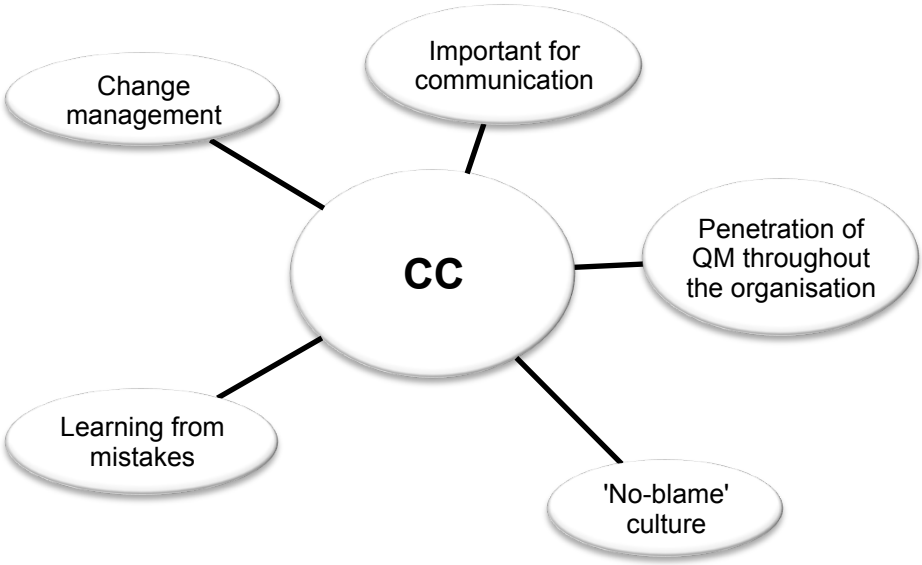


Source: Appendix 17, pp. 375-379

At D-1, however, staff only vaguely mentioned the coordination between the different sectors in healthcare, e.g. primary and secondary care. This can be interpreted as an aspect of teamwork and partnerships. In the case of D-pilot, the link of teamwork and partnerships became more apparent, as staff spoke about internal and external cooperation and information sharing.

Cultural changes were not explicitly mentioned during the interviews at D-pilot, D-1 and D-2. Staff at D-3 were more explicit and saw cultural changes as important to achieve communication and penetration of quality management throughout the organisation. Finally, staff at D-4 had the most advanced understanding of the role of culture for quality management by including a ‘no-blame’ culture, learning from mistakes and change management to be prepared for the future in their understanding. These points are summarised in Figure 22 below.

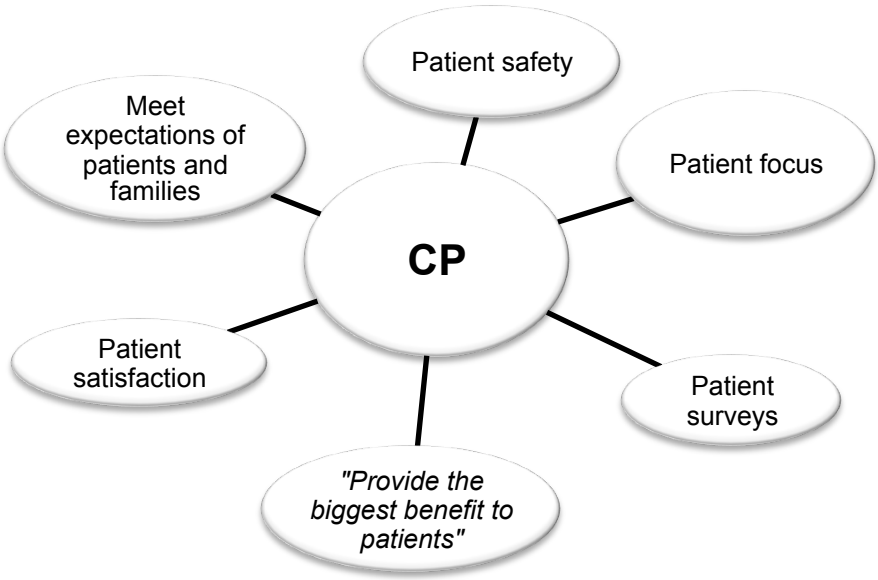
Figure 22: Staff Understanding (D) – Cultural Changes



Source: Appendix 17, pp. 375-379

The idea of customer priority found a similarly diverse appreciation in the understanding of quality management, as displayed in Figure 23 below.

Figure 23: Staff Understanding (D) – Customer Priority



Source: Appendix 17, pp. 375-379

Staff at D-1 did not mention anything in this regard. Staff at D-2 only implicitly included it – patient safety was indirectly linked to a patient focus of the organisation. At D-pilot, staff were more direct by referring to patient focus and patient surveys. The most direct statements about customer priority came from a ward physician at D-3, *"quality management aims to provide the biggest benefit to patients"* (*"Qualitätsmanagement will den größt möglichen Vorteil für die Patienten realisieren"*), and from a nurse at D-4 who would rather fulfil more patient wishes than to fill in yet another form (*"den Papierkram mach' ich als letztes"*). Other staff at D-4 highlighted the importance within quality management of meeting the expectations of and, with this, satisfying the patients as well as their families.

The staff understanding of customer priority reflects the problematic customer definition in healthcare, as discussed in the academic background[68]. Staff generally agreed on the patients as their main or only customers. Table 14 below provides more detail about the different views. M stands for management, C for consultants, N for nursing care, T for therapists and S for support staff. D-pilot is abbreviated to P, D-1 to 1 and so on.

Table 14: Customer Definition (D)

	M	C	N	T	S
Patients	✓	1, 3, 4	✓	✓	✓
Relatives	3, 4		P, 4	3	2
Internal Staff	3		1	3	1, 2, 3
External consultants	4				
Referring GPs	3, 4				
SHI	4	2			
Care homes	4		2 (head of nursing)		
Rehabilitation clinics	4		2 (head of nursing)	3	

Source: Appendix 19, pp. 393-395

[68] See Section 2.2.4. The customer definition was originally grouped as an issue. Therefore, it is included in the related interview tables in Appendix 19.

At least one staff group at each organisation raised concerns about the customer concept, as summarised in Table 15 below. The support staff at D-pilot directly said that customer was a *"horrible word"* (*"ein furchtbares Wort"*). More formally, the QMB at D-1 addressed traditional patient dependency by explaining *"the patient feels like a patient not like a customer"* (*"der Patient fühlt sich als Patient nicht als Kunde"*). In their view, the customer concept was not common in the hospital setting. This was slightly confirmed by staff hesitating to answer this question during the interviews.

Table 15: Disagreement with Customer Concept (D)

	M	C	N	T	S
D-Pilot					✓
D-1	✓				
D-2			✓		
D-3					✓
D-4		✓	✓		

Source: Appendix 19, pp. 393-395

One nurse at D-2 agreed with the idea of patient dependency: *"the patient needs help and is not really a customer"* (*"der Patient braucht Hilfe und ist nicht wirklich ein Kunde"*). This also found the agreement of the consultants and nurses at D-4 – they did not think it was the same to go to the hairdresser as to be treated for severe health issues. Accordingly, they did not accept that medical services could be understood in the same way as other services. Finally, support staff at D-3 explained the inadequacy of the concept by the lack of monetary transactions for the services, which they provided to both patients and staff.

In general, staff showed a comprehensive understanding of quality management, even though a nurse at D-4 admitted difficulties in defining quality management. Staff at D-pilot, D-2 and D-4 seemed to confirm this

by using partly imprecise terminology[69]. These findings were consistent with the results of the documentary analysis of the quality reports as well as the vision and mission statements.

In contrast to this, the QMBs at D-pilot and D-1 thought that staff had problems understanding quality management. In the view of the QMB at D-pilot, the main issue for the employees was to get an overview of the quality management activities and to understand why they were pursued in certain ways. The concerns of the QMB at D-1 went along similar lines, when he criticised a lack of critical reflection and structured holistic thinking amongst staff to understand organisation-wide quality management. He admitted, nonetheless, that awareness about quality management had improved. Based on the data collected for this research, no judgement can be made about the more general claims by these two QMBs. Only the last point regarding relative awareness can be confirmed.

Further, the QMB at D-2 identified staff understanding of quality management as a major obstacle and source of resistance. According to him, staff perceived quality management as control and feared rationalisation. The staff understanding of quality management indeed included control, as highlighted by the QMB. But staff also appreciated positive aspects of quality management. Therefore, the concerns of the QMB cannot be confirmed by this research. Finally, the QMBs of D-3 and D-4 did not identify any problems with regard to staff understanding and appreciation of quality management.

5.3 Perceived Effects

The following analysis of the effects of quality management, perceived by staff at their organisation, is based on the word tables, attached in Appendix 18. Most of the responses related to improvement, teamwork including partnerships and customer priority. Only at D-pilot did the QMB

[69] A nurse with managerial responsibilities at D-2 said about quality management that it was a big concept that encompassed everything. From the context of the interview, it remained unsure, however, if this reflected a truly holistic understanding of quality management or if he just did not know, how to define quality management more precisely.

claim that quality management had resulted in more dynamic leadership. A therapist at D-pilot said with regard to involvement that he was not directly affected, but more aware of quality management issues.

With regard to general improvement, the QMBs from all organisations agreed that quality management had increased transparency. The QMBs at D-pilot and D-1 added that clear structures and consistency had been achieved in spite of staff turnover. This idea was supported by the QMB at D-3 who maintained that projects were more sustainable within the quality management framework. Communication structures had also improved.

There was no agreement about the impact of the quality management initiatives on efficiency gains. The QMB at D-pilot claimed that efficiency had improved. The QMB at D-3 explained this with the synergy effects of quality management and DRG[70] implementation. Further, the QMB at D-4 more generally stated that the organisation was more efficient thanks to structured standardisation, implemented through quality management. In his view, the external image had improved and staff fulfilled tasks with more awareness and in a more structured way.

In contrast to this, the QMB at D-1 more carefully mentioned that cost savings were expected, but not measured, while staff accountability for their results had increased. The QMB at D-2 more pronouncedly cautioned that overall improvements could not be realised because of economic constraints resulting in a lack of resources. The QMB at D-pilot picked up on the contextual constraints and linked them to little impact of quality management on staff satisfaction. In the view of the QMB at D-1, quality management structures and procedures helped to induct new staff, especially young consultants. Finally, the QMB at D-4 cautioned that quality management often did not just simplify things, but could become a burden for staff. Therefore, he explained that staff could not always see the improvements, introduced with quality management.

[70] See Section 3.3.1.

The consultants at D-pilot and D-3 did not perceive any effects with regard to improvement. The consultants at D-1, D-2 and D-4 agreed that quality management and clinical guidelines were useful tools, which improved safe medical service provision and ensured its consistency. However, the consultants at D-4 were *"torn",* as they also thought that quality management requirements sometimes kept them away from the core tasks. This aspect is discussed further under customer priority below.

Nursing staff at the hospitals reflected to a different extent on the impact of quality management on improvement. The nursing staff at D-1 stated briefly that quality management improved the service provision indirectly by ensuring consistency of care. At D-2, in turn, the nursing staff did not say anything about improvements. Further, the nursing staff at D-3 agreed with the QMB at D-1 about the facilitation of training and incorporation of new employees. They also agreed that quality management required more time in the beginning, but that in the long run the effort put in would be compensated by efficiency gains.

Finally, the nursing staff at D-pilot and D-4 saw a need for formal quality management – standards made their work easier, more consistent and forms helped to save time. But, in their view, there were many new nursing standards, which especially very experienced nurses did not necessarily incorporate into their daily routine. Nursing staff at D-pilot agreed that quality management had positively influenced the adherence to these standards, spread the knowledge about improvements of these standards and improved staffing and staff coordination on the stroke ward.

However, nursing staff at D-4 stated critically that quality management caused more work and that they had to work extra hours – time that was gained through the use of technology, was offset by more documentation. They drew an analogy between washing up dishes in the past and documentation in the era of quality management – it would be impossible without it, as it increased accountability, but should be kept within limits.

The therapists also espoused different views on the relationship between quality management and improvement. For the therapists at D-pilot, their work had not changed greatly, whereas their work was positively more structured and formalised than before – quality management increased transparency. The therapists at D-1 agreed with this by saying that most quality management practices were common sense for experienced practitioners, but were needed for the younger ones – some crucial aspects of routine activities got forgotten under the time-tight day-to-day pressures. In a more general way, therapists at D-3 and D-4 praised that training, as part of quality management, had improved the service provision and that quality management had changed the working environment by introducing different qualifications.

Support staff did not have much to say about quality management and its effect on improvement. At D-1, they clarified that standards had been there before but had become clearer and more transparent, while also mentioning that they helped to induct new staff. Finally, support staff at D-3 explained that quality management had improved the design of the buildings and the signs, so that visitors could more easily find their way around. The researcher's observations during the visit supported this. Table 16 below summarises the perceived effects on improvement.

Table 16: Perceived Effects (D) – Improvement

IMPROVEMENT	M	C	N	T	S
Transparency	✓			P, 1	1
Efficiency gains - agree - disagree	 P, 3, 4 1, 2		 3 4		
Induction of new staff	1		3		1

Source: Appendix 18, pp. 380-381

While the QMBs at D-2 and D-3 did not mention any link between teamwork and quality management, the QMBs at D-pilot, D-1 and D-4 agreed that quality management supported and had improved teamwork in their organisations. The QMB at D-4 explained in more detail that staff felt

better in a nicer working atmosphere, which is characterised by more mutual respect, flatter hierarchies and more interdisciplinary communication structures. The QMB at D-pilot supported this positive impact on the working atmosphere – quality management at their organisation had helped to balance the interests of different staff groups. In contrast to this, the QMB at D-1 could not distinguish a clear impact of quality management on staff morale.

Among the consultants, only at D-3 and D-4 was something said about teamwork. The consultants at D-3 stated that, thanks to quality management, communication between different staff groups had improved considerably. Along with this, cooperation between different staff groups had changed. Staff were more aware of the need for cooperation to improve quality, said the consultants. In their view, the elitist status of consultants as *"demigods in white" ("Halbgötter in Weiß"*) had come to an end. Contrarily, the consultants at D-4 opined that in stroke care the different professional groups had developed good teamwork independently of quality management, because of the complex patient structure.

The nursing staff at all organisations, apart from D-1, defended some more developed viewpoints about teamwork. The nursing staff at D-pilot explained that quality management and a special stroke unit certification on their ward had helped to foster cooperation and join the different aspects of stroke care, by clearly defining the responsibilities of every staff group. One nurse at D-2 and the nursing staff at D-4 supported this, whereas the latter still saw room for improvement in this regard.

However, nursing staff at D-4 acknowledged that teamwork in general was better in stroke care than on a less acute ward, because staff really had to work together quite closely – the condition did not leave a choice and consultants were very closely involved, as there were many acute, emergency patients. The nursing staff at D-3 fully agreed with this without seeing any link between quality management and teamwork. They attributed their functioning immediate team to *"individual good luck, that*

the team members are a good match" (*"individuell Glück gehabt, dass es passt"*). Additionally, the head of nursing at D-3 addressed another issue that belongs to teamwork. In their view, quality management had contributed to *"making nursing more visible"* (*"Pflegearbeit sichtbar machen"*), i.e. improved the respect for the nursing profession within the organisation.

Unlike the other professions, those therapists that mentioned quality management and teamwork saw a positive link between the two. The therapists at D-pilot agreed with the nurses at their organisation stating that quality management and a special stroke unit certification on their ward had helped to foster teamwork and join the different aspects of stroke care, by clearly defining the responsibilities of every staff group. The therapists at D-1 fully supported this – quality management fostered the human factor and helped to improve relationship quality. Among support staff, teamwork was not mentioned to a great extent. The support staff at D-4 agreed with the more critical voices among consultants and nursing staff – good communication and cohesion within the team reflected the individual ethos of the stroke ward and was a requirement of the patient structure. Table 17 below summarises the perceived effects on teamwork and partnerships.

Table 17: Perceived Effects (D) – Teamwork & Partnerships

TEAMWORK and PARTNERSHIPS	M	C	N	T	S
Better communication and cooperation	P, 1, 4	3	P, 2, 4	P, 1	
QM supports TW (clear definition of responsibilities)	P, 1, 4		P, 2, 4	P, 1	
TW depends on local personalities			3		
Nicer working atmosphere	P, 4				
Stroke reason for TW		4	3, 4		4

Source: Appendix 18, pp. 383-384

With regard to customer priority, the QMBs across all cases agreed that quality management was beneficial for the patients. The QMBs related this to standardised service provision, improved emergency, risk and complaint management, which should ensure safer services for the patients. But as this was not measured, they could not prove their point. The QMB at D-4 understood that quality management documentation was needed for consistency. Otherwise, staff would forget about already established progress and this would endanger future progress. However, on the downside he explained that documentation resulted in less time with the patients. Further, the QMBs at D-pilot and D-1 thought that quality management increased consistency.

Further, the QMB at D-pilot cautioned that quality management had little impact on patient satisfaction because of contextual constraints and scarce resources in healthcare. Yet, the QMB at D-4 connected growing competition in the market with more effort being put into patient service. He saw quality management as a general trend in the market, which was pushed by legislative changes and also employed by the hospital to respond to the needs of more empowered patients and relatives.

The idea of empowerment leads to what the QMB at D-2 referred to as improved soft quality. In his view, staff became increasingly aware of patient needs. Additionally, the QMB at D-3 mentioned patient involvement via surveys and explained that quality management had initiated the redesign of the wards and the open areas, so that patients and visitors felt more at home, rather than being in a sterile and cold environment.

The consultants at the organisations held different opinions about the positive impact of quality management on the patients. The consultants at D-1 and D-2 thought that quality management was good for patients, as the mortality rates had gone down. In part, the consultants at D-4 agreed with this – for them, the outcome quality had gone up, but this was more due to medical progress than to quality management. Further, they stated critically that certain quality indicators were not conducive to improving the service provision, because of being susceptible to manipulation. For

instance, they explained the mortality of stroke could be manipulated by discharging the patients, so that they did not die in hospital. This would also represent an ethical conflict in the sense that the patients should be cared for rather than just discharged to die.

Finally, the consultants at D-2 thought that the general external conditions and a lack of trained consultants caused the quality of the medical service provision to deteriorate. Therefore, they were convinced that quality management became even more important to use scarce resources efficiently. The consultants at D-pilot and D-3 did not say anything related to customer priority.

Among nurses, there was no agreement on the impact of quality management on the patients. The nurses at D-1 maintained that quality management improved consistency, but not necessarily the quality of care. A nurse at D-4 supported this view: service provision was more transparent but not necessarily better for the patients. Nonetheless, the other nurses at D-4 were more positive that quality management improved hygiene, consistency increased with this and risk went down. All of this was beneficial to the patients. In support of this, another nurse at D-3 summarised that nursing staff, more competent because of better training and CPD thanks to quality management, monitored the patients more efficiently and effectively.

Further, nurses at D-pilot explained that quality management had improved consistency and increased staffing on their ward. This, in turn, had improved the service provision for the patients. A nurse at D-2 detailed that quality management projects had optimised the cooperation within the care teams and that patients benefited from this, as staff responded more to their needs. The head of nursing at D-2 developed this idea further, explaining that staff were more aware of patient needs thanks to patient surveys and, therefore, adapted their behaviour accordingly. More neutrally, the head of nursing at D-3 opined that quality management standardised treatment procedures, while still leaving room to address individual patient needs, so that they received the care they needed.

According to another nurse at D-3, the patients were better informed about their treatments, their stay at the hospital and more involved by patient surveys.

Finally, the nurses from all the organisations, apart from D-1, did not agree on the influence quality management tasks had on the time practitioners could spend with their patients. In the view of nurses at D-2, being the most positive, quality management did not have a major time-consuming impact on their daily activities except during audits or certification. The topic was more controversial amongst nurses at D-4 – quality management required a lot of time for documentation (*"man macht letztendlich mehr, als man aufschreibt" – "you end up doing more than you write down"*), while also making sure that practitioners spend more time with the patients. A younger nurse at D-3 praised standardised, simplified documentation for allowing more time to work with the patients.

However, a more experienced nurse at D-3 understood that patient safety had improved thanks to more documentation and transparency, but at the cost of less time with the patients. Most radically, nursing staff at D-pilot explained that quality management documentation and other administrative tasks further aggravated the dilemma between the service, which they would like to provide to the patients, and what they could actually deliver within given time and manpower constraints. This contradicted the view of the consultants at D-2 and supported the QMB at D-pilot. Nonetheless, nursing staff at D-pilot appreciated the need for documentation. Nursing staff at D-4 agreed with this – it was important for handing over between shifts and staff groups and also in case of legal problems.

The therapists at D-1 and D-2 did not mention anything with regard to customer priority. The other therapists tended to have a negative view on quality management and customer priority. At D-pilot, they attributed shorter lengths of stay at the hospital to increased efficiency, resulting from quality management. They explained that this complicated the provision of effective post-stroke therapies. According to the therapists at

D-3, quality management was too *"extensive"* (*"umfangreich"*) for the employees – taking into account the general scarcity of resources, this time was missing to work with the patients. This opinion was coherent with those of the QMB and nursing staff at D-pilot but contradicted the consultants at D-2.

Nonetheless, the therapists at D-3 also acknowledged that training and CPD had improved alongside the implementation of quality management – this had positive effects on the patients. Finally, the therapists at D-4, similar to the experienced nurse at D-3, saw the impact of quality management on the patient as a 'double-edged sword': on the one hand, documentation helped to know exactly what had happened with the patient and adapt the therapies accordingly, but on the other hand, it took a lot of time.

Support staff at D-1, D-3 and D-4 shared some relatively moderate views on the impact of quality management on the patients. According to support staff at D-1, more documentation was generally good but *"the patient often became a number to keep the certification"* (*"Der Patient war oft nur eine Nummer, um den Standard zu halten."*) – the QMB was aware of this criticism and took it into account to improve quality management activities. Support staff at D-3 agreed with the local nursing staff that quality management ensured patients were better informed about their treatments, their stay at the hospital and were more involved via patient surveys.

Finally, the support staff at D-4 held a differentiated opinion about quality management – as they worked on a small ward, it was not difficult to address individual patient needs. Patient complaints about the limited choice of soups after surgery had been successfully addressed through quality management structures to increase this choice. In general, support staff at D-4 supported hygiene standards as they *"made sense"* (*"machten Sinn"*) and increased consistency, but did not agree with more specific working standards (i.e. with regard to the lay-out of the food). They thought that the standards creator did not have enough working

knowledge to address these issues meaningfully and improve services for the patients. Table 18 below summarises the perceived effects on customer priority.

Table 18: Perceived Effects (D) – Customer Priority

CUSTOMER PRIORITY	M	C	N	T	S
Beneficial for patients					
Safer / less risk	✓	1, 2, 4	P, 3, 4	3, 4	1
Consistency		1, 2, 4	P, 1, 4	P, 1	
More aware of patient needs	2, 4		2, 3		4
Required to spend more time with pat.			3, 4		
Better informed pat.			3		3
QM helps to use scarce resources more efficiently		2			
Negative for patients					
Less time	4		P, 3	3, 4	
Less time during audit			2		
Scarce resources, patients cannot benefit from QM			P		

Source: Appendix 18, pp. 385-387

In summary, staff across the organisations agreed on the area of effects resulting from quality management, i.e. general improvement, teamwork including partnerships and customer priority. However, there was no agreement as to whether these effects were positive, negative or neutral.

5.4 Perceived Issues

The analysis of issues, which staff perceived at their organisation with regard to quality management, is based on the word tables, attached in Appendix 19. Staff did not perceive any issues around improvement. Improvement seemed to be the analytical category, which was best

understood during the interviews. Staff mentioned a variety of different improvement aspects in their quality management understanding. Further, the majority of perceived effects, relating to improvement, were positive. Further research should investigate why staff did not perceive any issues in this regard[71].

Different staff groups identified leadership issues at D-1, D-pilot, D-2 and D-3. The QMB at D-1, from a nursing background, found it difficult to gain the respect of consultants and more generally cautioned that frequent management changes compromised the working climate. Further, the nursing staff at D-pilot criticised the leadership of head physicians who did not positively appreciate the work of the other employees and rather complained and disciplined mistakes. There was little interaction with staff on the ward, *"you do not see them, you do not meet them"* (*"man sieht keinen, man trifft keinen"*). They were seen to focus only on their speciality without any interest in holistic quality management concerns.

Less critically, the QMB, supported by the nursing staff, at D-3 said that this depended on personal interest and character of head physicians ('Chefärzte') and their speciality. Finally, this lack of commitment to quality management was taken up by the QMB at D-2 to criticise the top management of his organisation – if they were not committed, it was seen to be a logical consequence that staff were not too involved either. Additionally, the QMB explained how the higher managerial levels consciously sabotaged quality management: managers misused quality management for *"horse-trading"* (*"Kuhhandel"*) to increase their influence and power – *"if you give me this, I will do quality management"* (*"wenn du mir das gibst, dann mache ich QM"*). The QMB saw this as a reason why quality management projects could not achieve sustainability. Morgan and Murgatroyd (1994, p. 169) call this type of resistance contrapreneurship and identify it as *"a key barrier to the effective introduction of TQM in the public sector"*. Table 19 below summarises the perceived leadership issues.

[71] See Chapter 10.

Table 19: Perceived Issues (D) – Leadership

LEADERSHIP	M	C	N	T	S
Nursing background as a problem	1				
No consistency	1, 2				
No top / general mgmt. commitment	2				
No pos. feedback			P		
Problematic consultant LS - depends on personal interest and speciality	3		P 3		

Source: Appendix 19, pp. 388-389

In terms of issues around involvement, different staff groups espoused different opinions across the organisations. At D-1, the QMB experienced the challenge to develop a common language, which he solved successfully to overcome an initial 'them versus us' between ward staff and quality management. The QMBs at D-2, D-3 and D-4 agreed that personal interest could usually make or break involvement. Nursing staff and consultants at D-1, nursing staff and therapists at D-pilot, nursing staff, therapists and support staff at D-3 supported this.

In more detail, the QMB at D-3 opined that most involved employees came from the nursing profession and named three reasons for this dominance. First, the head of nursing was actively involved in quality management and led nursing staff by example. Secondly, nursing staff enjoyed the most noticeable improvements in their daily activities. Thirdly, they represented the largest staff group and were always on the ward. Further, the younger nurses at D-2 explained that their training included quality management – they never knew any differently. The head of nursing at D-2 and the nursing staff at D-1 supported that the field of nursing was a traditional *"trendsetter"* (*"Vorreiter"*) for quality management, but this did not mean that they were more dominantly involved than other groups.

In contrast to this, the consultants at D-3 and D-4 stated that they were not actively involved. Further, support staff at D-2 and D-4 as well as nurses at D-4 complained that they were not asked about anything relating to quality management, were lucky if they were selected to be on a project group and were usually *"presented with fait accompli"* (*"vor vollendete Tatsachen gestellt"*). Finally, nursing staff at D-4 remarked critically that documentation changed constantly and the associated training took too long for staff who attended it after a shift and when they were tired. Table 20 below displays the perceived involvement issues.

Table 20: Perceived Issues (D) – Involvement

INVOLVEMENT	M	C	N	T	S
Personal interest	2, 3, 4	1	P, 1, 3	P, 3	3
Nurses are more involved	3				
Nurses as trendsetters, but not more involved			1, 2		
Not involved		3, 4			
Never asked, but would want to be more involved			4		2, 4

Source: Appendix 19, pp. 390-391

The organisations could be divided into groups depending on how advanced their teamwork practices were. At some point, these practices always presented an issue at all the organisations. D-pilot and D-1 appeared to have the most issues with teamwork. At D-pilot, the QMB experienced difficulty in raising awareness among the head physicians for quality management and general business issues in addition to their medical expertise. Nursing staff also criticised the consultants for lacking interest in quality management, while the therapists demanded that consultants needed to understand and appreciate more of the activities involved in the healthcare services provision. Due to access issues, the opinions of consultants could not be assessed – but the views of the other staff groups reflected a considerable potential for conflict.

At D-1, the QMB criticised the consultants for only paying 'lip service' to quality management – they were used to giving orders and did not to accept non-medical, business-oriented concepts, such as quality management. Additionally, the nurses explained that communication between different staff groups represented a problem. Finally, the support staff claimed that the quality management certification process, especially, neglected interpersonal relationships and the *"togetherness"* (*"Miteinander"*), instead of supporting teamwork.

Teamwork did not appear to represent a major problem at D-2 and D-3. Only one member of the support staff at D-2 criticised the lack of acceptance from other staff who saw them as the most unimportant department. However, he argued that this had changed, since support staff had generally become more involved in quality management activities. The QMB at D-3 did not see any issues around teamwork and extended that partnership development appeared to be working well. However, the head of nursing cautioned that on the wards nursing staff and consultants became allies against administrative staff. Finally, the QMB at D-4 related that there used to be the issue of the over-powering *"doctor in white"* (*"Doktor in weiss"*) in the past – but in the meantime teamwork had become well integrated thanks to staff cultivating a good work atmosphere (*"es menschelt sehr"*). Nurses, therapists and support staff agreed with this. Table 21 below summarises perceived teamwork and partnerships issues.

Table 21: Perceived Issues (D) – Teamwork & Partnerships

TEAMWORK and PARTNERSHIPS	M	C	N	T	S
Difficult role of consultants	P, 1, 4 (in the past)		P	P	
Difficult to communicate			1		
S not equal in team					2
No major problems	2, 3, 4				

Source: Appendix 19, pp. 391-392

Staff held different opinions about the relationship between quality management and cultural changes. Nursing staff at D-pilot maintained that the acceptance of technical changes did not represent an issue any longer, whereas one therapist cautioned that new technical standards should not automatically be adopted, but that everybody should critically question their value. Even though the QMB at D-2 claimed that staff understanding of quality management was a major obstacle and source of resistance, this did not seem to be a major issue in the staff interviews. However, the consultants remarked critically that the *"quality label"* (*"Qualitätsstempel"*) was put on all new initiatives, dealing with organisational structures. This misuse of the terminology was perceived to be counter-productive by creating resistance and initiative fatigue.

Further, the QMB at D-1 explained that missing internal communicative structures had represented the largest obstacle in the beginning – the therapists at D-3 criticised *"frozen structures"* (*"eingefrorene Strukturen"*) for preventing the project teams from efficiently implementing change. The QMB at D-1 continued that staff resisted the change towards quality management for two reasons. First, they did not see the need to change anything - everything had worked well as it was for many years. The QMB at D-4 supported that staff did not want to break their routine. Secondly, the QMB at D-1 thought that *"information is power"* (*"Wissen ist Macht"*) and quality management increased transparency, which endangered this. The QMB at D-2 agreed with this second point.

The consultants and QMB at D-3 concurred that resistance to change had been an issue at the beginning. The QMB further explained that some head physicians had resisted, depending on age and personality, because they had feared that increased bureaucracy would keep them and the other members of staff on the wards away from the patients. The nursing staff and therapists at D-4 alongside the nursing staff at D-3 complained about *"typically German bureaucracy"* (*"typisch deutsche Bürokratie"*) – it still appeared to be an issue. A nurse at D-3 stated critically that ticking a box for so-called accountability did not necessarily mean that this task had actually been fulfilled. Finally, the nursing staff at D-4 more generally

described how the nature of the service changed more towards hospitality, independently of quality management, and saw the need to find the right human balance between being honest without a fake ‘airhostess smile’ and cultivating respectful treatment of the patients. Table 22 below displays the perceived issues around cultural changes.

Table 22: Perceived Issues (D) – Cultural Changes

CULTURAL CHANGES	M	C	N	T	S
Organisational structures as obstacle	1			3	
Ticking boxes doesn’t mean real change			3		
Reasons for resistance					
Misuse of quality label		2			
All ok before, why change?	1, 4				
More transparency is dangerous	1, 2				
Increased bureaucracy keeps staff away from patients	3		3, 4	4	

Source: Appendix 19, pp. 392-393

This leads to the issues around customer priority within quality management. Staff at various hospitals, as depicted in Table 23 below, agreed that lack of time and resources impeded full quality management implementation and adequate service provision to the patients.

Table 23: Perceived Issues (D) – Customer Priority

CUSTOMER PRIORITY	M	C	N	T	S
Not enough time and resources	P, 1		P, 1	P, 1, 2	P, 1, 2

Source: Appendix 19, pp. 393-395

The consultants at D-3 more generally cautioned that there was an overall lack of consultants – if one consultant left the organisation, no replacement was hired and the remaining consultants had even less time to care for the patients. They explained this with young consultants leaving the organisation to work abroad or in the pharmaceutical industry, because of better working conditions and higher salaries. Further, the nursing and support staff at D-3 maintained that patients were better informed but especially elderly patients with certain conditions were not able to absorb or understand this information.

In summary, staff across the organisations mentioned issues under all analytical categories, apart from improvement. The main agreement focused on involvement, resistance to change and critically scarce resources.

5.5 Perceived 'Valued' Practice and Lessons-Learned

The analysis of the 'valued' practice and lessons-learned that staff perceived at their organisation with regard to quality management is based on the word tables, attached in Appendix 20.

In terms of improvement, the QMB at D-1 warned against wasting time on too much documentation. A nurse at D-3 also cautioned that excessive unnecessary documentation took too much time and it was important to focus on the essentials. Further, the QMB at D-1 advised that results transparency had to be achieved by measuring and analysing implementation progress for further development – internal and external comparisons could highlight good practices and areas for improvements.

Apart from this, the QMB at D-pilot recommended applying and implementing one model for quality management consistently across the entire organisation to achieve holistic improvements. No staff at D-2 contributed any ‘valued practices or lessons-learned. Finally, the support staff at D-4 praised that most standards were really good and well integrated into daily practices, even though some made no sense and they were occasionally difficult to put into practice. Table 24 below summarises ‘valued’ practice around improvement.

Table 24: ‘Valued’ Practice (D) – Improvement

IMPROVEMENT	M	C	N	T	S
Streamlined documentation	1		3		
Measurements for results transparency	1				
Only one model throughout the organisation	P				
Good integration of standards					4

Source: Appendix 20, pp. 396-397

With regard to leadership, different staff groups from various organisations agreed, as displayed in Table 25 below, that complete support and commitment by general management was important to reassure staff and avoid resistance.

However, the QMB at D-pilot cautioned that leadership from the top was not enough – it had to cascade down through the organisation. Therefore, each department appointed their own quality management representative – in the medical service provision both a member of the nursing staff and a consultant took over this role, in addition to their regular obligations on the ward, to make quality management more relevant for the practitioners.

Table 25: 'Valued' Practice (D) – Leadership

LEADERSHIP	M	C	N	T	S
Complete support and commitment by management	P, 1, 3	3	P		
Cascade it throughout the organisation	P, 1				
Action plan for implementation	1, 2		1		
Clinical background is helpful	✓				
Leaders should be present in the organisation			3	1	3

Source: Appendix 20, pp. 397-398

The QMB at D-1 supported and further expanded this to include charismatic advocates and emotional leaders who fostered the implementation, while not necessarily bearing official leadership or management positions. Yet, he was aware that clinical managers and leaders were difficult to incorporate. Accordingly, he advised for the QMB to have relevant experience in the field, including project and change management. This helped, he explained, to develop a common language for quality management communications, showing empathy for the employees in their daily routines (*"tägliches Hamsterrad"*). He understood that it could be difficult for staff to step back and reflect about their job, as required by quality management.

Further, the QMB at D-3 highlighted the importance of an accurate self-assessment report that staff could identify with. Overall, the QMBs at D-1 and at D-2 agreed on planning for the implementation process and balancing the time requirements – enough but not too much, so that things got done noticeably. The QMB at D-1 further detailed that the implementation efforts needed to be well focussed and organised with a concrete action-plan, including smart objectives as well as prioritising

important issues. The nursing staff at D-1 underlined this point – there was a need to actually do things and not just talk (*"Nägel mit Köpfen machen"*).

The QMBs across the organisations did not agree, whether being from a nursing background made it more difficult in their role, but they did agree that a clinical background at the same organisation was helpful to know, how the organisation functioned, and to be known by staff. The therapists at D-1 as well as nursing and support staff at D-3 supported that their QMBs were visibly present in the organisation and helped with quality management issues. Finally, the QMB at D-4 explained that the privatisation of the organisation in 2000 had made a difference – they were not just aiming at the quality management certification any longer (previously they were *"Papiertiger"*), but also focused on results.

The QMBs across the organisations agreed that effective communication was vital in the implementation and maintenance of quality management and involvement. The QMBs at D-2 and D-3 explained in more detail that an initial information event and several kick-off events had helped to initiate the project. At D-3 the momentum for quality management was maintained through ongoing information of staff via newsletters. The QMB at D-4 related that communication in this regard worked both ways – for instance, staff could also complain about new standards on scientific grounds. Further, the QMBs at D-pilot and D-3 advised the use of a common language with short sentences and clear terminology, so that clinical staff understood the non-clinical, business concepts.

A common language was one way of addressing the need to make quality management tangible for staff, identified across the organisations by the QMBs. At D-pilot, D-1 and D-4, the QMBs concurred that certification against KTQ helped to achieve this and provided motivation. The QMB at D-pilot linked this back to communication by highlighting the importance of positive feedback to staff in this regard.

Alongside communication, the QMBs at D-pilot, D-1 and D2 had experienced training as a powerful tool to involve staff. Finally, the QMBs

at D-pilot, D-1 and D-3 advised to initially build involvement on the personal interest of staff and to then develop further from there. All staff from D-pilot and D-1, as well as consultants and support staff at D-3 confirmed that the QMBs and the organisation as a whole handled involvement adequately, while some nurses at D-4 praised their local training. Table 26 below summarises 'valued' practice and lessons-learned around involvement.

Table 26: 'Valued' Practice (D) – Involvement

INVOLVEMENT	M	C	N	T	S
Effective communication	✓				
Common language	P, 3				
Make QM tangible	✓				
KTQ as motivation	P, 1, 4				
Training	P, 1, 2				
Build on personal interest of staff	P, 1, 3				
Involvement is ok	P, 1	P, 1, 3	P, 1, 4	P, 1	P, 1, 3

Source: Appendix 20, pp. 398-401

In terms of teamwork and partnerships, few members of staff across the organisations contributed 'valued' practice or lessons-learned. The nursing staff at D-4 described the internal clinical teamwork 'valued' practice on their ward – consultants, therapists and nurses met once a day to discuss their patients. For the teamwork between clinical and non-clinical staff, the QMB at D-1 stated critically that the *"God in white"* (*"Herr Gott in weiss"*), i.e. the consultants, needed to support quality management for teamwork to succeed.

The QMB at D-pilot described how this was achieved at his organisation – in order to build an awareness for quality management among future generations of head physicians ('Chefärzte'), he motivated senior physicians ('Oberärzte') to become quality management representatives for their wards. He explained that they were younger, more open towards new ideas and usually achieved high levels of acceptance among other

staff groups. This impact, in his view, compensated for the fact that they often moved on quickly to develop their career. Further, he brought medical and business leaders together in project teams at early stages to mitigate resistance from consultants and foster teamwork between clinical and non-clinical staff.

In terms of external partnerships, the QMB at D-3 explained that quality management was introduced simultaneously at all hospitals, belonging to the corporate group, to achieve efficient and effective implementation and maintain momentum. Accordingly, he had experienced the hospitals working more closely together, learning from each other and exploiting synergies, e.g. for CPD, in order to avoid *"reinventing the wheel every time"* (*"nicht das Rad jedes Mal neu erfinden"*).

Further, the QMBs of D-2 and D-3 explicitly mentioned 'valued' practice with regard to close external partnerships including cooperation with local elderly care homes and mobile nursing service providers or external speech-, physio- or music-therapists and rehabilitation clinics. The QMB at D-4 explained this with general changes in the care landscape – in the past the patients had stayed in hospital as long as needed, until they had fully recovered. This had been changing due to scarce resources and required closer cooperation with the outpatient sector to prepare patients for going home earlier. Table 27 below summarises 'valued' practice around teamwork and partnerships (PS).

Table 27: 'Valued' Practice (D) – Teamwork & Partnerships

TEAMWORK and PARTNERSHIPS	M	C	N	T	S
Consultants have to support TW	P, 1				
More external PS in response to scarce resources	2, 3, 4				

Source: Appendix 20, pp. 401-402

In dealing with resistance, the QMBs across the organisations had developed 'valued' practices and concluded lessons-learned to achieve cultural changes in support of quality management. The QMB at D-pilot advised the appointment of local quality management representatives as ambassadors to support implementation, maintain momentum and create horizontal connections throughout the hospital for organisational learning. The experiences of the QMB at D-2 mirrored this need – without local ambassadors, quality management and the solidarity with the rest of the hospital were too intangible for staff to appreciate the need for quality management.

In contrast to this, the QMB at D-3 had easily overcome resistance by showing staff that all the components had already been put in place and quality management just gave these more structure. More generally, the consultants at D-3 explained that it was easier to implement and apply quality management procedures on a non-emergency ward. Finally, the QMBs at D-1 and D-4 advised the confronting of resistance by either isolating resisting parties, encircling them with quality management supporters and presenting them with convincing evidence or by intensely working with resisting staff to explain quality management, clarify its goals and set incentives to realise a 'no-blame' culture. Table 28 below summarises 'valued' practice around cultural changes.

Table 28: 'Valued' Practice (D) – Cultural Changes

CULTURAL CHANGES	M	C	N	T	S
Local QM ambassadors	P, 2				
Manage resistance					
Show, that QM already in place	3				
Confront by isolation or intense involvement	1, 4				

Source: Appendix 20, pp. 402-403

Finally, only the QMB at D-1 suggested supporting customer priority by carrying out staff, referrer and patient surveys on a regular basis. In summary, mainly the QMBs contributed lessons-learned and 'valued' practice, in particular with regard to improvement, leadership, involvement, teamwork and partnerships.

5.6 Suggested Improvements

The analysis of improvements that staff suggested for their organisation with regard to quality management is based on the word tables, attached in Appendix 21.

Staff groups across the organisations agreed that improvements were always possible, as displayed in Table 29 below. Staff at D-pilot were unanimously completely *"happy"* (*"zufrieden"*) with how quality management was dealt with at their organisation. At D-2, nursing and support staff demanded streamlining of documentation, as did nurses and therapists at D-4. This found the agreement of nursing staff at D-3 who additionally asked for structuring rosters on the wards. Nursing staff at D-4 picked up on the idea of structure and asked for simplified quality management structures with less bureaucracy – it would be good to have formal structures for patient reports, which were often written in a rush and illegible.

Table 29: Suggested Improvements (D) – Improvement

IMPROVEMENT	M	C	N	T	S
Always possible	4	3	4	4	3
Streamline documentation			2, 3, 4	4	2
Give more structure			3, 4		

Source: Appendix 21, pp. 405-406

In leadership terms, staff at D-1 and D-4 did not suggest any improvements, as is evident from Table 30 below. All staff at D-pilot asked for more positive feedback, especially from medical management who mainly focused on mistakes and negative feedback. Nursing and support

staff at D-2 also demanded more rewards for hard work, which they perceived was taken for granted. Further, the QMBs at D-pilot and D-2 concurred that consistent and stable quality management and general leadership needed to be continuously pursued. The QMB at D-pilot added that an awareness of the importance of positive leadership for successful quality management should be communicated and trained from management to ward level. Along similar lines, the nursing staff at D-3 saw a need for executive development (‘Führungskräfteentwicklung’).

Table 30: Suggested Improvements (D) – Leadership

LEADERSHIP	M	C	N	T	S
Positive feedback and rewards	P		P, 2	P	P, 2
Consistency	P, 2				
Train leadership	P		3		

Source: Appendix 21, pp. 406-407

No member of staff at D-pilot or D-1 contributed any suggestions for improvement of involvement. As summarised in Table 31 below, various staff groups at D-2 concurred that the quality manager and the affected employees needed to be more involved in the decision-making process to ensure practicality and practice orientation of changes.

Table 31: Suggested Improvements (D) – Involvement

INVOLVEMENT	M	C	N	T	S
More involvement	2		2, 4		2
More information, communication about QM	4		4		2
More training			2, 3, 4		3

Source: Appendix 21, pp. 407-408

The QMB at D-2 exemplified this with new staff facilities planned by management, which remained unused, because they were too far away from the working environment. The nursing staff at D-4 more generally

thought that quality management needed to address the working needs of ward staff – staff surveys to evaluate areas for improvement would offer an opportunity to balance theory and reality. The remaining suggestions for improvement focused on communication and training. One member of the support staff at D-2 asked for more communication and feedback. Further, the QMB at D-4 demanded better information and communication structures – contradicting information about structural changes on the ward had been passed on to staff and had, it would appear, caused resistance. The nurses at D-4 supported this and explained the beneficial impact of open, honest communication on staff motivation. Apart from this, support staff at D-3 linked training and communication by suggesting the need of training in respectful and friendly communication with patients and other staff. Nursing staff at D-3 suggested that the hospital should help finance training courses and invest more in continuous professional development. In comparison to nursing training, the consultants' training needed to put an additional, stronger emphasis on quality management issues, advised the nursing staff at D-2. Finally, nursing staff at D-4 suggested that training should be 'bundled' and they should get time off for it.

Staff across the organisations, apart from at D-1, saw a need to further develop and improve teamwork and partnerships, as summarised in Table 32 below.

Table 32: Suggested Improvements (D) – Teamwork & Partnerships

TEAMWORK and PARTNERSHIPS	M	C	N	T	S
More mutual respect	P		P, 3	P	P
More interdisciplinary cooperation			3, 4	2, 4	
Better communication with after-care and catering providers					2, 4
Use TW to increase respect for nurses			3		

Source: Appendix 21, pp. 408-409

At D-pilot, teamwork and mutual respect between staff groups left room for improvement – the consultants especially received harsh criticism from the other staff groups for being bad team players. The stroke unit certification seemed to have been a step into the right direction to improve and should be further pursued. Additionally, the head of nursing at D-3 claimed that the organisation-wide awareness of the importance of and respect for the nursing profession needed to be further developed and, in his view, a good platform for this was offered by quality management.

More generally, the nursing staff at D-4 thought that interdisciplinary work could still improve. Further, the therapists at D-2 suggested increased cooperation with nursing staff, in order to harmonise standards of care and therapy. The nursing staff at D-3 asked for better coordination of appointments in multi-disciplinary care. The therapists at D-4 supported this – they worked on two or three different wards and had to walk back and forth several times because of the workflow on the wards. Finally, support staff at D-2 and D-4 identified areas for improvement around external partnerships, i.e. communication with after-care organisations or catering providers.

Staff at D-pilot, D-1 and D-2 did not suggest any improvements, with regard to cultural changes. The criticism at D-3 focused mainly on useless certification and change that did not happen. The consultants claimed bluntly, *“certification does not necessarily mean anything”* (*“Zertifizierung muss nichts heißen”*), and the therapists stated critically that it was just a written proof every other year, which did not make a difference, as long as nothing was questioned practically. More generally, they said: *“there is too much talk but nothing happens”* (*“es wird viel geredet, aber es passiert nichts”*).

The nursing staff supported this – the implementation of improvements and changes agreed upon in project teams remained difficult. In their view, this had to change because, otherwise, involvement in such activities became meaningless. The therapists further explained that there were no incentives to actually implement these improvements and sometimes it was not even possible, because those, working on these projects, did not

have the power to decide about the implementation. In contrast, the nursing staff at D-4 criticised the speed of change at their organisation. They had the impression that management kept on changing their mind, reinventing the wheel every six months. They asked for better planned, more consistent changes. Table 33 illustrates this contrast.

Table 33: Suggested Improvements (D) – Cultural Changes

CULTURAL CHANGES	M	C	N	T	S
Certification, but no real changes		3		3	
Too much talk, no change			3	3	
Less change, more consistency			4		

Source: Appendix 21, pp. 409-410

With regard to customer priority, Table 34 below shows that many staff across the organisations agreed on the need for more resources in terms of time and manpower, in order to achieve full implementation of quality management and deliver adequate services to their patients. Further, the therapists at D-3 explained in more detail that high staff turnover represented the main obstacle to deliver consistent quality treatment – if the organisation hired new staff on full-time contracts and not just part-time, this problem could be improved or solved.

Table 34: Suggested Improvements (D) – Customer Priority

CUSTOMER PRIORITY	M	C	N	T	S
More resources (time and manpower)	P, 1	1	P, 1, 2, 4	P, 1, 3, 4	P, 1, 2
More respect for patient needs			4		2

Source: Appendix 21, pp. 410-411

To truly measure the quality of patient treatment outcomes, the consultants at D-4 suggested changing the mortality indicators from 'in hospital' to six months after the treatment. Otherwise, the hospital could discharge severely ill patients, so that they would not die in hospital, in order to improve the indicator. Support staff at D-2 and nursing staff at D-4 would like to see customer priority improved by more respect for the needs of and patience with elderly patients. Support staff at D-4 gave an example for this. They would have liked to have more fresh food for their patients, but there was not enough storage space. This could contribute to a holistic quality management improvement project.

In summary, the main agreement between staff across the organisations focused on improving teamwork and partnerships as well as more resources to deliver quality services to the patients.

5.7 Summary

This chapter looked at the similar **organisational context** for the case-study organisations in Germany. Staff showed a balanced **understanding of quality management** and mentioned a few components under improvement, involvement and cultural changes. The main agreement focused on control as part of quality management leadership, problematic customer priority and the key role of teamwork to implement quality management. The customer definition remained difficult, as supported by the theoretical discussions in Section 2.2.4. Of the staff groups, 96%[72] understood the patient to be their main customer and some also added relatives (25%) or internal staff (25%). However, 25% of the staff groups questioned the adequacy of the customer concept in a medical environment.

Staff across the organisations agreed on the areas of **perceived effects** of quality management, but not necessarily on the positive, negative or neutral nature of the effect itself. Of the staff groups, 33% thought that quality management improved consistency and transparency of care, but

[72] The percentages are calculated as the number of staff groups, which mentioned the statement, divided by the total number of staff groups included in Germany (24).

were not sure about the impact on efficiency: 17% saw a positive, 13% no effect on efficiency. Further, quality management was seen to improve and support teamwork by 33% of the staff groups and 38% explained this as being due to further developed communication structures within the teams. However, 17% opined that this was also related to the stroke speciality requiring integrated approaches. Moreover, staff held controversial views about the impact of quality management on the customers: 54% concurred that patients received more consistent, safer services with less risk, whilst 21% thought that practitioners were more aware of patient needs. The consultants at D-2 added that quality management fostered the efficient use of scarce resources. In contrast to this, 21% of the staff groups, including one QMB, nursing staff and therapists, saw a negative impact of quality management on the amount of time, they could spend with the patients.

With regard to **issues**, staff did not perceive any under improvement and only a few under leadership. With regard to involvement, 42% of the staff groups agreed that it mainly depended on personal interest. Moreover, 13% added that nursing staff were trend-setters in quality management because of professional traditions. Teamwork was perceived to have been an issue throughout the organisations at some point with 21% of the staff groups criticising consultants for their approach to teamwork. This was also related to professional traditions. At three organisations, representing 63% of the staff groups, teamwork was no longer seen to be a major issue. The most important reason why staff resisted cultural changes necessary for quality management was the worry about increased bureaucracy, which would keep them away from the patients. This was mentioned by 17% of the staff groups. Finally, 42% of the staff groups saw scarce resources and not enough time as barriers to truly realising customer priority.

‘Valued’ practices and lessons-learned were mainly contributed by the QMBs. They did not mention a lot about improvement. With regard to leadership, they all agreed on top management commitment and support. Two QMBs added, that this should be cascaded throughout the

organisation to counter resistance. Three QMBs explained that quality management should be implemented, following a clear action-plan. There was no agreement, whether a nursing background was problematic for a QMB, but generally a clinical background was seen to be helpful by all.
The QMBs achieved staff involvement by building on personal interest of staff (three of them), training (three of them) and effective communication of tangible aspects and results of quality management (all) with a language, which avoided management jargon (two of them). Three QMBs further explained the motivating role of the KTQ certification process: 54% of the staff groups supported these approaches to quality management involvement stating that they felt well involved. In relation to the issues under teamwork, the QMBs contributed a few 'valued' practices and lessons-learned to teamwork development. Two QMBs underlined the importance of consultant support within clinical and managerial teams. Further, three QMBs experienced external partnerships as helpful to respond to scarce resources in healthcare. In terms of cultural changes, all QMBs had developed individual 'valued' practices and had drawn lessons-learned to deal with organisational resistance to quality management. Customer priority was only addressed by one QMB.

Finally, 21% of the staff groups across the organisations agreed that **improvements** were always possible and particularly asked for simplified, streamlined documentation. With regard to leadership, 25% of the staff groups would like to see more positive feedback and rewards. Further, staff should be more involved, said 17% of the staff groups, by more communication (13%) and adequate training (17%, nurses and support staff). Teamwork and partnership practices were also seen to be in need of further development by an increase in mutual respect (21%) and interdisciplinary cooperation (17%). Yet, staff at two organisations mentioned cultural changes but there was no agreement on improvements in this respect. Even though quality management did not directly control this, 58% of the staff groups would like to see more resources in terms of money, manpower and time to strengthen the customer priority in their organisation.

After the analysis of the case-study organisations in Germany, the next chapter analyses the case-study organisations in England following the same structure, before the findings are brought together and linked to the literature in the cross-case analysis in Chapter 7.

6 Results: Case-Studies England

This chapter discusses the results from the case-study organisations in England and looks at the organisational context, staff understanding, perceived effects, perceived issues, perceived 'valued' practice and lessons-learned as well as suggested improvements for clinical governance.

6.1 Organisational Context

Prior to the site visits, the author performed documentary analysis for all the cases, using the six analytical categories of improvement (IMP), leadership (LS), involvement (INV), teamwork including partnerships (TW), cultural changes (CC) and customer priority (CP). Table 35 below summarises the findings from this activity. A tick indicates agreement across the organisations.

Table 35: Overview Documentary Analysis (E)

	IMP	LS	INV	TW	CC	CP
National Sentinel Stroke Audit	✓	✓		✓		✓
Care Quality Commission Rating	✓	✓	✓	✓	✓	✓
Media Coverage	✓					✓
Quality Account	✓	✓	✓	✓	✓	✓
Vision and Mission Statement	✓	✓	✓	✓	✓	✓

Source: the author

The National Sentinel Stroke Audit (Hoffman *et al.*, 2009) compares the quality of stroke care across England, Wales and Northern Ireland. Further, the Care Quality Commission ratings assess the general performance of hospitals[73]. The organisations received similarly good

[73] The rating reports can be downloaded from http://www.cqc.org.uk/ under 'Find care services', 'Find health care services', 'Summary Information'.

rankings for overall performance, management of stroke care, interdisciplinary treatment and patient involvement in the care process.

The researcher assessed the media coverage via online searches in the archives of the local newspapers as well as in the news sections of the hospitals' websites. The presence of the organisations in the local newspapers depended on their involvement with or impact on the local community via educational discussion rounds or construction projects. In general, the media reported about the case-study organisations in neutral or positive ways. One of the hospitals, for instance, had improved the catering services, which was positively appreciated by the media. More neutral articles informed the readers about parking changes, new buildings or stroke-specific issues.

The organisations published similar information about the quality of their services within the quality accounts[74]. All the organisations used different names to refer to the vision and mission statements on their website. They could be found as vision and strategic aims, strategy and commitment, about us and chairman and chief executive messages, or trust values and objectives.

The following background information about the clinical governance initiatives is based on the interviews with the clinical governance managers. Appendix 22 contains detailed tables about the interviews. Table 36 above provides a summarised overview of the main findings.

[74] Downloaded from http://www.nhs.uk/ServiceDirectories/Pages/ServiceSearchAdditional.aspx?ServiceType=Trust.

Table 36: Overview Organisational Context (E)

	E-1	E-2	E-3	E-4
Timing	Around 2000			
Reason	Medical scandals, the government reaction to these			
Initiator, choice of model	The government and local adaptations			
Implementation details				
- Model:				
Seven pillars	✓	✓	✓	✓
Standards for Better Health	✓	✓		✓
- Certification				
- Strategic importance	✓	✓	✓	✓
- Management consultants				
- Role of ownership	n/a	n/a	n/a	n/a
Opinion about ICT	+	-	+	neutral
Benchmarking, academic projects	✓	✓	✓	✓

Source: Appendix 22, pp. 412-415

The timing for the start of clinical governance activities was fairly similar, due to the centralised structure of the NHS. All the organisations started to implement clinical governance around 2000, following medical scandals[75] and the government reaction to it. The clinical governance managers saw the government as the initiator of the clinical governance initiatives. Only the clinical governance manager of E-2 added that it was internally lead by the medical director. The managers further agreed that the clinical governance model to be implemented was chosen by the government.

This seemed to have been true in the beginning, as all clinical governance managers mentioned that they had started with the seven pillars model. In addition to this, the clinical governance managers at E-1, E-2 and E-4 included the Standards for Better Health in the models that they currently worked to and used as a reporting framework. Yet, the clinical governance manager from E-2 cautioned that these standards were *"good for working,*

[75] See Section 3.3.2.

but people understood the seven pillars better". Therefore, the seven pillars were still used for staff training.

The clinical governance manager at E-3 did not mention the Standards for Better Health, but said that the organisation had recently started to develop an integrated governance model, including clinical and financial aspects of governance. The DoH (2006b, p. 10) defines integrated governance as *"systems, processes and behaviours by which Trusts lead, direct and control their functions in order to achieve organisational objectives, safety and quality of service and in which they relate to patients and carers, the wider community and partner organisations"*.

None of the hospitals were certified against a quality management model or standard. The clinical governance manager of E-2 held the opinion that the EFQM excellence model and the ISO 9000 standards series were not applicable to his organisation. Further, the clinical governance managers at E-1 and E-4 both mentioned a guiding quality framework used in their organisations: the National Stroke Strategy and the quality framework by the Care Quality Commission.

The clinical governance managers from all hospitals agreed on the strategic importance of clinical governance, quality of the service provision and its management. More pointedly, the clinical governance manager at E-3 saw a *"growing quality agenda"*. Yet, the clinical governance manager at E-4 more cautiously said that clinical governance was one of the top issues in the Trust, while also admitting that the financial climate made it difficult to place quality as the number one priority. Nevertheless, he claimed that patient safety always came first.

None of the hospitals relied on the help of management consultants to implement or maintain clinical governance. Because of the systemic differences, ownership issues, as discussed for the hospitals in Germany, did not play a role for the NHS hospitals.

The clinical governance managers of the hospitals held very different views about the role of ICT for the implementation of clinical governance. Overall, the managers at E-1 and E-3 were in favour of ICT. The manager at E-4 held a neutral opinion, while the manager at E-2 showed a slight rejection. For E-1, the clinical governance manager said that communication had improved significantly thanks to email – this was helpful to involve staff in clinical governance. He also mentioned the building of a database of patient statistics to increase transparency of the operations. The implementation of an electronic document management system, however, had turned out to be problematic, he explained, because of poor project scoping and lack of sufficient financial resources. He saw the ICT landscape of E-1 to be far from a holistic hospital information system.

The clinical governance manager at E-3 agreed with this last point, *"ICT is very limited here and there is still a long way to go"*. Further, an electronic training system, also including clinical governance issues, was in place at E-3. The new information officer had devised a new ICT strategy for the development of a single interface to data resources within the organisation, so that everybody could access the data they needed – the data should be integrated into a single system and people needed to have confidence that the data were correct.

In contrast to this, the clinical governance manager at E-4 just mentioned that there were forums and databases to support clinical governance. Further, he added that the Internet gave patients the opportunity to more easily access information, such as guidelines and policies. In his view, *"that's life these days"*. The clinical governance manager at E-2 stated more pointedly that there was no need for more ICT or specific software packages – the organisation already had a good intranet and a small, over-stretched ICT department, which organised electronic complaints and incident reporting as well as an online database, containing clinical audit and patient information leaflets and guidelines. He also cautioned, *"many don't like ICT"* – thus, *"you can have as much ICT as you want, if the*

awareness about it is not there". This was another reason for his rejection of more ICT.

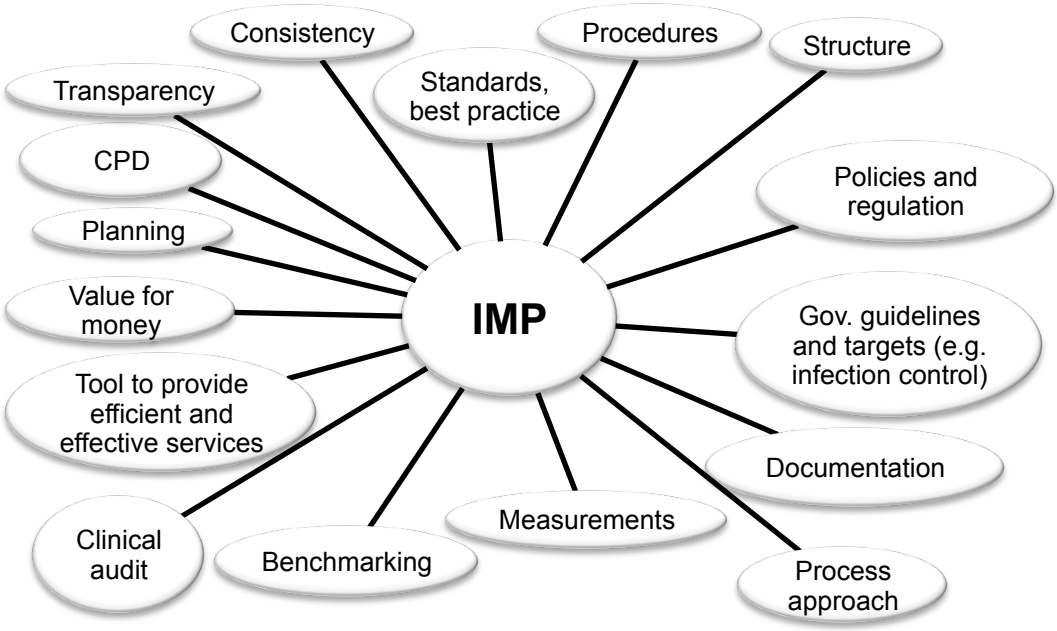
All the organisations participated in or organised benchmarking activities, most prominently the National Sentinel Stroke Audit. The managers mentioned that their organisations participated in other academic projects, but none of the same type as this research.

6.2 Staff Understanding

The following analysis of staff understanding of clinical governance at their organisation is based on the word tables, attached in Appendix 23, which summarise the interviews with medical and non-medical staff at the case-study organisations.

Figure 24 below depicts the improvement aspects staff attributed to clinical governance. Staff generally included clinical audit based on, for instance, standards, procedures, policies, regulation, government guidelines and targets (e.g. infection control), documentation, process approach, measurements and planning.

Figure 24: Staff Understanding (E) – Improvement

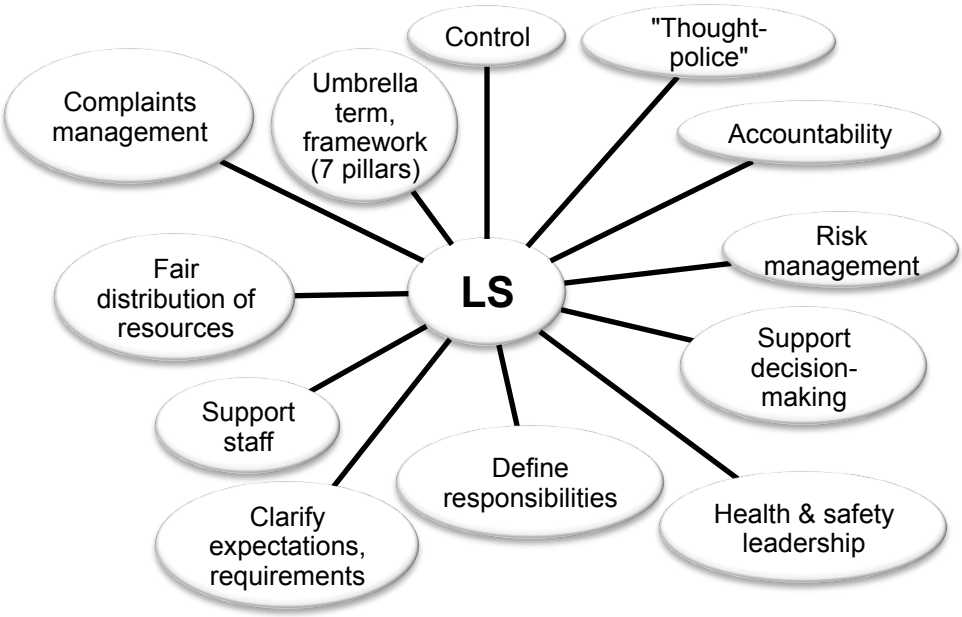


Source: Appendix 23, pp. 416-419

Accordingly, clinical governance gave structure, transparency and consistency, in their view. Overall, staff understood clinical governance as a framework and tool to provide efficient and effective services, which gave value for money. Further, staff at all organisations, apart from E-1, mentioned continuous professional development (CPD). Staff at E-1 and E-3 also added Benchmarking. Moreover, there was wide agreement on the inclusion of best practice. A consultant at E-4 summarised: *"clinical governance is all about improvement"*.

For leadership, staff from all the organisations included some sort of control, e.g. quality, infection or financial, in their clinical governance understanding, as displayed in Figure 25 below. At E-2, this received a negative connotation, as staff saw clinical governance as a *"pain in the backside"* and as the *"thought-police"*. But there were also positive sides to the idea of control – all staff agreed on accountability and risk management as important elements of clinical governance. Staff at E-2 thought that clinical governance supported decision-making without replacing it.

Figure 25: Staff Understanding (E) – Leadership

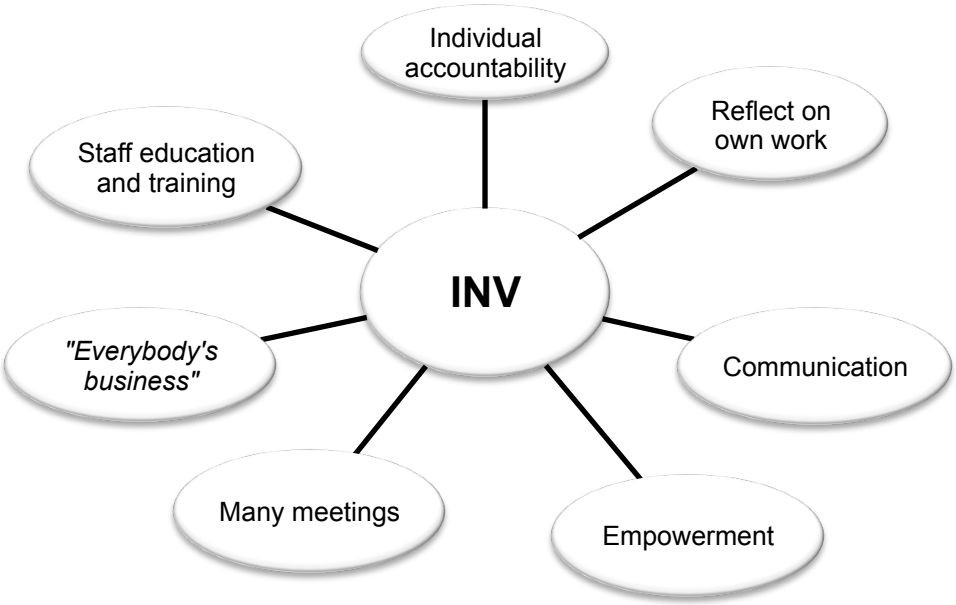


Source: Appendix 23, pp. 416-419

Further, staff at E-3 and E-4 linked health and safety leadership to clinical governance. For them, clinical governance leadership meant to define responsibilities, clarify expectations and requirements. Staff at E-3 took this even further and said that clinical governance leaders supported staff, ensured fair distribution of resources and dealt with complaints management to appreciate the voice of the customer. Finally, all staff perceived clinical governance as an umbrella term or framework – staff at E-3 and E-4 referred to the seven pillars model.

Figure 26 below summarises staff understanding of involvement. Staff at all hospitals, apart from E-4, explicitly mentioned that clinical governance fostered individual accountability for one's own work. At E-4, staff stated more subtly that clinical governance encouraged them to reflect on their own work. Communication was seen as an important means of involvement. Staff at E-3 developed this idea further by saying that clinical governance empowered staff and *"makes you think about wider issues than your own job"*.

Figure 26: Staff Understanding (E) – Involvement



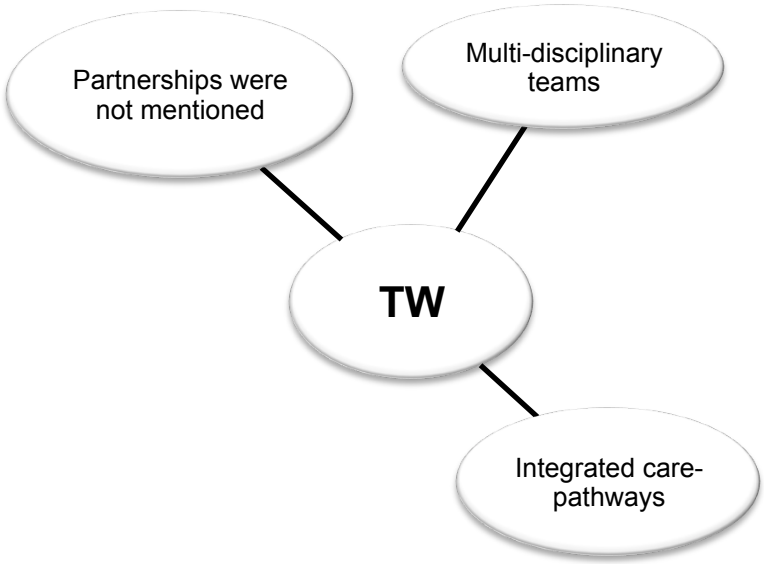
Source: Appendix 23, pp. 416-419

In contrast to this, the staff views at E-1 and E-2 also highlighted the downsides of clinical governance involvement. At E-1, clinical governance was understood as *"everybody's business"*. This received a negative

connotation when staff complained about the amount of meetings and paperwork. Staff at E-2 cautioned that clinical governance and accountability also implied practitioners' liability for patient safety. Lastly, staff at E-3 and E-4 added staff education and training to maintain staff competencies to their clinical governance understanding.

Staff from all cases agreed on the importance of multi-disciplinary teamwork within clinical governance to support other elements, such as Benchmarking and audit. A nurse at E-4 summarised that *"clinical governance makes you work together"*. Additionally, staff at E-2 included integrated care-pathways in their understanding of clinical governance, which implied teamwork. Nobody at any of the organisations, however, mentioned external partnerships within their clinical governance understanding, as depicted in Figure 27 below.

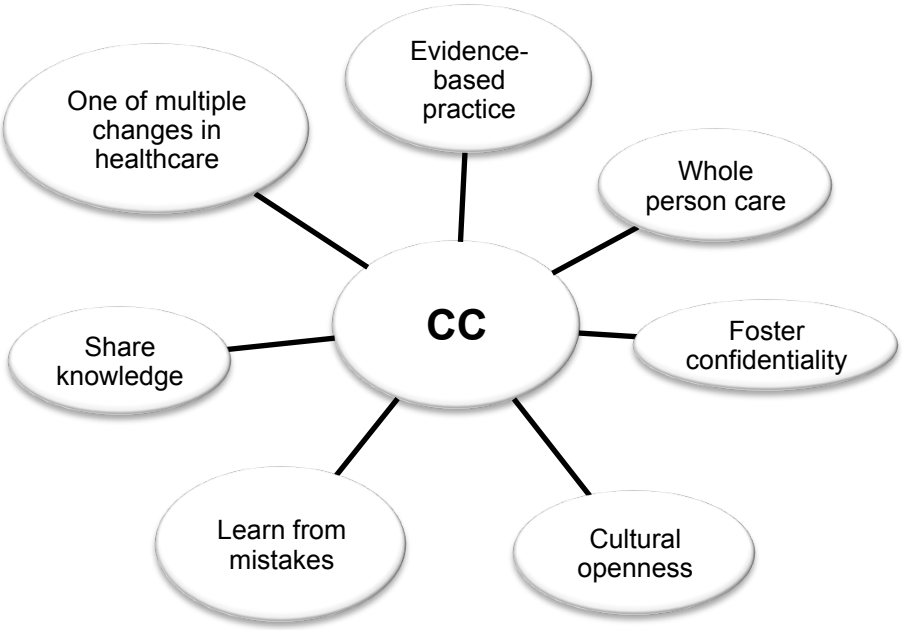
Figure 27: Staff Understanding (E) – Teamwork & Partnerships



Source: Appendix 23, pp. 416-419

Figure 28 below displays staff understanding of cultural changes. In the view of staff at E-2, E-3 and E-4, cultural changes through clinical governance resulted in more evidence-based practice, taking into account up-to-date research.

Figure 28: Staff Understanding (E) – Cultural Changes

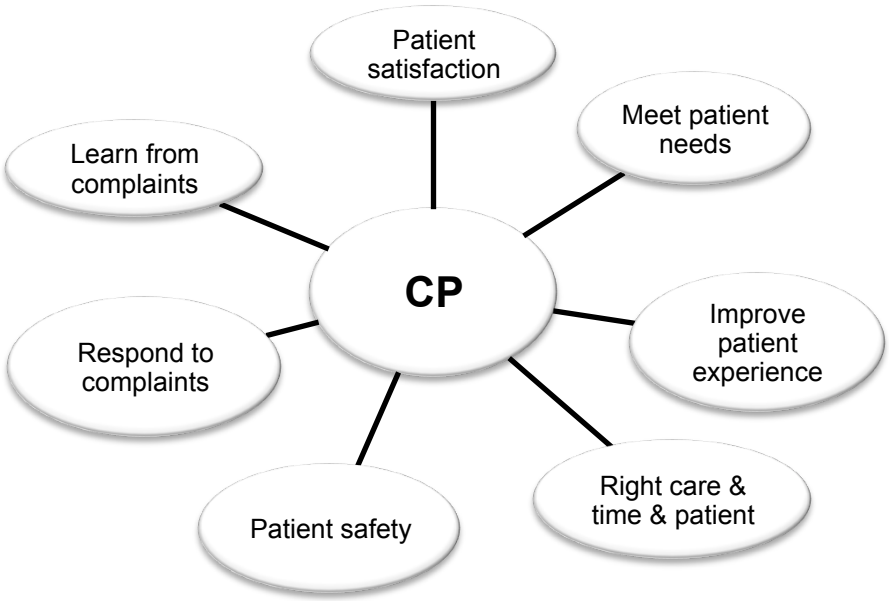


Source: Appendix 23, pp. 416-419

At E-1, however, staff saw clinical governance as an umbrella for whole person care, which fostered the concept of confidentiality. Further, staff at E-3 and E-4 understood a cultural openness to learn from mistakes and share this knowledge, as an important feature of clinical governance. Yet, staff at E-4 cautioned that clinical governance formed part of multiple changes in healthcare.

The idea of customer priority found a similar appreciation in the understanding of clinical governance, as depicted in Figure 29 below. Staff agreed on patient satisfaction by meeting their needs, improving the patient experience and providing the right care at the right time to the right patient. At E-2 and E-3, staff added patient safety. Staff at E-3 further developed these ideas to responding to and learning from complaints.

Figure 29: Staff Understanding (E) – Customer Priority



Source: Appendix 23, pp. 416-419

The staff understanding of customer priority reflected the problematic customer definition in healthcare, as discussed in the academic background[76]. Staff generally agreed on the patients as their main customers who should be at the heart of the service. Table 37 below provides more detail about the different views. M stands for management, C for consultants, N for nursing care, T for therapists and S for support staff. E-1 is abbreviated to 1, E-2 to 2 and so on.

Table 37: Customer Definition (E)

	M	C	N	T	S
Patients	✓	✓	✓	✓	1, 2, 4
Relatives, families, friends	1	1, 2	2, 3, 4	1, 4	1, 2
Commissioners	1, 4	3		3	
External partners	1		1	1, 3	
Everybody walking through front door or phoning	2, 3		3	2	

Source: Appendix 25, pp. 436-439

[76] See Section 2.2.4. The customer definition was originally grouped as an issue. Therefore, it is included in the related interview tables in Appendix 25.

As summarised in Table 38 below, only the clinical governance manager at E-1 and the support staff at E-2 did not like the customer concept as such, because it was seen as being cold and not adequate for the human aspects of care.

Table 38: Disagreement with Customer Concept (E)

	M	C	N	T	S
E-1	✓				
E-2					✓
E-3					
E-4					

Source: Appendix 25, pp. 436-439

In general, many staff (nurses and support staff at E-1; clinical governance manager, nurses and therapists at E-2; consultants and nurses at E-3) agreed that they themselves or their colleagues lacked understanding about clinical governance. A therapist at E-3 cautioned that people had not understood clinical governance at the beginning and that *"managers did it"*, while he thought that, in the meantime, understanding had become more mainstream. A chaplain at E-2 supported this, admitting that his comments could reflect a lack of knowledge, with regard to clinical governance.

Further, the clinical governance manager at E-2 also remembered that he was not aware of clinical governance when it had been initially introduced on the ward he had worked at the time. He, then, cautioned that many nurses still did not understand the related ideas and were not aware of the overall concept. Yet, the clinical governance manager and nurses at E-2 as well as the therapists at E-4 concurred that staff understanding of clinical governance increased with seniority. The nursing staff at E-1, the clinical governance manager at E-3 and the consultants at E-4 maintained that understanding had been easier with the seven pillars model.

From the managerial point of view, the situation at E-1 was similar – the clinical governance manager in stroke care cautioned that staff might not

always understand the "*big picture"* of clinical governance, even though they should know their related responsibilities. More pointedly, the general manager for elderly care identified different understandings of clinical governance among staff as a problem and promoted the *"need to take the big perspective"*.

In contrast to this, the clinical governance manager at E-4 opined that students learnt about clinical governance during their professional training. In theory, he explained, it did not mean much to them, but in practice they would understand. Finally, the clinical governance manager at E-3 did not perceive major issues in staff understanding of clinical governance and thought: it *"supplies the conscience of the organisation"* to challenge practice.

In spite of this dissent, staff from most organisations showed a general understanding of clinical governance. This is consistent with the findings from the documentary analysis of the vision and mission statements as well as the quality accounts.

6.3 Perceived Effects

The following analysis of the effects of clinical governance, as perceived by staff at their organisation, is based on the word tables, attached in Appendix 24. Most of the responses related to improvement, teamwork including partnerships and customer priority. Only the consultants at E-2 mentioned, with regard to cultural changes, that there was more openness to recording and reporting accidents (e.g. falls or administration of the wrong drugs) to the organisation and to the patient – clinical governance had fostered the assessment and accountability of clinicians for mistakes via risk management. In terms of involvement, the clinical governance manager at E-3 stated that clinical governance gave staff a framework to work within, which ensured staff had the right skills, knowledge and competences to do their jobs – sharing best practice online through the NHS Institute also gave staff more confidence. Further, he hoped that clinical governance increased job satisfaction – if staff understood what and why they did it, they would do it better and more would get done.

With regard to general improvements resulting from clinical governance, the managers shared similar viewpoints. The clinical governance managers at E-1 and E-3 thought that clinical governance ensured evidence-based practice and at E-2 the manager expected clinical governance to improve efficiency, transparency and openness. In his experience, clinical governance had helped the improvement of these aspects, but not in isolation. The clinical governance manager at E-3 agreed on the increased transparency thanks to quality measures, which were published by the foundation trusts. He saw staff at the heart of efficiency gains and believed that genuine improvements and safer quality services cost less, as they reduced MRSA[77], re-admissions and pharmaceutical errors. This, in turn, reduced the administrative burden and in his view clinical governance was needed.

The clinical governance manager at E-4 as well as the general manager for elderly medicine and the patient safety manager at E-3 supported this. However, the patient safety manager cautioned that, by preventing negative outcomes, there was nothing to be measured – only historical Benchmarking was possible. This, however, made it difficult to cost efficiency gains, in his view. Further, he stated critically that clinical governance increased the workload of staff, for instance, through unnecessary additional paperwork. This was required, he explained, for external assurance or formal reports, where internally an email would be enough. The clinical governance manager at E-3 also held a critical view about additional costs, resulting from the different regulatory bodies overseeing quality issues in the NHS. In his view, this offset savings achieved with quality improvements. Finally, the clinical governance manager at E-4 added that clinical governance had become an embedded part of practice – elements of it had been there before, they were just more formalised with the increased government attention to the subject.

The consultants at E-1 did not reflect on the link between clinical governance and improvement. The consultants at the other three

[77] MRSA stands for multi-resistant staphylococcus-aureus. It is a bacteria infection, which patients might acquire at hospital. It is resistant to most medication and very difficult to treat.

organisations agreed that clinical governance was needed – the consultants at E-4 directly linked clinical governance and improvement stating: *"clinical governance is all about improvement and it does happen"*. Further, the consultants at E-2 and E-4 were convinced that clinical governance had increased staff awareness about safety issues and risk management – they had become more used to questioning themselves and their practice.

In contrast to this, the consultants at E-2 considered more negatively that more documentation increased the workload. Yet, they still thought, it had changed the face of medicine in the UK for the better, while it was missing abroad, as seen during their charitable work, usually in Africa. The consultants at E-3 supported this – they had heard *"horror stories"* from the past and clinical governance seemed to have made a difference. Further, they explained that clinical governance formed part of the general trend in the NHS to cut costs, reduce investigations and achieve a maximum effective use of scarce resources.

Nurses at E-2, E-3 and E-4 explicitly shared the view that clinical governance was needed. In contrast to this, the nursing staff at E-1 were not sure whether it was good or bad to have *"loads of paperwork"* and more managers with clinical governance than in the past. Nonetheless, they agreed that clinical governance, as a framework, made their work more ordered, efficient and organised to support evidence-based care with more clearly defined responsibilities, especially in terms of risk management.

The consultants at E-2 and E-4 as well as nursing staff at E-3 and E-4 also underlined the importance of time-consuming risk management within clinical governance. They explained this with a higher fear of litigation. Further, nursing staff at E-2, E-3 and E-4 agreed that new clinical governance protocols made their job more consistent and transparent.

The views on paperwork, documentation and impact on workload differed. At E-2, the nursing staff maintained that documentation was user-

friendlier. On the surface it might seem, as though this part of clinical governance in particular had an impact on the workload. But, they explained, paperwork was the first thing that was not done when it was busy on the wards. Nonetheless, they added, staff still knew they had to be accountable for what they did. Another nurse at E-2, however, did not realise any difference.

More pointedly, nursing staff at E-4 confirmed that documentation took time, whereas they were not sure if the workload had changed because of clinical governance or for other reasons, such as reduced staffing levels. The modern matron[78] at E-3 more clearly linked clinical governance to an increase in workload, but did not perceive this as a problem – clinical governance helped to focus on the essentials. However, other nursing staff at E-3 cautioned that clinical governance put strain on time management when managers who did not understand the daily routine on the wards defined – in the nurses' view – odd priorities for audits.

Nursing staff at E-2 were convinced that quality of care had improved, was more evidence-based and service provision was more accountable. As a lot of Trusts only paid 'lip service' to clinical governance, they were not sure if the improvement had been triggered by clinical governance or by public and managerial pressures. In contrast to this, nursing staff at E-3 and E-4 directly related clinical governance with the pursuit of improvement and highlighted the importance of audit in this regard. According to them, clinical governance had put the focus on evidence-based care. Further, they agreed that clinical governance had clarified for staff, what they were measured against, and had also changed staff education to be more academic.

The therapists at different organisations picked up most of the ideas addressed by the nursing staff. At E-1 and E-2, they explained how responsibilities were defined more clearly, especially in terms of risk management, and how this helped to protect from litigation. In the view of

[78] Modern matron is the expression used for this person's position and does not have anything to do with the modern matron being a modern person or not.

the therapists at E-1 and E-3, staff knew better what was expected from them.

Increased documentation and structure at E-1 and E-4 were seen to make the organisation work with more focus, accountability, goal orientation and system thinking. The therapists at E-2, E-3 and E-4 agreed with the nursing staff that clinical governance was needed for these reasons. Yet, the therapists at E-4 cautioned that since clinical governance was everywhere it was difficult, in their view, to compare how it would be without it.

Further, the therapists at E-2 and E-4 saw a positive effect of clinical governance in improved learning from mistakes and staff development in general to embrace improvement and evidence-based practice. The therapists at E-3 added that clinical governance provided consistency within and between organisations nationally, e.g. in terms of infection control. Unlike the consultants and nursing staff, they would expect clinical governance to reduce the workload. But this had not happened, they explained, as it also depended on the number of patients that came in and on staffing levels.

Finally, the therapists at E-1 limited the positive improvement effects of clinical governance, saying that most of the projects and guidelines were common sense and reflected practices they had adopted anyway. Table 39 below summarises the perceived effects on improvement.

Table 39: Perceived Effects (E) – Improvement

IMPROVEMENT	M	C	N	T	S
CG is needed	3	2, 3, 4	2, 3, 4	2, 3, 4	4
CG had already been embedded into practice, more formalised now	4		1	1	
Impact on workload					
Higher with CG	3	2, 4	1, 3	1, 4	
Not sure			2, 3, 4		4
Expected decrease, but still the same				3	
Paperwork as good opportunity for learning					1
Increase in					
Clarity of responsibilities			1	1, 2	
Awareness of safety, risk		2, 4	1, 3, 4		
Evidence-based practice	1, 3		✓	2, 4	
Accountability			2	1, 4	
Efficiency	2, 3	3	1		
Openness	2				
Transparency	2, 3, 4		2, 3, 4	3	
Structure			1	1, 4	

Source: Appendix 24, pp. 420-422

Support staff at E-3 did not perceive any effects of clinical governance on improvement. The opinions of support staff at the other organisations largely supported ideas, brought to the fore by the other staff groups. At E-1, they held a positive opinion about increased documentation resulting from clinical governance, as it helped to learn from mistakes by root-cause analysis, offered an opportunity for training and protected from litigation. The support staff at E-2 agreed with this and added that new patient information leaflets and a new ICT website represented a good start for

tangible improvements. In contrast to this, the support staff at E-4 did not see an impact of clinical governance on their job, but accepted that clinical governance was needed to increase the awareness among staff about the nature of good services and how to improve them.

In terms of teamwork and partnerships, the clinical governance managers across the organisations, apart from E-2, agreed that stroke and elderly patients in general required teamwork, independently of clinical governance. Further, the managers at E-1 and E-3 explained how they had developed good partnerships with clinicians to address clinical governance issues, such as patient safety or audit, so that the clinicians were less burdened with administrative tasks and could fully focus on their clinical work. The clinical governance manager at E-4 had experienced good results from audits, such as more information sharing among staff.

The consultants largely agreed with these opinions. In their view, teamwork on their wards worked well, but this was probably independent of formal structures, such as clinical governance, and depended more on local personalities and the clinical speciality.

The nursing staff across all organisations supported the idea that stroke required teamwork and, therefore, staff on their wards worked well together as a team. In contrast to the other professional groups, they added that clinical governance also played a part in supporting teamwork, particularly by increasing communication within these teams and helping them to work more efficiently to clarified standards. The modern matron at E-3, however, cautioned that local line management structures did not support integrated working.

The therapists agreed that the team on their wards worked well together to the common goal of providing good patient service. In the view of the therapists at E-1, E-2 and E-3, stroke care *“lends itself more to”* teamwork, because of a complex patient group, which required medical, nursing and therapeutic care over a longer period of time. Clinical governance was seen to further support teamwork.

Finally, support staff at E-1 and E-4 confirmed the views of the other professional groups that the stroke team cooperated well and that this probably related to the speciality. The support staff at E-4 further explained that stroke care and prevention were high on the government agenda and that this high profile further fostered proactive teamwork in stroke. Table 40 below provides a summarised overview about perceived effects on teamwork including partnerships.

Table 40: Perceived Effects (E) – Teamwork & Partnerships

TEAMWORK and PARTNERSHIPS	M	C	N	T	S
Required by stroke patients	1, 3, 4	✓	✓	1, 2, 3	1, 4
Depends on personalities		✓			
Audit supports TW	1, 3, 4				
CG supports TW			✓	1, 2, 3	
CG improves team communication and clarifies standards			✓		
Reduced administrative burden for clinicians thanks to TW with admin.	1, 3				

Source: Appendix 24, pp. 424-425

With respect to customer priority, the clinical governance managers held diverging views. At E-1, the clinical governance manager recorded that more patients were treated per month and that clinical governance, as an holistic approach, encouraged the consideration of smaller issues, such as exemptions from parking fees for close relatives, if the patient had to stay in hospital for longer. The clinical governance managers at E-2, E-3 and E-4 agreed that clinical governance ensured safer service provision for the patients, based on adequately trained staff, Benchmarking of good practice, feedback and complaints management. The clinical governance manager at E-3, however, cautioned that the patients often did not know

about many improvements, as they did not see them or know that they existed (e.g. bedsores).

The consultants also did not agree on the impact of clinical governance on the patients. The consultants at E-1 held the most negative opinion stating: *"some things have changed and others not"*. They doubted that the overall quality of patient services had improved. Whenever a project or initiative was supposed to implement improvements for the patients, they explained, other unforeseen consequences interplayed to make things worse instead of improving them. As an example for this, they mentioned the reduction of working hours for junior doctors. This way they were supposedly fitter for work, but spent less time with the patients, thus learnt less from them and consistency became an issue because of more staff handovers.

In contrast to this, the consultants at E-2, E-3 and E-4 had experienced that patients benefited from clinical governance by receiving safer, more consistent, more patient-centred, better quality care. In agreement with the clinical governance manager at E-3, the consultants at E-4 cautioned that patients were usually not aware of the reduction or elimination of adverse outcomes. Finally, the consultants at E-2 and E-4 critically stated that clinical governance commitments, such as additional data collection or meetings, took time that would be better spent with the patients.

Overall, the nursing staff across the hospitals agreed with the consultants that patients benefited from clinical governance, as it ensured customer-focused, up-to-date, consistent care that met patient needs. Further, the nursing staff at E-2 and E-3 underlined the positive impact of clinical governance on patient complaints. The number of complaints had actually decreased, they added, and the patients were better informed about health services to know what to expect and how to make informed hospital choices. This supported the views of the clinical governance managers. In agreement with the clinical governance manager at E-3 and the consultants at E-4, the nursing staff at E-1 and E-2 cautioned that patients

did not actually see clinical governance as such and could not judge changes it identified to improve, for instance, therapeutic procedures.

Finally, nursing staff – similar to other staff groups – disagreed on the value of increased documentation for the patients, as also discussed under general improvements. Most positively, the nursing staff at E-3 were convinced that documentation protected patients from harm and staff from litigation. However, the nursing staff at E-2 cautioned that most people did not understand the importance of clinical governance. Therefore, they explained, it was the first thing they stopped doing, when it was busy on the wards. At E-1, the nursing staff most critically described that increased paperwork took staff away from *"being hands-on with patients"* and the focus had switched to *"getting everything right on paper rather than spending more time with the patients"*.

The therapists largely disagreed as to how clinical governance affected the patients. At E-1, they maintained – alongside the consultants at E-2 and E-4 as well as the nursing staff at their own organisation – that time-wise clinical governance required additional effort because of the associated meetings. They held an overall neutral opinion that some aspects had improved, while others had worsened, just as the consultants at their organisation. The therapists at E-4 supported the idea that clinical governance distracted from clinical work, while more positively thinking that overall the patients benefited from safer and better care.

This last point found the agreement of most other staff groups across the hospitals and the therapists at E-3. They cautioned, however, that it was hard to say, whether patients felt more satisfied. They received mixed responses. Clinical governance should change this, they suggested, by including the patient experience in service developments. The therapists at E-2 also mentioned the idea of patient experience, how they benefited from more consistent care and – alongside the nursing staff at E-3 – explained that clinical governance protected staff from litigation and ensured that patients received the best treatment.

The support staff espoused similarly diverse viewpoints about the link between clinical governance and customer priority. In accordance with the therapists at E-2 and E-3, the support staff at E-4 estimated cautiously that clinical governance had the potential to improve the patient experience of the hospital stay. The support staff at E-1 agreed with this, while cautioning that the journey was better but not necessarily the outcome.

Table 41: Perceived Effects (E) – Customer Priority

CUSTOMER PRIORITY	M	C	N	T	S
Less patient complaints			2, 3		
Hard to say if patients are more satisfied				3	
CG impacts on patient experience				2, 3	1, 4
Patients don't see improvements	3	4	1, 2		
CG protects staff from patient litigation			3	2	
Beneficial for patient					
Better informed	2, 3		2, 3		1, 2
Needs are met			✓		
Safer	2, 3, 4	2, 3, 4	✓	2, 3, 4	
Customer-focused care		2, 3, 4	✓		
More consistent		2, 3, 4	✓	2	
Negative for patient					
CG distracts from patients, time would be better spent with patients		2, 4	1	1, 4	
Question quality improvement		1		1	

Source: Appendix 24, pp. 426-428

Further, the support staff at E-2 stated critically that there was more information for patients about the hospital, but that these leaflets were not displayed properly so that patients were not always aware. At E-1, the

support staff explained more positively that better communication between staff and patients, thanks to clinical governance, empowered the latter to understand and form part of the decision-making for their healing process. Table 41 above summarises the perceived effects around customer priority.

In summary, staff across the organisations agreed on the area of effects, resulting from clinical governance, i.e. general improvement, teamwork including partnerships and customer priority. However, there was no agreement as to whether this effect was positive, negative or neutral.

6.4 Perceived Issues

The analysis of issues that staff perceived at their organisation with regard to clinical governance is based on the word tables, attached in Appendix 25. Staff did not perceive any issues around improvements. Improvement seems to be the analytical category that was best understood during the interviews. Staff mentioned a variety of different improvement aspects in their clinical governance understanding. The majority of perceived effects, relating to improvement, were positive. Further research should investigate why staff did not perceive any issues around improvements[79].

In terms of leadership in relation to clinical governance, staff at all organisations identified different issues, as summarised in Table 42 below. The consultants at E-1 had the impression that the organisation was just trying to *"cover its backside and diffuse responsibility to others"* with documentation. For them, a good reason would be to protect the patients. But they were convinced that the real reason was to protect the government, the organisation and the managers – they criticised clinical governance for being *"used as a weapon to intimidate staff by asking unachievable things and transferring blame downwards to the coal face"*. The consultants at E-4 critically mentioned the role of the government and management to impose changes with regard to clinical governance.

[79] See Chapter 10.

Table 42: Perceived Issues (E) – Leadership

LEADERSHIP	M	C	N	T	S
Negative CG LS		1, 4	1, 3		
CG LS depends on personal interest, individual character, overall willingness	2		1, 3, 4	1, 2	1

Source: Appendix 25, pp. 429-430

In contrast to this, the clinical governance manager at E-2 was relieved that clinical governance was starting to receive more attention from the top again. The modern matron at E-3 criticised some quite senior managers for not taking clinical governance as seriously as they should. A nursing team-leader at E-1 detailed how the information flow about clinical governance depended on how the team leaders dealt with it – it was their choice to take their staff to meetings or at least inform them about the outcomes. However, he explained, there were no hierarchical motivations or incentives to participate and involve the team in clinical governance. Further, nurses, therapists and support staff at E-1, as well as the therapists at E-2 and the nurses at E-4, agreed that the impact of clinical governance depended on the personal interest, individual character and overall willingness of those leading clinical governance and in general managerial positions.

Staff across the organisations identified the largest number of issues under the category of involvement, as displayed in Table 43 below. The consultants at E-1, all staff groups at E-2, consultants and nurses at E-3 as well as the clinical governance manager, nurses and therapists at E-4 agreed that personal interest influenced the extent to which staff sought to be involved in clinical governance. Additionally, professional affiliation seemed to play a role. The support staff at E-2 and E-4 were not, or not a lot, involved in clinical governance. They explained this with the fact that it was not a common concept in their field and they also lacked interest to pursue more involvement.

Table 43: Perceived Issues (E) – Involvement

INVOLVEMENT	M	C	N	T	S
Depends on personal interest	2, 4	1, 2, 3	2, 3, 4	2, 4	2
'Them versus us' between staff and CG			2, 3	3	2
Professions have different mind-sets that influence INV			2	2, 3, 4	
S not much involved					2, 4
N more involved			2, 3		
C worst for using standards of care		3	2, 3	3	
C and N lead CG		4			
T get forgotten				3	
T have more time for CG			4	2	
CG engrained in work		2, 3, 4	2, 3, 4	2, 4	
CG competes with other priorities	3	4	4		
Communication about CG is not consistent or missing entirely			1, 2	2	
Never trained in CG		3, 4	✓	2, 3, 4	1, 2, 4

Source: Appendix 25, pp. 430-434

Further, the nursing staff at E-3 explained more involvement in and awareness of clinical governance among nurses with the fact that it took up a larger part of training for nurses than for the other professions. Therapists at E-3 explained that the professions had unique mind-sets and clinical governance did not fit in with all of them. Nursing staff at E-2 agreed that clinical governance and quality management standards had a longer tradition in nursing and that academic training helped them to take on board concepts, such as clinical governance, whereas accountability was a less common concept among nurses. In general, nurses at E-3 supported the idea that university training of nurses facilitated the academic understanding of clinical governance and the need for evidence-

based practice within it, even though nursing staff often found it boring and dry and they questioned the balance between practical and intellectual skills.

In the view of the nursing staff at E-2, consultants least adhered to standards of care. The consultants, nurses and therapists at E-3 agreed with this point. Yet, the therapists at E-3 added that therapists tended to get forgotten in clinical governance, they had pushed for integration and involvement of the therapy services at their organisation. In contrast to this, the consultants at E-4 highlighted the fact that clinical governance was medically led by consultants and nurses, even though the latter found it difficult to come to meetings due to shift work and a lack of understanding. The nurses at E-4 confirmed this, saying that the therapists had more time for clinical governance than they had. The therapists at E-2 agreed that consultants and nurses probably had less time for clinical governance related activities and were also taught with a different mind-set. Further, the therapists at E-4 thought that therapists seemed to be quite good at CPD and continuous improvement, as their *"university training really focused on all of this"*.

The consultants, nurses and therapists at E-2, consultants and nurses at E-3 as well as the consultants, nurses and therapists at E-4 showed agreement about how engrained clinical governance had become in their work via, for instance, clinical audit activities. However, the consultants and nurses at E-4 also cautioned that clinical governance activities competed with other tasks, such as dealing with the patient, which were more important. More negatively, the clinical governance manager at E-3 explained critically that staff experienced the challenge of integrating clinical governance as an add-on to their daily activities.

In spite of this integration of clinical governance into daily activities, nursing staff at E-1, the therapists and nurses at E-2 complained that communication about clinical governance was not consistent or missing entirely. Further, nurses and support staff at E-1, nurses, therapists and support staff at E-2, consultants, nurses and therapists at E-3 as well as

consultants, nurses, therapists and support staff at E-4 complained that they had never been formally trained about clinical governance as a whole concept – training was usually more focused on sub-aspects, e.g. specific patient safety procedures. Nonetheless, the support staff at E-4 positively appreciated that training was not just for consultants and managers but for all. Further, the clinical governance manager at E-2 explained that staff did not extensively take up the training offered online.

In relation to staff lacking understanding of clinical governance, the stroke nurse specialist at E-2 explained the 'them versus us' phenomenon – having a separate department for clinical governance, staff on the ward invariably perceived it as something that someone else did rather than everybody's responsibility. This was supported by the support staff at E-2 when they wondered *"what clinical governance is doing, who they are"*, by the nursing staff at E-3 when they said *"they (clinical governance) are visible, attend meetings to support projects and make sure guidelines are met"*, by the therapists at E-3 when they said *"at the beginning managers did it and there was no understanding among staff about it"*.

Teamwork did not seem to represent an issue overall. However, the clinical governance manager at E-1 cautioned that no nurse representation formed part of the World Stroke Organisation[80]. In his view, this might allude to a lower appreciation of nurses in the field. Further, the clinical governance manager at E-3 explained that the relationship between consultants and the other professional groups used to be difficult and that this was changing for the better with the younger generation of consultants. He thought that it helped that other professional groups also had academic degrees – but hands-on training should not fall short. Table 44 below summarises the perceived issues around teamwork including partnerships.

[80] See World Stroke Organisation (2009).

Table 44: Perceived Issues (E) – Teamwork & Partnerships

TEAMWORK and PARTNERSHIPS	M	C	N	T	S
TW is difficult for and with C	3	3			1, 2
Younger generation of C better for TW	3	4			
C are too arrogant					1, 2
S not accepted as equal part of the team					1, 2

Source: Appendix 25, pp. 434-435

The consultants at E-4 agreed that there were no strong negative doctor characters any longer. The consultants at E-3 explained that, for consultants, teamwork was more difficult to develop because they moved on quickly, while nurses stayed in one place for longer. Nonetheless, support staff at E-1 and E-2 criticised consultants, as they often still behaved *"as though they were being God"*. In their view, support staff were not accepted as an equally important part of the team within clinical governance. Further, nurses at E-3 critically pointed out that nurses sometimes developed a similarly arrogant attitude towards healthcare support workers.

In terms of cultural changes, many members of staff across the organisations, as summarised in Table 45 below, agreed that the rate of change in the NHS was too high and this resulted in clinical governance being seen as *"just another initiative"*, said the clinical governance manager at E-1. Improvements were seen to lack sustainability. This speed of change caused resistance. The clinical governance manager at E-2 summarised a common attitude towards change with this question: *"why should we change if it was always done like this?"* The therapists at E-2 confirmed that people did not like change.

Table 45: Perceived Issues (E) – Cultural Changes

CULTURAL CHANGES	M	C	N	T	S
Too many changes in the NHS	✓	2	1		1
Resistance to change	2, 3			2	
No real, sustainable changes	1, 3		4		

Source: Appendix 25, pp. 435-436

The clinical governance manager at E-3 agreed with this and further developed: consultants and the ethos of their profession that 'they know better' made it difficult to move to a learning organisation with a 'no-blame' culture. This was further aggravated by the fact that clinical governance was often not recognised as a benefit but rather was seen as a burden – occasionally even by the chief executives – and staff turnover made it difficult to achieve permanent sustainable change.

The nursing staff at E-4 also addressed the latter point. They stated that clinical governance could look OK on paper without any changes on the ward. In their view, it turned into a 'ticking boxes' exercise, which was dropped when people were dying on the ward. However, the nurses at E-2 were convinced that clinical governance was *"here to stay"*, as it had been around for ten years.

The nursing staff at E-3 explained that older person care required different skills, such as effective communication with both patients and relatives, calming agitated patients and having empathy. They further described the different mind-set in elderly care to appreciate small glimpses of hope for patient improvements. This was different for staff who had chosen to work with the elderly. The support staff at E-4 added that privacy and dignity were important in dealing with patients and patient data. Across the organisations, there was no agreement if elderly or older persons' care was the more adequate terminology, while staff agreed that geriatric carried a negative, too medically orientated connotation.

In general, staff across the organisations had a lot to say about issues around customer priority. Table 46 below summarises these views. Most members of staff across the organisations concurred that external financial pressures and scarce resources made it difficult to focus on clinical governance and to realise the benefits it could have for the patients.

Table 46: Perceived Issues (E) – Customer Priority

CUSTOMER PRIORITY	M	C	N	T	S
Scarce resources	✓	2, 4	1, 3, 4	1, 4	1, 2, 4
Elevated public expectations	1, 2, 3				
University training is not hands-on enough			2, 4		

Source: Appendix 25, pp. 436-439

The clinical governance manager at E-1 cautioned that elevated public expectations caused more expenses. This aggravated the situation even further. Patient expectations, explained the clinical governance manager at E-3, were very high because of increased information availability via the Internet. The clinical governance manager at E-2 stated more directly that Internet literacy caused the problem of too high patient expectations and that patients had to understand that they had responsibilities in addition to their rights, especially with regard to substance abuse or teenage pregnancies. This reflects the earlier discussion of individual and collective perspectives of health and quality of life[81].

The nursing staff at E-4 created a link between scarce resources and nursing training: university training for nurses was very academic and they needed to learn the practical skills on the wards. However, the nurses on the wards were very busy and did not have time to carry out this practical training. The nursing staff at E-2 stated critically that nursing training needed to focus more on the patients.

[81] See Section 2.1.3.

In summary, staff across the organisations mentioned issues under all analytical categories, apart from improvement. The main agreement focused on involvement issues, the rate of change within the NHS and scarcity of resources, which prevented the realisation of customer priority within clinical governance.

6.5 Perceived 'Valued' Practice and Lessons-Learned

The analysis of 'valued' practice and lessons-learned, as perceived by staff at their organisations, is based on the word tables, attached in Appendix 26.

Very few clinical staff across the organisations, apart from E-2, identified 'valued' practice and lessons-learned with regard to improvement. The therapists at E-1 thought that responding to local needs was key to the agenda for improvement and quality. The support staff at the same organisation explained that specialised committees and groups, such as clinical services support or patient experience, fed ideas for improvement into the overall clinical governance structure, so that improvement happened not only in the core medical services.

At E-3, the consultants praised the Sentinel Stroke Audit as a great tool to review quality over time. Further, the modern matron at the same organisation appreciated that, within the local clinical governance structures, there was a lot of information about very low infection rates and falls. Finally, the consultants at E-4 acknowledged the simplified access to knowledge and journals to stay up-to-date. Nursing staff at the same organisation were impressed by the simplified documentation structure (i.e. make a dot next to the right answer), which just focused on key things, e.g. changing a catheter. Table 47 below provides an overview of 'valued' practice around improvement.

Table 47: 'Valued' Practice (E) – Improvement

IMPROVEMENT	M	C	N	T	S
Respond to local needs				1	
Specialised sub-committees					1
Sentinel stroke audit is a great tool		3			
Low infection rates			3		
Easier to stay up-to-date		4			
Simple structures for documentation			4		

Source: Appendix 26, p. 440

In terms of leadership, the clinical governance managers at E-3 and E-4 advised to prioritise the most important risks and address them within clinical governance. These could be some of the tangible actions, the clinical governance manager at E-1 suggested to be taken from meetings. The clinical governance manager at E-2 and the therapists at E-3 joined him to underline the positive effects of managerial presence throughout the organisation, as summarised in Table 48 below.

Table 48: 'Valued' Practice (E) – Leadership

LEADERSHIP	M	C	N	T	S
Prioritise	3, 4				
Managerial presence throughout the organisation	1, 2			3	
Lead by example	1, 2				
Clinical background is helpful	1, 2, 3				
Top management commitment	1, 3			1	

Source: Appendix 26, pp. 440-441

The clinical governance managers at E-1 and E-2 further explained that leading by example and being passionate about clinical governance resulted in respect from staff. This respect and credibility was seen to be enhanced, if the managers were from a clinical background and knew what they were speaking about. The clinical governance manager at E-3 agreed with this, but also thought that a non-clinical background did not pose a problem with staff, rather with other managers with a clinical background. The consultants at E-4 confirmed this – they expected a strong and strict leader no matter from which background. Finally, the therapists at E-1, the clinical governance and other managers at E-1 and E-3 agreed that top management needed to support clinical governance.

Different staff groups across the organisations contributed different aspects of 'valued' practice and lessons-learned to involvement, which are displayed in Table 49 below. The clinical governance and another manager at E-1, the clinical governance managers at E-2 and E-3 highlighted the need to inter-professionally involve everybody, communicate enthusiastically about clinical governance and explain in detail why they pursued projects in a certain way.

Table 49: 'Valued' Practice (E) – Involvement

INVOLVEMENT	M	C	N	T	S
Inter-professionally involve all	1, 2, 3				
Communicate enthusiastically	1, 2, 3				
Explain what CG means for each job	1				1
Training supports INV	2, 3		3	2, 4	

Source: Appendix 26, pp. 442-443

The clinical governance manager at E-1 further advised the use of a language, adequate for the clinical professionals, and to ensure that everybody understood what clinical governance meant for their job. This latter point was confirmed by the support staff at E-1, who added incentives, such as positive feedback from leaders in the clinical

governance report, to motivate staff, foster the spirit of improvement and clinical governance. In the view of the therapists at E-1, the will to develop improvements existed already.

The nursing staff at E-3 added that the comments book for patients and relatives provided positive, and not only negative, feedback to increase staff morale. Additionally, the clinical governance managers at E-2 and E-3 focused on the role of training to involve staff in clinical governance – it raised awareness and showed staff the benefits of clinical governance. The therapists at E-2 supported the importance of training – they accepted clinical governance, as they had been trained with this mind-set at university. Further, the nursing staff at E-3 positively appreciated the induction at the hospital that also included clinical governance aspects. The therapists at E-4 also responded positively to the general training at their organisation.

The clinical governance manager at E-3 ensured that staff owned and wrote the strategies for which they were responsible. The nursing staff at E-2 sort of agreed with this stating that it was better to be involved in clinical governance and to think-through than to be surprised and confronted with new issues. In terms of staff differences in involvement, the clinical governance manager at E-2 had positive experiences with the local consultants – they chaired most subcommittees – whereas the clinical governance manager at E-3 saw clinical governance as providing good mechanisms to challenge consultants. The consultants at E-2 gave the general advice that clinical governance meetings could be short and frequent or longer and infrequent, as long as they were focused. Finally, the therapists at E-4 explained how the projects were divided into different groups that shared the results of their work every two months. One of the therapists attended Trust board meetings and communicated the results to the team.

Not many members of staff across the organisation identified ‘valued’ practice or lessons-learned about teamwork and partnerships, as depicted in Table 50 below. This could be because, as the consultants at E-2

explained, the concept of multidisciplinary teams had become embraced in more fields. The therapists at E-4 showed empathy with nurses about their working hours including night shifts. Further, a nurse at E-2 thought that nurses received more respect from the other professions thanks to having a degree, which gave them more credibility and a better standing amongst the team.

Table 50: 'Valued' Practice (E) – Teamwork & Partnerships

TEAMWORK and PARTNERSHIPS	M	C	N	T	S
Respectful communication within the teams		3	1		
Degree improves respect for N			2		
Non-clinical staff also important in team	3				
TW is embraced		2			

Source: Appendix 26, p. 443

In order for teamwork to succeed the nursing staff at E-1 underlined the need for a common language between consultants and nurses – but as long as they were *"not talked down to"*, this did not represent a major concern. The consultants at E-3 picked up on communication within the team – it was important to communicate. Even though it was impossible to agree all the time, they said, the members should always try to move forward as a team, sharing the value of patient safety. Further, they explained that, on their ward, a new set of twenty minute meetings on Mondays and Wednesdays, involving all the disciplines, helped to treat patients more efficiently, as the team members were aware of potential problems almost in real-time. Finally, the clinical governance manager at E-3 highlighted the important role of non-clinical staff in teamwork – as managers they tried to balance all administrative tasks, so that clinicians could focus on their job. He always aimed to plan for an adequate staff balance on the wards, taking into account the need to do more with less due to scarce resources. In addition to this, he developed training

programmes in human factors to overcome hierarchical barriers to further support multidisciplinary teamwork.

With regard to cultural changes to facilitate clinical governance, various staff across the organisations, as summarised in Table 51 below, agreed that they had a good local culture, which supported development, learning from mistakes in a 'no-blame' environment.

Table 51: 'Valued' Practice (E) – Cultural Changes

CULTURAL CHANGES	M	C	N	T	S
Local 'no-blame' culture	3	4	1, 4	2	1
Address resistance					
Proceed incrementally	1				
Show that CG is already done				2	
Make staff believe, the change was their idea	3				
Show how change makes things easier	3				
Facilitate change with enthusiastic staff	2, 3				
Pull 'regulatory card'	3				

Source: Appendix 26, p. 444

Similarly, the consultants at E-3 understood that clinical governance changed the structures. This changing, they explained, was embraced in their culture, as staff were willing to change.

In terms of overcoming resistance to change, the clinical governance manager at E-1 suggested proceeding incrementally, instead of trying to solve everything at once and, as a manager, not to take resistance personally. Further, the therapists at E-2 advised taking fear away by showing staff that they were already doing clinical governance. The clinical

governance manager at E-3 developed this idea further to introduce change in a way that staff thought it was their idea and demonstrate how the change would make things easier for them. For instance, nursing staff initially resisted ICT. But as it was easier to print wristbands and stickers, instead of handwriting them, they embraced the change. Both the clinical governance manager at E-2 and E-3 agreed on working with enthusiastic staff to facilitate and drive change. If this did not show any effect, however, the clinical governance manager at E-3 pulled the 'regulatory card', saying that they had to do it or they would get in trouble externally.

Only two groups of staff highlighted 'valued' practice and lessons-learned with regard to customer priority. The consultants at E-2 appreciated the FAST stroke initiative to increase public awareness about stroke, its symptoms and facilitate immediate treatment. The patient safety manager at E-3 understood the need for formal structures to keep quality and clinical governance on the agenda also in times of financial difficulty.

In summary, different members of staff contributed lessons-learned and 'valued' practice in dealing with clinical governance – in particular for improvement, leadership, involvement, teamwork including partnerships and cultural changes but hardly anything about customer priority.

6.6 Suggested Improvements

The analysis of improvements that staff suggested about clinical governance at their organisation is based on the word tables, attached in Appendix 27.

In terms of improvement, therapists at E-2 maintained that they were always possible. More concretely, the support staff at E-2 would like for their work to be measured with a qualitative tool, taking into account the number of voluntary supporters to help improve what they did. This found the agreement of the clinical governance manager at E-2. The nursing staff at E-4 developed more detail about management, measuring and targets, which had to be met. For instance, they accepted the importance of raising awareness and highlighted the need for hand hygiene. In their

view, a meaningful measurement would be the development of MRSA cases, not 'ticking boxes' if staff had washed their hands.

Further, the clinical governance manager at E-1 and the consultants at E-4 agreed on Benchmarking as an area for improvements. The consultants thought that every speciality should have a tool comparable to the National Sentinel Stroke Audit, while the clinical governance manager suggested changing the collection of comparable process and outcome data from provider to commissioners, as they were seen to be more neutral.

Table 52: Suggested Improvements (E) – Improvement

IMPROVEMENT	M	C	N	T	S
Always possible				2	
More qualitative measurements	2				2
Revise measurements			4		
Revise and extend Benchmarking	1	4			
Improve record-keeping	2				
Consolidate paperwork	3	4			
Simplify language in documentation					1

Source: Appendix 27, pp. 446-447

Finally, various staff mentioned improvements for documentation, as summarised in Table 52 above. On the one hand, the clinical governance manager at E-2 demanded that record keeping had to improve. On the other hand, the clinical governance manager at E-3 and the consultants at E-4 saw a need to consolidate paperwork. The support staff at E-1 suggested simplifying the language of some of the documentation.

With regard to leadership, staff addressed areas for improvements at three levels – the national, the top management and the ward management level. Table 53 below summarises the suggested improvements.

Table 53: Suggested Improvements (E) – Leadership

LEADERSHIP	M	C	N	T	S
Nationally					
Too politicised		1			
Less regulatory bodies	3		3		
Make CG less jargonistic			2		
Top management					
True CG commitment	2, 3				
On the wards					
Initiatives should be thought through and prioritised		1, 4			
Managers should also work on the wards			3	2	
Make CG more tangible and relevant		2	2		
Give more positive feedback			3		
CG lead as main job			4		

Source: Appendix 27, pp. 447-448

At the national level, the consultants at E-1 stated critically that there was too much DoH information about clinical governance, the topic was too politicised and the nursing staff at E-3 would have liked for clinical governance to be more local with less regulatory bodies. The clinical governance manager at E-3 agreed with this. Nursing staff at E-2 added that clinical governance needed to be less jargonistic. Further, the consultants at E-2 demanded the government to say not just what, but also how and when to do it.

At the top management level, the clinical governance managers at E-2 and E-3 agreed that the organisations had to get back to the quality agenda with true commitment by top management. This should be shown, in the view of the clinical governance manager at E-3, by ‘walk rounds’

throughout the hospital including non-clinical areas and concrete action-plans should implement the change.

At the ward management level, the consultants at E-1 criticised the initiatives for not being thought-through and consultants at E-4 doubted that too many, un-prioritised initiatives really helped. Accordingly, the therapists at E-2 and nursing staff at E-3 suggested that managers *"get their hands dirty on the ward"*, so that they would better understand the business. The consultants at E-2 agreed with the nurses that managers needed to make clinical governance more tangible and relevant for staff. Nursing staff at E-3 added that managers did not provide enough positive feedback to staff. Finally, nursing staff at E-4 recommended that leading clinical governance should be a main job not just an additional function.

As depicted in Table 54 below, most staff across the organisations who suggested improvements for involvement focused on training about clinical governance and why it was needed.

Table 54: Suggested Improvements (E) – Involvement

INVOLVEMENT	M	C	N	T	S
Train to inform about CG, the need for it	2, 3	2, 3	✓	2, 4	2
Adapt the language used to communicate about CG	3		2, 3	2	
More coherent communication about CG to all			1, 2, 4	3	1
Make CG tangible for staff	3		2		
CG staff "*live in another world"* and should seek more involvement		1	1, 3	2	

Source: Appendix 27, pp. 448-450

Therapists at E-2 and nursing staff at E-3 concurred that clinical governance included too many *"buzz-words"*, while the nursing staff at E-2 said clinical governance was a *"big word"*. Accordingly, the clinical governance manager at E-3 cautioned to watch the language used in dealing with clinical governance issues – quality and improvement was usually better understood by staff, as it was more tangible for them. The nursing staff at E-2 also asked for tangible examples to illustrate the training, but also recommended considering e-learning due to lack of time. Further, the support staff at E-2 suggested the inclusion of qualitative aspects in training.

The therapists at E-3 asked to also involve non-clinical staff, the therapists at E-1 missed investment in people at their organisation and the nursing staff at E-1 suggested incentives to involve lower levels of staff. Nursing staff at E-1, E-2 and E-4 as well as support staff at E-1 and therapists at E-3 would like to see more coherent communication about clinical governance projects to a broader public.

Finally, various staff alluded to the 'them versus us' problem. The nursing staff at E-2 would rather call it 'clinical governance support department', because otherwise staff did not see clinical governance as their own responsibility. Further, therapists at E-2, consultants and nursing staff at E-1 maintained that clinical governance staff seemed to be *"living in another world"*. Therefore, clinical governance managers should, as suggested by the nursing staff at E-3, seek more input from the wards to achieve a better balance.

Staff across the organisations, apart from E-2, contributed suggestions to improve teamwork in various senses, as summarised in Table 55 below. On the one hand, there was the teamwork between clinical and non-clinical staff. The clinical governance manager at E-3 suggested the development of teamwork at the managerial level with senior medical staff to move towards more strategic approaches of medical management. Further, the nursing staff at E-3 would like to see improved line

management structures to support teamwork for integrated service provision.

Table 55: Suggested Improvements (E) – Teamwork & Partnerships

TEAMWORK and PARTNERSHIPS	M	C	N	T	S
Develop TW between clinical and non-clinical staff	3	4	3	4	1
Increase communication between shifts		4			
Support TW by changing 'Dr's are being God'					1
Improve pathways throughout the NHS				3	

Source: Appendix 27, pp. 450-451

At E-4 consultants and therapists disagreed about the integration of clinical governance into the team – while the consultants suggested joining the roles of stroke nurse and clinical governance administration to support the speciality, the therapists would rather have a non-clinical support to teams for the clinical governance documentation and similar non-clinical tasks.

Additionally, the support staff at E-1 saw themselves playing a special role in the organisation – they had a good overview about it and could ask questions to trigger improvements, which might sound stupid for a medical person but a non-clinical person could ask these questions. They thought that management should recognise this and take advantage of it. However, the clinical governance manager at E-3 thought that support staff at their organisation did not understand their importance in clinical governance. Overall, there seemed to be a need to develop teamwork along these lines.

On the other hand, staff also recommended improvements for teamwork amongst clinical professionals. The therapists at E-3 suggested generally that clinical governance should provide a forum for staff to exchange experiences for problem solving. More concretely, the consultants at E-4 asked for better communication between shifts. With regard to the role of consultants, support staff at E-1 saw a need to further develop teamwork practices to move away from *"doctors are being God"* and the consultants at E-3 recommended more teamwork in the sense of moving more responsibilities from senior to junior consultants. Finally, nursing staff at E-4 asked for more team involvement of healthcare assistants. With regard to partnership, the therapists at E-3 suggested improving the pathways through the whole NHS including social services, PCTs and Trusts – initiatives had started for this and should be further developed.

Staff only suggested one improvement with regard to cultural changes: reducing the pace of change in the NHS and depoliticising clinical governance. The therapists and support staff at E-1, the clinical governance manager at E-2 and the clinical governance manager at E-3 agreed on this.

Table 56 below summarises the improvements suggested for customer priority. Staff across the organisations focused on the need to increase capacity, funding and manpower to attend to clinical governance issues and deliver quality services to the patients. The consultants at E-2 and E-4 agreed that clinical governance and medical service provision needed to refocus on the patients – the support staff at E-2 asked for better patient information. However, the clinical governance manager at E-3 did not agree with the need for more staff to deliver quality services, but recommended developing more efficient practices through clinical governance with the available resources.

Table 56: Suggested Improvements (E) – Customer Priority

CUSTOMER PRIORITY	M	C	N	T	S
More resources	4	1, 2, 4	3, 4	3, 4	2
Use existing resources more efficiently	3				
Focus more on the patients		2, 4			
Do more prevention and evaluate its impact	1	2			
Balance practical and theoretical training to teach the human aspects of care	3		3, 4		

Source: Appendix 27, pp. 452-453

Further, the clinical governance manager at E-1 suggested doing more to prevent strokes. In this regard, the consultants at E-2 stated that research was required to evaluate the impact of the FAST stroke initiative. Further, the clinical governance manager at E-3 advised the extension of national targets from infection control to falls and linking them into clinical governance.

Finally, nursing staff at E-4 maintained that, fresh from university, staff still had clinical governance in mind, but got distracted from it on the wards – they suggested keeping up the awareness of clinical governance to achieve good patient results. In contrast to this, the clinical governance manager at E-3 opined that staff needed to care more for elderly patients, even if they were dying – this should be achieved by better balancing theoretical training at university and practical training on the wards. Nursing staff at E-3 agreed with this. In terms of patient involvement, the clinical governance manager at E-3 added that feedback needed to be extended from asking about hospitality (e.g. entertainment, food, parking)

to also including the medical aspects (e.g. friendliness and competence of medical staff, treatment experience, information about the treatment).

In summary, the main agreement between staff across the organisations focused on improving involvement by training, increasing teamwork between clinical and non-clinical staff, reducing the speed of change in the NHS and increasing resources to deliver quality services to the patients.

6.7 Summary

This chapter looked at the similar **organisational context** for the case-study organisations in England. Staff showed a balanced **understanding of clinical governance**. They linked a wide range of different aspects to improvement and control in positive and negative ways to leadership. Further, individual accountability was understood as clinical governance involvement and teamwork to play a key role in its implementation and maintenance. Staff saw clinical governance as one of many changes in healthcare. Cultural changes were further manifested in learning from mistakes and sharing knowledge. In terms of customer priority, clinical governance included patient satisfaction by meeting their needs and improving the patient experience by providing the right care at the right time to the right patient. The customer definition remained difficult, as supported by the theoretical discussions in Section 2.2.4. All staff groups understood the patient to be their main customer and more than half (53%)[82] also added relatives, family and friends; 21% of the staff groups also included commissioners, external partners or everybody that walked in through the front doors or called. However, one clinical governance manager and support staff at one organisation questioned the adequacy of the customer concept in a medical environment.

Staff across the organisations agreed on the areas of **perceived effects** of clinical governance, but not necessarily on the positive, negative or neutral nature of the effect itself: 58% of the staff groups agreed that

[82] The percentages are calculated as the number of staff groups, which mentioned the statement, divided by the total number of staff groups included in England (19).

clinical governance was needed and 42% added that clinical governance strengthened the implementation of evidence-based practice. In their view, clinical governance should improve efficiency (21%) and risk management (26%) by a more structured (16%) and more transparent (37%) service provision that clarified expectations to staff (16%). However, staff groups cautioned that clinical governance increased the workload (37%), although others did not see any impact on the workload (21%). Further, staff concurred that clinical governance supported teamwork (53%) but was also a requirement of the patient structure in stroke and elderly care (84%) – the effect was not exclusively linkable to clinical governance. Finally, staff espoused diverging views about the impact on customer priority. On the one hand, clinical governance ensured safer service provision (68%), which was more consistent (42%), customer-focused (37%) and met the needs (21%) of better informed patients (32%). But on the other hand, staff had less time to spend with the patients (26%) and patients could not see or understand most changes that came with clinical governance (21%). Nonetheless, 21% of the staff groups saw a positive impact on patient experience.

With regard to **issues**, staff did not identify any in the area of improvement and differed on their views concerning leadership, whereas clinical governance success seemed to depend on the personal interest of the person leading it (37%). Staff concurred on the largest issues surrounding involvement. As with leadership, it appeared to be a question of personal interest (58%) and of the professional mind-set of the staff group (21%). Nurses were said to be more involved because of professional traditions (11%), therapists to have more time for clinical governance (11%) and support staff to be the least involved (11%). Consultants were, in part, heavily criticised (21%). Overall, most staff thought that clinical governance was well engrained (42%), e.g. via audit practices, but competed with other obligations and tasks (16%). However, many staff complained that they had never received any proper training about clinical governance as a whole (63%) and that communication about clinical governance was missing or not consistent (16%). Even though clinical governance was seen to be engrained, various interviews reflected the

'them versus us' phenomenon (21%) – clinical governance was perceived to be the responsibility of a department and not within the individual realm of responsibility of each member of staff.

Further, teamwork was not perceived to represent an issue overall. Some, however, said that consultants played a difficult role in this regard (21%). Different staff groups across the organisations (37%) agreed that too much change was happening too quickly and in a contradictory way in the NHS, which caused resistance among staff. Finally, staff complained about scarce resources and external financial pressures that prevented the realisation of customer priority (74%).

Not many staff contributed **'valued' practices and lessons-learned** about improvement and teamwork – the latter appeared to be well embraced. With regard to leadership, staff advised for clinical governance leaders to be present in the organisation (16%), a clinical background was seen to be supportive (16%). Further, staff concurred that top management support for clinical governance was essential (16%). For involvement, staff developed different 'valued' practices and lessons-learned. All staff groups should be equally involved (16%) by communication (16%) and training employing adequate language (26%). With regard to cultural changes, some staff advised how to best deal with resistance, whereas 32% of the staff groups agreed that they had a good local culture for development and learning within a 'no-blame' environment. Rarely anything was mentioned about customer priority.

Staff suggested **improvements** for all the six areas of analysis: 16% of the staff groups concurred that measurements needed to improve and be extended to consider qualitative aspects (11%), while 11% of the staff groups saw the need to improve documentation. With regard to leadership, staff contributed various improvements at three levels, the national, top management and ward management level, that could be summarised in linking clinical governance activities better with staff. This led to questions of involvement. Even though 'valued' practice and lessons-learned about training (58%) and communication (26%) were

identified, staff still perceived room for improvement in this regard. Clinical governance appeared to employ too many ‘buzz words’, which should be replaced by a language more commonly understood by clinical staff (21%).

The phenomenon of ‘them versus us’ should be addressed by more involvement, because 21% of the staff groups perceived clinical governance staff to *“live in a different world”*. Further, 26% of the staff groups advised the continuation of teamwork development between clinical and non-clinical staff and to continuously work on the improvement of clinical teams (11%). In order to establish cultural changes, 21% of the staff groups demanded a reduction in the speed of change in the NHS. Finally, 47% of the staff groups asked for an increase in resources to ensure adequate patient service provision and, thus, to strengthen the customer priority in their organisation, even though clinical governance initiatives did not directly control this. In addition to this, 16% of the staff groups suggested another balance of practical and theoretical aspects in university training to improve the human aspects of care.

After the analysis of the case-study organisations in Germany in the previous chapter and England in this chapter, the following chapter brings the findings together in the cross-case analysis and compares them to the literature.

7 Discussion: Cross-Case Analysis

This chapter compares the findings from the case-study organisations in England and in Germany. In order to facilitate the integration of the literature as well as further analysis, the structure of the chapter differs from the previous two chapters after the organisational context. The findings are regrouped under the six analytical categories of improvement, leadership, involvement, teamwork including partnerships, cultural changes and customer priority.

7.1 Organisational Context

The results of the documentary analysis before visiting the organisations in England and Germany yielded similar results – based on nationally different sources of information, they showed overall good performance. Media coverage of the organisations was also comparable. The structured quality reports in Germany, the quality accounts in England and the vision and mission statements across the countries reflected the various aspects of quality management and clinical governance.

Further, the interviews with the QMBs and the clinical governance managers provided similar insight into the organisational context. In spite of the different national impulses to do so, the quality management and clinical governance initiatives at the hospitals had started around the same time responding to changes in the political landscape – in Germany 1998 and in England 2000. Due to the different structures of the healthcare systems, the government had initiated the implementation and chose the model in England, whereas the top management and owners did so in Germany. The hospitals in England had consistently applied the seven pillars model in the beginning and more flexibly blended it in with the new input from the Standards for Better Health – organisations did not pursue quality management certifications. In contrast to this, four of the five hospitals in Germany were KTQ certified. Internally, they used KTQ and EFQM as orientational models for their quality management systems.

With regard to strategic importance of quality management and clinical governance, the QMBs and clinical governance managers concurred that clinical governance and quality management positioned and prepared the organisation for the future. There were, however, some critical voices in both countries, questioning how much of this was actually true and not just 'lip service'.

The main differences between the organisational contexts of England and Germany manifested themselves around the help of management consultants to implement and maintain quality management and clinical governance, ownership issues in the German sense and the use of ICT. The former two did not apply to England and in both cases this probably related to the system structure and how quality management and clinical governance had been introduced. In England, clinical governance had always been government developed and driven, while in Germany the KTQ model and certification had been developed independently of the government[83]. Further, the implementation of clinical governance in England was not certified, so that the hospitals did not require the help of external consultants to prepare for the certification process as the German organisations did.

Additionally, the ownership ('Trägerschaft') could play a role in the German healthcare system, because the hospitals were not managed within one national system as in England. But there was no agreement amongst the QMBs, if the quality management orientation was actually influenced by the ownership. Further, it remained unclear from where the differences in ICT usage originated. In England, the clinical governance managers disagreed about the importance of ICT to support clinical governance. In contrast to this, the QMBs in Germany explained that various ICT systems had supported the implementation and maintenance of their quality management initiatives.

Across the countries, the organisations participated in or organised Benchmarking activities and academic projects. In summary, clinical

[83] See Section 3.3.2.

governance and quality management had a comparably stable tradition in both countries and were approached in similar ways, as summarised in Table 57 below. A tick indicates agreement across the organisations.

Table 57: Overview Organisational Context

	Germany	England
Timing	Around 2000	Around 1998
Reason	Changes in the political landscape	Medical scandals, the government reaction to these
Initiator, choice of model	Management or corporate owner	The government and local adaptations
Implementation details		
- Model	4 out of 5 KTQ with EFQM	Seven pillars, 3 out of 4 also Standards for Better Health
- Certification	4 out of 5	
- Strategic importance	✓	✓
- Management consultants	✓	
- Role of ownership	No agreement	n/a
Opinion about ICT	Important to support QM	No agreement
Benchmarking, academic projects	✓	✓

Source: the author

The differences related mainly to aspects of how to choose the model, support the implementation and not to clinical governance or quality management as such. The findings from the documentary analysis of the quality reports, quality accounts as well as the vision and mission statements further support that the six analytical categories were considered in both countries. This confirms the assumption, made by the researcher on theoretical grounds, that clinical governance and quality management are comparable.

Further, staff attributed similar aspects to quality management and clinical governance, as discussed below for each of the analytical categories. Nonetheless, all staff groups at three organisations in Germany and 47%

of the staff groups in England[84] cautioned, about themselves or the staff they worked with, that they might not fully understand clinical governance and quality management.

7.2 Improvement

In terms of **staff understanding**, the ideas of staying up-to-date with new technologies or best practice, quality control or assurance by standards, procedures and guidelines, process approach, documentation, planning, Benchmarking and continuous professional development came up in interviews across the countries, as summarised in Table 58 below.

Table 58: Staff Understanding – Improvement

UNDERSTANDING	Germany	England
Agreement		
Stay up-to-date	✓	✓
Quality control / assurance by standards	✓	✓
Procedures, guidelines	✓	✓
Process approach	✓	✓
Documentation	✓	✓
Planning	✓	✓
Benchmarking	✓	✓
CPD	✓	✓
Structure for efficient use of resources	✓	✓
Transparency	✓	✓
Disagreement		
Consistency		✓
Bureaucracy	✓	
Clinical audit		✓
Measurements		✓
Government regulation and targets		✓

Source: the author

Further, staff concurred that clinical governance and quality management gave structure for efficient use of resources and increased transparency.

[84] Managers at two organisations, consultants at one, nursing staff at three, therapists at one and support staff at two.

In England, staff positively appreciated consistency as part of clinical governance, while in Germany they criticised bureaucracy as part of quality management.

Staff in England added other aspects to their understanding of clinical governance that did not correspond to anything mentioned by staff in Germany – such as clinical audit, measurements and government regulation or targets. Clinical audit rarely came up during the interviews in Germany. The role that audit, the National Stroke Sentinel Audit in particular, played in England for external evaluation and comparison between hospitals, was taken up by KTQ or other stroke specific quality management certifications in Germany. Accordingly, the respondents often referred to the certification process, but did not include it in their understanding of quality management. Finally, the appreciation of measurements, government regulation and targets in England could be explained with the influence the government had on the NHS as a whole and on governing issues, resulting form the overall structure of the system.

Table 59 below summarises the **perceived effects** on improvement. Staff largely agreed that clinical governance (37%) and quality management (33%) increased transparency.

Table 59: Perceived Effects – Improvement

EFFECTS	Germany					England				
	M	C	N	T	S	M	C	N	T	S
Agreement										
Transparency	5			2	1	3		3	1	
Efficiency gains	3		1			2	1	1		
Disagreement										
Higher workload						1	2	2	2	
Unsure impact on workload						2	1	1		
No efficiency gains	2		1							
CG is needed						1	3	3	3	1
Evidence-based practice						2		4	2	
QM helps to induct staff	1		3		1					

Source: the author

In Germany, 17% of the staff groups and 21% in England saw a positive impact on efficiency. Yet, 13% of the staff groups in Germany disagreed with this. Quality management was helpful for the induction of new staff in Germany (21%). The largest agreement in England focused on two aspects that were not mentioned in Germany: 58% of the staff groups concurred that clinical governance was needed and 42% thought that it supported evidence-based practice. Across the countries, support staff contributed the smallest number of perceived effects and in Germany this was also true for the consultants. In both countries, improvement was not **perceived** as an **issue**. Improvement seems to be the analytical category, which was best understood during the interviews. Staff agreed on a variety of different improvement aspects in their quality management and clinical governance understanding. Further, the majority of perceived effects, relating to improvement, were positive. Yet, the lack of perceived issues around improvements could not be explained and should be further researched[85]. Further, questions of improvement did not appear to play a major role under **'valued' practice and lessons-learned**. In England, very few non-managerial members of staff mentioned different related aspects, while in Germany one QMB and nursing staff at one organisation agreed that documentation had to be streamlined and, during implementation, time should not be wasted on designing too much documentation.

Table 60: Suggested Improvements – Improvement

IMPROVEMENTS	Germany					England				
	M	C	N	T	S	M	C	N	T	S
Agreement										
Always possible	1	1	1	1	1				1	
Streamline and consolidate documentation			3	1	1	1	1			
Disagreement										
Do more Benchmarking						1	1			
More qualitative measures						1				1

Source: the author

[85] See Chapter 10.

As summarised in Table 60 above, 21% of the staff groups in Germany and the therapists at one organisation in England agreed that **improvements** were always possible. More concretely, various members of staff (21% in Germany, 11% in England) demanded that documentation should be streamlined and consolidated. In England, the clinical governance manager and the consultants at one organisation would like to see more benchmarking including, as suggested by one clinical governance manager and the support staff at one organisation, more qualitative measures, such as staff friendliness.

Table 61: Literature – Improvement

LITERATURE	Occurrence	Support
Disagreement about efficiency gains	PE	Heras Saizarbitoria (2006, p. 792), Wayhan *et al.* (2010, p. 761)
Streamlined documentation	U, VP, SI	KTQ (2004, p. 192), The Joint Commission (2008, p. 357)
Improvements are always possible	SI	EFQM (2003), BSI (2005, pp. v-vi), Dale (2003, p. 26), Goetsch & Davis (2006, p. 6), Kelemen (2003, p. 100-101)
Key: PE stands for perceived effects, U for staff understanding, VP for 'valued' practice, SI for suggested improvements		

Source: the author

Table 61 above summarises important statements about improvement and links them to the literature. Transparency is discussed in Section 7.9, as it forms part of the emerging themes, which cut through the analytical categories. Issues of workload and efficiency are also further addressed under the emerging themes.

7.3 Leadership

With regard to **staff understanding**, staff in both countries concurred that control formed part of clinical governance and quality management. Especially in England, this control carried a negative connotation, although its positive sides, such as accountability and risk management, were also appreciated. In Germany, the positive sides of leadership control related to

rewards and constructive criticism. At one organisation in each country, staff linked fair distribution of resources to leadership. Staff agreed that clinical governance and quality management provided a framework to orientate staff about expectations and requirements of their daily routine, as depicted in Table 62 below.

Table 62: Staff Understanding – Leadership

UNDERSTANDING	Germany	England
Agreement		
Control	✓	✓
Fair distribution of resources	1 out of 5	1 out of 4
Framework to orientate staff about expectations and requirements	✓	✓
Disagreement		
Negative aspects of control		✓
Accountability and risk management as positive control		✓
Rewards and constructive criticism as positive control	✓	

Source: the author

Only one QMB in Germany **perceived** more dynamic leadership as an **effect** of quality management.

Staff in both countries **perceived** various different **issues**. Agreement across the countries (8% in Germany, 37% in England) focused on the importance of personal interest of the leaders for successful clinical governance and quality management, as summarised in Table 63 below.

Table 63: Perceived Issues – Leadership

ISSUES	Germany					England				
	M	C	N	T	S	M	C	N	T	S
Agreement										
LS depends on personal interest of the leaders	1		1			1		3	2	1

Source: the author

The general idea of focusing implementation efforts fell under **'valued' practice and lessons-learned**. Two clinical governance managers in England, two QMBs and nursing staff at one organisation in Germany agreed on this and suggested prioritising issues within a concrete action-plan. Further, staff in both countries (21% in Germany, 16% in England) underlined the crucial role of management support and commitment to quality management and clinical governance. Table 64 below provides an overview of the 'valued' practice and lessons-learned around leadership.

Table 64: 'Valued' Practice – Leadership

'VALUED' PRACTICE	Germany					England				
	M	C	N	T	S	M	C	N	T	S
Agreement										
Prioritise implementation in an action-plan	2		1			2				
Management support and commitment	3	1	1			2			1	
Leaders have to be visible in the organisation			1	1	1	2			1	
Clinical background helps leaders	5					3				

Source: the author

Nurses, therapists and support staff at one organisation in Germany, two clinical governance managers and therapists at one organisation in England added that this support should manifest itself by managerial presence throughout the organisations. If managers were not seen in the

organisation, they would seem to work remotely from their office without any contact with the operational aspects of the organisation. Moreover, most managers across the countries (all in Germany, three out of four in England) suggested that a clinical background helped managers to lead improvement within clinical governance and quality management in a sensible way.

Table 65: Suggested Improvements – Leadership

IMPROVEMENTS	Germany					England				
	M	C	N	T	S	M	C	N	T	S
Agreement										
Extend positive feedback, rewards	1		2	1	2			1		
Disagreement										
Management commitment						2				
Prioritise implementation							2			

Source: the author

Table 65 above summarises the **suggested improvements** for leadership. Management commitment to clinical governance was also identified as ‘valued’ practice; two clinical governance managers in England suggested that leadership needed to be further improved. The consultants from two organisations in England demanded that initiatives be thought-through and prioritised prior to implementation, as also identified under ‘valued’ practice. 25% of the staff groups in Germany and the nursing staff at one organisation in England saw the need to extend positive feedback and rewards.

Table 66: Literature – Leadership

LITERATURE	Occurrence	Support
Control (pos. & neg.)	U	Soltani *et al.* (2010, p. 67-68), Oakland (2001, p. 9), Goetsch & Davis (2006, p. 261)
Personal interest of leaders	PI	Koch (1991, p. 13), Natarajan (2006, pp. 573-574)
Management support, commitment	VP, SI (E)	Koch (1991, p. 13), Ruiz & Simón (1994, p. 537), Oakland (2001, p. 16)
Visible leaders	VP	Koch (1991, p. 13)
Key: U stands for staff understanding, PI for perceived issues, VP for 'valued' practice, SI for suggested improvements, (E) for (in England)		

Source: the author

Table 66 above summarises important aspects of leadership and links them to the literature. The orientation of staff about expectations or requirements, as well as the prioritised implementation in an action-plan, form part of the emerging themes, as further discussed in Section 7.9.

7.4 Involvement

Staff understanding of involvement differed significantly between the organisations in England and Germany. In Germany, hardly anyone included involvement aspects in their understanding of quality management – occasionally training for staff awareness and employee surveys were mentioned. In England, however, staff at three out of four hospitals understood individual accountability as an important part of clinical governance. Staff in England also added training and education. Only at one organisation did staff appreciate empowerment as a more advanced form of involvement in clinical governance, as depicted in Table 67 below.

Table 67: Staff Understanding – Involvement

UNDERSTANDING	Germany	England
Agreement		
Training	2 out of 5	2 out of 4
Disagreement		
Employee surveys	1 out of 5	
Individual accountability		3 out of 4
Empowerment		1 out of 4

Source: the author

Only two members of staff **perceived effects** on involvement resulting from clinical governance and quality management. One therapist in Germany felt that he had become more aware of quality management issues. In England, one clinical governance manager hoped that clinical governance would improve staff satisfaction, as it ensured that staff had the right skills, knowledge and competences to do their job.

Staff in England **perceived** the main **issues** in the field of involvement - more than their German counterparts. Many staff groups across both countries (42% in Germany, 58% in England) agreed that involvement depended highly on personal interest of the people to get involved, as displayed in Table 68 below. Further, 63% of the staff groups in Germany and 53% in England identified problems in understanding quality management and clinical governance. One clinical governance manager, nursing staff and therapists at one organisation in England explained that understanding improved with seniority. Another clinical governance manager, consultants and nursing staff at one organisation in England remarked that staff used to better understand the seven pillars model of clinical governance.

Table 68: Perceived Issues – Involvement

ISSUES	Germany					England				
	M	C	N	T	S	M	C	N	T	S
Agreement										
Personal interest	3	1	3	2	1	2	3	3	2	1
N play a special role	1		2					2		
Feel like get forgotten			1		2				1	
C are worst		2					1	2	1	
Disagreement										
Professional affiliation								1	3	
Therapists have more time to be involved								1	1	
S not much involved										2
CG is engrained							3	3	2	
Training							2	4	3	3
Communication								2	1	
Them vs. us								2	1	1

Source: the author

Further, professional mind-sets also seemed to play an important role, in the view of 21% of the staff groups in England. One QMB in Germany explained the special role that nurses seemed to play in quality management involvement with the fact that they represented the largest staff group, which enjoyed most of the improvements. Nursing staff at two organisations in both countries further supported the idea that quality management and clinical governance had a longer tradition in their profession and occupied a substantial part in their training. The therapists at one organisation in England, however, cautioned that they tended to get forgotten in clinical governance matters, even though they thought they had more time to get involved.

In England, 21% of the staff groups controversially discussed the involvement or not-involvement of consultants, while in Germany consultants at two organisations admitted bluntly that they were not involved. Support staff at two organisations in Germany would like to be more involved, but their counterparts at two organisations in England

thought that clinical governance was just not a common concept in their field.

In England, 42% of the staff groups agreed that clinical governance was well engrained in their daily activities. Nonetheless, they stated critically that they had never been trained about clinical governance as a whole (63%) and were not involved through regular communications about clinical governance progress (16%). Accordingly, 21% of the staff groups across the organisations in England espoused the 'them versus us' phenomenon. One QMB in Germany also experienced it in the beginning and overcame it by communications in a common language about quality management – initially, he perceived the finding of this common language as a major challenge.

In terms of **'valued' practice and lessons-learned**, all managers in Germany and three out of four in England saw the need to communicate enthusiastically about quality management and clinical governance. Three out of five German QMBs suggested building staff involvement with those who had a personal interest in the subject. Further, one clinical governance manager in England and two QMBs in Germany advised the use of a common language to involve all staff groups in England (three out of four managers), and to make quality management tangible in Germany (all QMBs). Three out of five QMBs had experienced that the KTQ certification process had helped in this regard and motivated staff. According to three QMBs, two clinical governance managers, the nursing staff at one and therapists at two organisations in England, training further supported this. One manager in England, however, picked up on the contentious role of consultants, when claiming that clinical governance offered a good tool to challenge consultants. Even though most of the responses regarding 'valued' practice and lessons-learned were contributed by the QMBs, 54% of the staff groups across the organisations in Germany confirmed that involvement was dealt with adequately. Table 69 below summarises the 'valued' practice and lessons-learned.

Table 69: 'Valued' Practice – Involvement

'VALUED' PRACTICE	Germany					England				
	M	C	N	T	S	M	C	N	T	S
Agreement										
Communicate enthusiastically	5					3				
Use a common language	2					1				
Training supports INV	3					2		1	2	
Disagreement										
Involve all professions						3				
Make QM tangible	5									
KTQ motivates	3									
Build on personal interest	3									
INV is OK	2	3	3	2	3					

Source: the author

The idea of managers not understanding the operations of a ward came up as a **suggested improvement** for involvement. As summarised in Table 70 below, four clinical staff groups in England explained that the 'them versus us' phenomenon, in part, resulted from the clinical governance managers *"living in a separate world"* and not knowing the daily routines on the wards – this should be overcome by more involvement of clinical staff. Staff in Germany agreed with this.

Table 70: Suggested Improvements – Involvement

IMPROVEMENTS	Germany					England				
	M	C	N	T	S	M	C	N	T	S
Agreement										
More involvement	1		2		1		1	2	1	
More training			3		1	2	2	4	2	1
More information and communication	1		1		1			3	3	1
Disagreement										
Find a common language						1		2	1	
Make CG tangible for staff						1		1		

Source: the author

Further, 13% of the staff groups in Germany and 26% in England asked for consistent communication about clinical governance and quality management. Nursing staff at three organisations and support staff at one organisation in Germany as well as 58% of the staff groups across the English organisations demanded more training. Nursing staff at one organisation in Germany suggested that the academic training of consultants should also include a stronger emphasis on quality management. Finally, 21% of the staff groups in England remarked critically that clinical governance became nebulous when 'buzz words' were used and, therefore, managers should watch the language they used to communicate about clinical governance. One clinical governance manager and the nursing staff at one organisation in England explained that quality and improvement were more tangible concepts and better understood by staff than clinical governance.

Table 71: Literature – Involvement

LITERATURE	Occurrence	Support
Training	U, PI (E), VP, SI	Natarajan (2006, pp. 573-574), Ruiz & Simón (1994, p. 537), Deming (1982, p. 23)
Personal interest	PI, VP (D)	Arasli *et al.* (2008, p. 10), Hudelson *et al.* (2008, p. 31), Huq & Martin (2000, p. 80)
Communication	PI (E), VP, SI	Mathews *et al.* (2001, p. 703), Goetsch & Davis (2006, p. 257, 460)
Key: U stands for staff understanding, PI for perceived issues, (E) for (in England), VP for 'valued' practice, (D) for (in Germany), SI for suggested improvements		

Source: the author

Table 71 above summarises important aspects of involvement and links them to the literature. The contentious role of consultants and the 'them versus us' phenomenon are discussed in Section 7.9 as part of the emerging themes, which cut across the analytical categories.

7.5 Teamwork including Partnerships

Staff in both countries concurred about the importance of multi-disciplinary teamwork within their quality management and clinical governance **understanding**. Further, staff in Germany thought that teamwork supported respect among staff and enabled other activities, such as Benchmarking or audit. However, only staff at one organisation in Germany developed the teamwork idea further to also include external partnerships.

With regard to **perceived effects** and as summarised in Table 72 below, 84% of the staff groups in England and 17% in Germany agreed that stroke and elderly patients required teamwork anyway, while 37% of the staff groups in England and 33% in Germany added that clinical governance and quality management could further support successful teamwork.

Table 72: Perceived Effects – Teamwork & Partnerships

EFFECTS	Germany					England				
	M	C	N	T	S	M	C	N	T	S
Agreement										
Stroke and elderly patients require TW		1	2		1	3	4	4	3	2
TW also depends on local personalities			1				4			
CG and QM support TW	3		3	2				4	3	
Clarified responsibilities	3		3	2				4		
Positive impact on communication	3	1	3	2				4		

Source: the author

All nurses in England, the nursing staff at three organisations in Germany, three QMBs and the therapists at two organisations in Germany explained the latter point in more detail – clinical governance and quality management clarified responsibilities and standards within teams, so that they functioned smoothly. All nurses in England as well as three QMBs, the nursing staff at three, consultants at one and therapists at two

organisations in Germany highlighted the positive impact on communication within the team. However, all consultants in England and the nurses at one organisation in Germany cautioned that teamwork, in part, also depended on good luck with matching local personalities to make things work.

Staff in England and Germany **perceived** different **issues** around teamwork and partnerships, as displayed in Table 73 below. While teamwork did not represent an overall issue in England, it caused problems at two out of five organisations in Germany. Nonetheless, 21% of the staff groups in both countries concurred that consultants played a critical role in this regard. The consultants at one organisation in England explained this by the fact that consultants moved on faster to new jobs in other hospitals, whereas other staff groups, nurses in particular, tended to work in the same organisation and on the same ward for longer. Further, support staff at two organisations in England criticised the arrogant attitude of consultants towards other members of staff. Finally, support staff at one organisation in Germany and at two organisations in England had the impression that they were not treated as equals within the care team.

Table 73: Perceived Issues – Teamwork & Partnerships

ISSUES	Germany					England				
	M	C	N	T	S	M	C	N	T	S
Agreement										
No issues, major problems	3 out of 5					4 out of 4				
C play a critical role in TW	3		1	1		1	1			2
S not equal in teams					1					2
Disagreement										
TW is an issue	2 out of 5									
C are too arrogant for TW										2
C move on faster to new jobs, TW is difficult							1			
TW improves with younger generation of C						1	1			

Source: the author

Not many members of staff across the countries **perceived 'valued' practice and lessons-learned about teamwork**, as summarised in Table 74 below. There was no agreement across the countries. In Germany, only managerial staff contributed 'valued' practice, while in England only clinical staff did so. Consultants at one organisation in England explained that multidisciplinary teamwork had become an embraced concept. Further, the consultants and nursing staff at one organisation mentioned that respectful communication supported teamwork. In Germany, two QMBs underlined the need for consultants to support teamwork. One QMB had positively experienced this crucial role consultants played to achieve teamwork, in contrast to the discussion of issues above. He had developed managerial-clinical teamwork with younger consultants. While in England partnerships were not considered, three out of five QMBs in Germany contributed 'valued' practices about external cooperation with other service providers in response to scarce resources.

Table 74: 'Valued' Practice – Teamwork & Partnerships

'VALUED' PRACTICE	Germany					England				
	M	C	N	T	S	M	C	N	T	S
Disagreement										
TW is an embraced concept							1			
Respectful communication supports TW							1	1		
C have to support TW	2									
Younger C are good for clinical-managerial TW	1									
PS in response to scarce resources	3									

Source: the author

Staff across the countries **suggested** different local **improvements** for teamwork, as summarised in Table 75 below. 21% of the staff groups in Germany suggested improving teamwork with more mutual respect between the professions. More specifically, nursing staff at one organisation saw quality management as a vehicle to further develop respect within the organisation for the nursing profession. Further, nursing

staff and therapists at two organisations in Germany identified a need for more multi-disciplinary cooperation.

Table 75: Suggested Improvements – Teamwork & Partnerships

IMPROVEMENTS	Germany					England				
	M	C	N	T	S	M	C	N	T	S
Agreement										
C need to make more effort for TW			1	1						1
Disagreement										
Improve TW between clinical and non-clinical staff						1	1	1	1	1
Develop more mutual respect	1		2	1	1					
TW to increase respect for nurses			1							
More interdisciplinary cooperation			2	2						
Improve communication with external partners			2	2						
Improve pathways throughout the NHS									1	

Source: the author

Even though teamwork had not been identified as an issue in England, representatives of all staff groups, but from different organisations suggested improvements of teamwork between clinical and non-clinical staff. There was no agreement, however, if this should happen by separating or joining administrative responsibilities. Support staff at one organisation in England concurred with nurses and therapists at one organisation in Germany that consultants needed to put more effort into supporting teamwork. Finally, therapists at one organisation in England and support staff at two organisations in Germany considered improvements for external partnerships through clearer pathways in England and increased communication in Germany.

Table 76: Literature – Teamwork & Partnerships

LITERATURE	Occurrence	Support
TW is important, supported by CG/QM	U, PE	Dale (2003, p. 182), Deming (1982, p. 24), Natarajan (2006, pp. 573-574), Cauchick Miguel (2006, p. 628), Mannion *et al.* (2009, p. 155)
Stroke requires TW	PE	Rudd *et al.* (2001, p. 141), Seenan *et al.* (2007, p. 1889), Naveh *et al.* (2006, p. 118)
Key: U stands for staff understanding, PE for perceived effects		

Source: the author

Table 76 above summarises important aspects of teamwork including partnerships and links them to the literature. The contentious role of consultants and clarified responsibilities in support of teamwork are discussed in Section 7.9, as part of the emerging themes.

7.6 Cultural Changes

Staff understanding of cultural changes as part of clinical governance and quality management differed in England and Germany. Staff at three out of five organisations in Germany did not refer to cultural changes at all. Only at one hospital did staff show a fairly advanced understanding of cultural changes for quality management, referring to a 'no-blame' culture to learn from mistakes. This understanding was mirrored at two organisations in England as cultural openness to learn from mistakes and share this knowledge. At three out of four hospitals in England, however, cultural changes within clinical governance were seen to result in more evidence-based practice taking into account up-to-date research.

Only the consultants at one organisation in England **perceived** an **effect** resulting from clinical governance. In their view, clinical governance had created a cultural openness to record and report accidents.

In terms of **perceived issues**, 37% of the staff groups in England, as summarised in Table 77 below, complained about too much change in the

NHS that caused resistance (16%), symptomatic for the centralised healthcare system. However, the consultants at one organisation in Germany also warned that the *"quality label"* was put on everything. This was seen to cause resistance to it.

Table 77: Perceived Issues – Cultural Changes

ISSUES	Germany					England				
	M	C	N	T	S	M	C	N	T	S
Agreement										
'Tick-box' exercises instead of real change			1			2		1		
Disagreement										
Too much change						4	1	1		1
Too much change causes resistance						2			1	
Reasons for resistance: - staff don't see need for change - dangerous transparency - increased bureaucracy - misuse of quality label	2 2 1	1	2	1						
Special resistance from head physicians	1									
Internal structures prevent change	1			1						

Source: the author

Additionally, one QMB and the therapists at one organisation in Germany cautioned that internal structures prevented change. Two QMBs had experienced resistance to quality management changes, because staff did not see a need to change, if things had worked in the same way for many years, and feared increased transparency. One QMB added that the head physicians had especially resisted quality management because it was seen to increase bureaucracy, which would keep staff away from their

clinical work on the wards. Nursing staff at two and therapists at one organisation in Germany agreed with this reason for resistance. Nursing staff at one organisation in England and Germany, as well as two clinical governance managers, cautioned that clinical governance and quality management were in danger of becoming 'tick-box' exercises, just looking good on paper without any real changes.

As a link between cultural changes and customer priority, staff in England described the special mind-set governing elderly care, while nursing staff at one organisation in Germany explained that the service developed more to incorporating hospitality concerns and demanded that the human aspects of care should not be forgotten.

In both countries, staff **perceived 'valued' practice** on how to deal with resistance. One QMB and the therapists at one organisation in England advised showing staff that they were already doing parts of quality management and clinical governance. Two QMBs and two clinical governance managers further suggested working with enthusiasts to convince resisting parties. One clinical governance manager, as well as consultants, therapists, support staff at one and nursing staff at two organisations in England, praised the local 'no-blame' culture at their organisation for learning from mistakes and further development.

Suggested improvements for cultural changes received different appreciation in the two countries. In England, two clinical governance managers, as well as the therapists and support staff at one organisation, demanded that the pace of change in the NHS should slow down and that clinical governance should be depoliticised. In Germany, however, at three organisations nothing was said in this respect. At one organisation, consultants, nursing staff and therapists critically stated that there was a lot of talk about changes and certification was a 'big deal' – but nothing happened. In contrast to this, the nursing staff at another organisation agreed with staff in England that change should be reduced, better planned and executed more consistently.

Table 78: Literature – Cultural Changes

LITERATURE	Occurrence	Support
'No-blame' culture	U, VP (E)	Mannion *et al.* (2009, p. 155), Huq & Martin (2000, p. 80)
Counter resistance, showing that QM/CG are already done and working with enthusiasts	VP	Huq & Martin (2000, p. 81), Goetsch & Davis (2006, pp. 182-183)
Key: U stands for staff understanding, VP for 'valued' practice, (E) for (in England)		

Source: the author

Table 78 above summarises important aspects relating to cultural changes and links them to the literature. The problem of quality management and clinical governance becoming 'tick-box' exercises is discussed in Section 7.9 with the other emerging themes.

7.7 Customer Priority

Staff understanding with regard to customer priority was similarly diverse across the two countries. Staff at all the organisations in England agreed on patient satisfaction by meeting their needs, improving the patient experience and providing the right care at the right time to the right patient. In Germany, staff at only one organisation included patient satisfaction and meeting the needs of patients and their families. One consultant at one organisation extended this to providing *"the biggest benefit to the patients"*.

In support of the difficulties identified in this regard in Section 2.2.3, staff defined different groups of people as their customers. Table 79 below compares the customer understanding across the countries. Almost all staff saw the patients as their main customers. But 25% of the staff groups in Germany, as well as one clinical governance manager and support staff at one organisation in England did not like the customer concept for different reasons.

Table 79: Customer Definition

DEFINITION	Germany					England				
	M	C	N	T	S	M	C	N	T	S
Agreement										
Patients	5	3	5	5	5	4	4	4	4	3
Relatives and friends	2		2	1	1	1	2	3	2	2
External partners	2		1	1		1		1	2	
SHI (D), commissioners (E)	1	1				2	1		1	
Don't like customer concept	1	1	2		2	1				1
Disagreement										
Internal staff	1		1	1	3					
Everybody phoning or walking in through front door						2		1	1	

Source: the author

Staff across the countries largely **perceived** the same **effects** of clinical governance and quality management on customer priority, as displayed in Table 80 below: 50% of the staff groups in Germany and 68% in England agreed that patients benefited from quality management and clinical governance, mainly because care was safer. In Germany, 33% of the staff groups and 42% in England explained this with increased consistency of care. Further, two QMBs, nursing staff at two organisations in Germany and at all in England, as well as support staff at one organisation in Germany, concurred that patients benefited from clinical governance and quality management, as staff became more aware of their needs through, for instance, patient surveys and responded to them. Nursing and support staff at one organisation in Germany and two in England, as well as two clinical governance managers, positively appreciated that patients were better informed about their stay at the hospital and their treatment.

Table 80: Perceived Effects – Customer Priority

EFFECTS	Germany					England				
	M	C	N	T	S	M	C	N	T	S
Agreement										
Safer care	4	2	3	2	1	3	3	4	3	
More consistent care		3	3	2			3	4	1	
Patients are better informed			1		1	2		2		2
More awareness of patient needs ensures they are met	2		2		1			4		
Less time for patients	1		3	2			2	1	2	
Disagreement										
Patients don't see improvements						1	1	2		

Source: the author

Yet, one clinical governance manager cautioned that patients often did not see or understand improvements and, therefore, were not necessarily more satisfied with their treatments. This viewpoint found the support of consultants at one and nursing staff at two organisations in England. Finally, staff also criticised a negative impact of quality management and clinical governance on the patients. The QMBs in Germany, the consultants at two organisations in England, nursing staff at three organisations in Germany and one in England, as well as therapists at two organisations in both countries, perceived that administrative obligations and meetings within quality management and clinical governance took time, which meant that they could spend less time with the patients.

Table 81 below summarises the **perceived issues** around customer priority: 42% of the staff groups in Germany and 74% in England saw external financial pressures and scarce resources as being in the way of truly implementing clinical governance and quality management. Yet, three clinical governance managers in England cautioned that patients tended to have too high expectations without also understanding their obligations for their own health. This reflects the discussion of individual and collective perspectives in Section 2.1.3.

Table 81: Perceived Issues – Customer Priority

ISSUES	Germany					England				
	M	C	N	T	S	M	C	N	T	S
Agreement										
Not enough time and money	2		2	3	3	4	2	3	2	3
Disagreement										
High patient expectations						3				

Source: the author

Finally, only very few staff **perceived 'valued' practice and lessons-learned** in the field of customer priority. The advice of managerial staff at one organisation in England, to ensure clinical governance stayed on the agenda in times of financial difficulty, reflects the issue of scarce resources.

Table 82: Suggested Improvements – Customer Priority

IMPROVEMENTS	Germany					England				
	M	C	N	T	S	M	C	N	T	S
Agreement										
More resources	2	1	4	4	3	1	3	2	2	1
Disagreement										
Respect patient needs more			1		1					
Refocus on the patient							2			
Balance practical and theoretical parts of training						1		2		

Source: the author

In terms of **suggested improvements** and as summarised in Table 82 above, 58% of the staff groups in Germany and 47% in England agreed that more resources were needed to provide adequate services to the patients – this was not directly dependent on clinical governance, though it could help to use scarce resources more efficiently, in the opinion of the consultants at one organisation in England. Further, consultants at two organisations in England saw the need to refocus on the patients. The nursing staff and support staff at two different organisations in Germany

would like to see more respect for patient needs. Finally, one clinical governance manager and the nursing staff at two organisations in England suggested the need to achieve a better balance between practical training on the wards and academic training at university, so that the patients received adequate care.

Table 83: Literature – Customer Priority

LITERATURE	Occurrence	Support
Patients are more satisfied because their needs are met	U, PE	Dey & Hariharan (2006, p. 601), Cauchick Miguel (2006, pp. 634-635), Macinati (2008, p. 238)
Safer, more consistent care	PE	Nielsen *et al.* (2004, p. 26), Suñol *et al*. (2009, p. i62)
Patients are more informed, involved	PE	Forster & Gabe (2008, p. 333), DoH (2010c, p. 13)
Key: U stands for staff understanding, PE for perceived effects		

Source: the author

Table 83 above summarises important aspects of customer priority and links them to the literature. Resource issues are discussed in Section 7.9 as part of the emerging themes.

7.8 Summary

The cross-case discussion in this chapter has shown that clinical governance and quality management had a comparably stable tradition in both countries and were approached in similar ways. However, the notes from the interviews in England were longer. Accordingly, staff identified more effects, issues, as well as ‘valued’ practice, and developed more suggestions around improvement. In Germany, most ‘valued’ practice and lessons-learned were contributed by the QMBs.

This could be explained by the fact that certain staff groups in England were more used to academic activities and research than in Germany. In England, nurses and therapists are trained at university, while in Germany their training is mainly practical. Yet, the reasons should be further

researched and confirmed[86]. Overall, many staff suggested general areas of improvement for quality management and clinical governance approaches without substantiating how these improvements should actually be realised.

Staff across the countries showed a general **understanding** of clinical governance and quality management. The main agreement focused on improvement, leadership and teamwork, while the main disagreement focused on involvement, cultural changes and customer priority. Nonetheless, staff defined their customers in a similar way, whereas 25% of the staff groups in Germany, as well as one clinical governance manager and support staff at one organisation in England, did not think that the customer concept was adequate, as discussed theoretically in Section 2.2.3.

Staff in both countries **perceived** similar **effects** of quality management and clinical governance on improvement, teamwork and customer priority. However, there was no agreement, neither nationally nor internationally, as to whether these effects were positive, negative or neutral.

Staff across the countries **perceived** similar **issues** with regard to implementing, maintaining and developing quality management and clinical governance. They did not identify any issues around improvement. Further, they agreed and disagreed about different aspects of the other analytical categories. The main issues focussed on involvement. Staff in both countries agreed on one part of the issues and another part of the issues was only perceived in England.

Staff in both countries contributed **'valued' practice and lessons-learned** for implementing, maintaining and developing clinical governance and quality management, whereas these contributions in Germany came mostly from the QMBs. On the one hand, agreement especially focused on leadership, involvement and cultural changes. On the other hand, staff

[86] See Chapter 10.

in the two countries addressed different areas of teamwork under 'valued' practice.

Staff across the countries **suggested improvements** for approaches to clinical governance and quality management. They agreed on suggestions with regard to improvement and involvement, even though staff in England contributed more suggestions. Teamwork and cultural changes were most controversial.

7.9 Emerging Themes

Six additional themes have emerged from the cross-case analysis. These themes cut across different analytical categories.

First, an increase in **transparency** was perceived to be an effect of clinical governance and quality management, under improvement. This is supported by OECD (2003b, p. 39). Under customer priority, staff agreed that consistency and an increase in risk awareness made care safer for the patients. Nielsen *et al.* (2004, p. 26) also make this link. This transparency, however, was perceived as a threat under cultural changes and caused resistance to quality management in Germany. Senior and Fleming (2006, p. 286) identify several reasons for individual resistance to change. Transparency corresponds to the general fear of the unknown and dislike of uncertainty in the sense that staff feared what could be revealed through clinical governance and quality management. Further, transparency also potentially endangered the power base of staff in leading positions.

Secondly, in terms of cultural changes, staff alluded to the danger that clinical governance and quality management could **look great on paper** without reflecting the operational reality on the wards. Staff in both countries cautioned that clinical governance and quality management could turn into '**tick-box exercises**' instead of instigating real change. In order to avoid this, 'valued' practice under leadership suggested developing concrete action-plans for quality management and clinical

governance implementation. Oakland (2001, p. 3), as well as Senior and Fleming (2006, p. 288), support this.

Thirdly, staff held controversial views on **workload and efficiency** under perceived effects of quality management and clinical governance on improvement. This mirrors the academic controversy, as discussed in Section 2.2.1. Further, staff understood that it was the responsibility of quality management and clinical governance leadership to fairly distribute resources. On a more negative note, practitioners in Germany resisted quality management under cultural changes, because they thought that it increased bureaucracy. Along the same lines, staff perceived that quality management and clinical governance took up time, so that they could spend less with the patients. Øvretveit (2000, p. 74) cautions that less successful quality management initiatives only increase bureaucracy. Further, Peters and Austin (1985, p. 312) see a general need of *"debureaucratisating"* company operations.

Further, for customer priority staff concurred that external financial pressures and scarce resources represented an issue and demanded more resources to provide adequate patient services. This reflects the general issues in healthcare, as discussed in Section 3.1.3, and the political responses to these, as discussed in Section 3.3.1. OECD (2003b, p. 39) also addresses the general scarcity of resources in healthcare and cautions hat an increase may be required for changes. The NHS Constitution (NHS, 2010a, p. 4) defines *"the most effective, fair and sustainable use of finite resources"* as one of the principles of the NHS.

Fourthly, staff understood quality management and clinical governance to positively orientate staff about **expectations and requirements**. Staff across the countries developed this idea further under perceived effects on teamwork – clinical governance and quality management clarified responsibilities of the team members so that teamwork improved. This is consistent with the views of Oakland (2001, pp. 153-155) that organisational excellence requires clarified responsibilities and clarity of expectation through performance management.

Fifthly, the **contentious role of consultants** cut through all analytical categories, apart from improvement and customer priority. Under leadership, staff in Germany thought that consultants' leadership represented an issue. Further, staff agreed that it was difficult to involve consultants in quality management and clinical governance and one clinical governance manager in England praised clinical governance as a good tool to challenge consultants. Involvement and teamwork were closely linked in this regard – staff concurred that consultants played a crucial role and some suggested the need for consultants to make more effort, if teamwork was to succeed. Accordingly, staff in Germany further explained that consultants especially resisted cultural changes for quality management and clinical governance. Zabada *et al.* (1998, p. 62), Huq and Martin (2000, p. 80), and François and Pomey (2005, p. 1S4) support the contentious role consultants play in promoting and implementing quality management in healthcare organisations. More generally, Kirkpatrick *et al*. (2005, p. 93) state: *"often, senior doctors, have been reluctant to change their practices in response to management"*. Freeman (2000, pp. 86-92) develops further detail to explain this with a traditional professional mind-set.

The analysis of the case-studies further suggested extending the role of support staff within quality management and clinical governance. Support staff were not much involved and did not feel like an equal part of the team, even though they thought that they could make meaningful contributions. Oakland (2001, p. 153) supports the general problem of low involvement of certain staff groups and highlights the need to appreciate the role of all staff to realise business excellence.

Sixthly, the **'them versus us'** phenomenon between ward staff and the clinical governance department was mainly observed in England. Goetsch and Davis (2006, p. 453) generally caution that this 'they' mentality is a sign of negativity, which prevents the realisation of optimum operational performance. Further, Morgan and Potter (1995, p. 173) explain that this 'them versus us' differentiation is a usual phenomenon between different professional groups in healthcare.

Staff in Germany and England concurred that clinical governance and quality management staff occasionally seemed to *"live in a separate world"* that did not have much to do with the operational reality on the wards. To avoid negative effects from this, staff suggested the more active involvement of the wards in decision-making and also by staff surveys. Dale (2003, pp. 181 & 183), as well as Goetsch and Davis (2006, pp. 554-555), support this.

In terms of leadership, staff across the countries opined that a clinical background helped managers to more effectively lead clinical governance and quality management by, as staff in England thought, understanding the wards better. Oakland (2001, p. 16), as well as Goetsch and Davis (2006, p. 263), more generally explain that managers need to understand the operations in their organisation to successfully lead them.

Using a common language to make quality management and clinical governance tangible for staff was closely related to the 'them versus us phenomenon' under leadership and involvement. One QMB in Germany had overcome an initial 'them versus us' problem by using a common language. Staff across the countries agreed that a clinical background helped managers to find this common language that should be used to involve staff. Especially in England, staff complained that clinical governance was not tangible enough and that too many 'buzz words' were used around it – they suggested making the concept more tangible by referring to quality and improvement. Hall and Holt (2008, p. 35) generally agree with this, with regard to the public sector. Goetsch and Davis (2006, p. 305) also recommend finding a common language for successful cooperation between different departments.

In summary, clinical governance and quality management played many-fold roles. On the one hand, they helped to orientate staff, even though the involvement of consultants and support staff should further be developed, and increased transparency as well as consistency. On the other hand, they required additional effort and time without an agreed impact on efficiency and there was the danger of just getting everything right on

paper. This potential discrepancy between operational reality on the wards and the reality on paper could be interpreted as a manifestation of the ‘them versus us’ phenomenon that should be attacked, as advised above. The following chapter compares these findings with the outcomes of the expert interviews, grouped according to the country of expertise, using the six analytical categories and the themes that cut across them, before Chapter 9 draws overall conclusions to prepare the recommendations in Chapter 10.

8 Discussion: Expert Interviews

This chapter uses the six analytical categories and the emerging themes to compare the findings from the cross-case analysis to the outcomes of the expert interviews in Germany, England and Florida.

8.1 Germany

The analysis in this section applies the analytical categories and themes identified above. It is based on the interviews with the experts in Germany. With regard to **improvement**, the experts agreed with staff at the hospitals in Germany that elements of quality management had been there before but had not been structured sufficiently. They thought that the competition in the health sector would increasingly foster quality considerations, as further discussed below under customer priority. Accordingly, they supported trends towards the specialisation of hospitals to increase the quality of the services.

The experts internationally compared the power of politics to take over the **leadership** of quality management efforts in healthcare, as summarised in Table 84 below. They concluded that, while in the UK and the USA a stronger position of the customers might facilitate this, in Germany the government and the SHI could not control the spread of quality management across the hospitals. In their view, the hospitals had to see the need for quality management and should lead it strategically, as supported by the QMBs and the clinical governance managers at the hospitals.

Table 84: Experts (D) – Leadership

LEADERSHIP	Staff in D	Staff in E
Lead QM/CG strategically	✓	✓
Appreciate employees	✓	✓
Management needs to show commitment to QM/CG	✓	✓

Source: the author

They cautioned, however, that the organisations were already overcharged in their daily operations, as becomes clear under customer priority when staff asked for more resources to make quality management work, and did not have time for strategic considerations of quality management – in privately owned hospitals the pressures for a strategic orientation seemed to be stronger. This could be confirmed by this research, whereas publicly owned hospitals started to approach quality management strategically according to their QMBs – even though priorities tended to change to the disadvantage of quality management.

Overall, the experts suggested an increase in accountability of the organisations by developing budget responsibilities based on direct allocation of process costs. Further, they criticised the education of managers in healthcare – they focused too much on money without appreciating the importance of their employees within a strategic vision of the organisation. This could be related to staff at the hospitals across the countries demanding more management presence throughout the organisations to show this appreciation of the important part staff played for company success.

More directly focused on quality management leadership, the experts recommended a more even spread of quality management responsibility across more people in the organisation to avoid frustration and achieve a thorough penetration of the organisation. This had to come from the top management with empathy for staff, as they had not experienced bottom-up approaches to succeed in healthcare quality management. Staff at the hospitals in both countries supported these points.

The experts confirmed various aspects of **involvement**, as identified in the case-study organisations. Nursing staff was said to be the most innovative in quality management involvement and efficient development but with the least influence. Further, the experts critically stated, alongside staff, that staff communication and training about quality management and clinical governance required more attention. However, they also cautioned that quality management did not seem to be the most interesting topic in the

training of young practitioners and it was crucial to explain to junior staff why it was important. Finally, the experts added that successful quality management required involvement through flatter hierarchies looking at the entire organisation.

With regard to **teamwork and partnership** development, the experts also supported aspects identified in the case-study organisations. As displayed in Table 85 below, they agreed, alongside staff, that quality management had a positive impact on interdisciplinary cooperation that could be further intensified. Nonetheless, they criticised staff for not paying enough attention to management issues. Accordingly, they suggested the development of managerial competences among medical personnel and vice versa. Interestingly, staff in Germany did not refer to this, whereas staff in England contributed this as suggestion for improvement of clinical governance. The experts developed this further to demand that the team members should focus more on their core competences – this was supported by staff in England. The political expert explained that staff in England embraced teamwork instead of just paying 'lip-service' to it because of systems pressure around scarce resources.

Table 85: Experts (D) – Teamwork & Partnerships

TEAMWORK and PARTNERSHIPS	Staff in D	Staff in E
QM/CG have a positive impact on TW	✓	✓
Stroke patients require TW	✓	✓
Staff should pay attention to management issues		✓
Team members should focus on core competences		✓
Improve partnerships	Hardly mentioned	

Source: the author

In agreement with the findings from the case-study organisations, the experts concurred that complex patients, such as multi-morbid elderly or stroke patients, required teamwork and that this seemed to be less of a problem for the younger generation of practitioners. The experts cautiously attributed some of the issues around respect between professions and teamwork in Germany to the different academisation of professional

training. Germany was one of the last countries that did not train nurses at university.

Finally, the experts recommended improvements of partnership approaches in healthcare as a whole and between hospitals. These issues were hardly addressed by staff at the case-study organisations. The experts thought that specialisations of the hospitals, as alluded to under improvement, should be decided on and realised in close cooperation and coordination of the local hospitals. Additionally, they suggested closer cooperation between different types of health service providers, e.g. GPs and hospitals, to improve information sharing and avoid the repetition of similar examinations by different providers on the same patient (‘Doppeluntersuchungen’).

The experts did not contribute much information about **cultural changes** but there was agreement that traditional inflexible structures at the hospitals and within the healthcare system inhibited changes. A cultural openness for change did not seem to be widespread. This was consistent with the views of staff at the case-study organisations in Germany.

In terms of **customer priority**, the experts agreed with staff at the organisations that the customer concept was not adequate because going into hospital could not be compared to going shopping, as summarised in Table 86 below.

Table 86: Experts (D) – Customer Priority

CUSTOMER PRIORITY	Staff in D	Staff in E
Don’t like customer concept	✓	✓
Patients have rights and responsibilities		✓
Patient satisfaction improves	Could not be proven	
More competition for better informed patients	✓	

Source: the author

They suggested developing the idea of a ‘Kunde’ (= customer) to somebody who is ‘kundig’ about themselves (= the best expert about

themselves) and, therefore, seeing the patient as a partner. This fell, according to the experts, into a EU-wide political trend to foster patient orientation in healthcare.

As health was the most important personal good and taking into account the public worry about worse care for the elderly, the experts were convinced that the public would be more willing to invest more in it on their own initiative. Therefore, they suggested putting more public health efforts into prevention – just as underlined by staff at the hospitals in England: patients had both rights and responsibilities.

Staff at the case-study organisations could not prove a positive impact of quality management on patient satisfaction and had doubts, because of the overall scarce resources in the system that counterbalanced potentially positive effects of quality management. The experts, however, had accompanied the implementation of quality management at a group of hospitals and could prove that patient satisfaction had improved at the cost of staff satisfaction – they had improvised with the scarce resources they had within quality management to do the best for the patients. The experts identified various sub-aspects under the issue of scarce resources. One expert critically stated that, in spite of substantial investments in healthcare, the results were not correspondingly satisfactory: *"we pay for a Mercedes and get a Polo."* Growth through innovation did not happen because of focussing on saving money, which resulted in staff frustration. Staff addressed this, asking for more resources to provide their services to the patients in the best possible way.

At the systems level, the experts complained that, in international comparison, patients in Germany stayed too long in hospital. The trend for improvement, which had started in this regard, needed to further continue in their view. This could happen, they explained, by introducing more competition in the health sector. The QMBs also demanded that this should be based on choice by informed patients. In the view of staff at the hospitals in Germany, patients were already better informed.

With regard to themes that cut across the analytical categories of the case-studies, as identified in Section 7.9, the experts agreed with staff at the hospitals across the countries that quality management increased **transparency**. This, in turn, was seen to improve the safety of the service provision for the patients. The experts recommended the further development of organisational transparency. They added that ICT could help to increase transparency also across different service providers and, therefore, improve external cooperation.

As summarised in Table 87 below, the experts also supported the second theme of **looking good on paper** instead of propelling real changes, based on prioritised action plans. They remarked critically that especially quality management certifications represented a bureaucratic way of making the organisations look good on paper. In their view, this was based on too much documentation – the focus should switch more towards continuous efforts to improve outcome quality. In agreement with mainly managerial staff at the hospitals, they advised prioritising issues and consequently addressing them, following a clear action plan.

Table 87: Experts (D) – Second Theme

SECOND THEME	Staff in D	Staff in E
Prioritise implementation in action-plans	✓	✓
Management consultants can help	✓	

Source: the author

Even though the QMBs at the organisations concurred on the positive influence of management consultants on making quality management work, the experts espoused contradictory views. On the one hand, half of the experts were convinced that staff had all the 'know-how' needed to identify and address areas for improvement. Therefore, management consultants were seen to cost in two senses: first, in the fee they charged and, secondly, in the not applied ideas for improvement, potentially held by staff. On the other hand, half of the experts agreed with the QMBs that management consultants could help to improve quality management outcomes – it would neither be efficient nor effective to train staff and

exempt them from work to assist in implementing quality management practices throughout the organisation.

With regard to the third theme, the experts agreed with staff on the ward that quality management required additional **effort** by staff and understood that staff could perceive it as a burden. In agreement with staff, they further thought that pursuing quality management was worth it especially taking into account scarce resources – the more persistently quality management was applied the more, they thought, this would have a positive impact on efficiency and financial profit. The experts, however, also questioned the overall scarcity of resources and asked for more efficiency in a system with less SHI companies to make the best use of the resources at hand. Quality management, training and a change in generation of practitioners were seen to be the only way to achieve this.

The experts did not directly refer to the fourth theme of **clearer expectations and requirements** for staff through quality management. But when they addressed better-structured quality management activities under improvement, this could also be understood as a clarification of expectations and requirements for staff.

In contrast to this, the experts developed similar views compared to the opinions of staff on the fifth theme – the **contentious role of consultants** in quality management. Unlike staff at the hospitals, however, they did not put any emphasis on the role of support staff within quality management. They criticised strong hierarchies and a high, unquestioned position of the head physicians (‘Chefärzte’) as a barrier to quality management. In accordance with the issues discussed under teamwork above, the experts highlighted the difficult relationship between the head physicians and management. Comparable to the strategic orientation of quality management, the experts thought that hospitals in private ownership coordinated this better.

In order to improve how consultants interacted with non-clinical managers and led staff as well as quality management, the experts suggested

incorporating teamwork, human resources and general management aspects in the academic training of consultants. Further, the experts cautioned that consultants often tended to understand the medical technical aspects of the treatment in hospital as quality without considering the social, interpersonal aspects, as developed in Donabedian's understanding of healthcare quality[87]. Accordingly, they further recommended communications training for consultants – especially because nursing staff were not allowed to inform the patients about their treatments. The experts, thus, explained parts of the contentious role of consultants, as identified by staff, and developed tangible suggestions of improvement.

With regard to the sixth theme identified in the case-studies, the **'them versus us'** phenomenon, the experts only focused on questions of language. They confirmed the impression of staff across the countries that linguistic issues could represent a strong barrier to successful quality management implementation. Further, they explained this, in part, with the origin of quality management in the Anglo-Saxon environment and a dominance of English terms in the field. Alongside staff across the countries, they recommended finding a common language as a basis for effective communication between managers and staff.

In addition to the analytical categories and the themes identified in the case-studies, two new themes – politics and international comparisons – could be distinguished in the expert interviews. In terms of **politics**, they saw a need to further develop the framework legislation for quality management in healthcare, including more powerful incentives that would go beyond monetary support. They added that this did not mean, however, that the government should control the healthcare market but rather should foster **competitive forces**.

Finally, the experts concluded, with regard to **international comparisons**, that healthcare cooperation at the European level would be desirable to exchange ideas on improvement at a wider scope. They admitted,

[87] See Section 2.1.2.

however, that there was usually not enough time for this. Further, they explained that prevention and pharmaceutical safety represented the main aspects of coordination at the European level. In comparison, the German system was said to use many financial resources with mediocre effect, whereas the English system was said to have focused substantially on saving money while still achieving better results in terms of the most common diseases.

8.2 England

The analysis in this section applies the analytical categories and themes identified above. It is based on the interviews with the experts in England. With regard to **improvement**, the experts in England agreed with the experts in Germany and staff across the countries that some elements, such as clinical audit, had been in place before the introduction of clinical governance. In their view, clinical governance systematically brought these elements together under one formalised and comparable framework. They confirmed that improvements were always possible. Further, the experts added that NICE and other regulators delivered good work to detect trends and to suggest further improvements.

The experts painted a mixed picture about the strategic importance of clinical governance **leadership**. Half of the experts supported it in agreement with their German counterparts, the clinical governance managers and the QMBs, whereas the current financial climate could make it more difficult to realise this strategic focus on quality management and clinical governance. The other half of the experts, however, remarked critically that too many aspects carried the label ‘clinical’ when they were not considered to be managerial – clinical as opposed to organisational governance. They cautioned that operational audits were not linked to strategic considerations. Table 88 below compares the different views on leadership.

Table 88: Experts (E) – Leadership

LEADERSHIP	Experts in D	Staff in D	Staff in E
Strategic importance of CG	✓	✓	✓
Senior management commitment	✓	✓	✓
CG to support decision-making			✓
Create more incentives for CG			✓

Source: the author

Further, they underlined, alongside their colleagues in Germany and staff in both countries, the importance of senior management commitment in leading and supporting clinical governance for its success. In their view, this made cultural issues disappear and staff more engaged as well as less afraid of change. Additionally, they supported the need for the clinical governance manager to be present amongst employees with the skills to persuade staff to make clinical governance work throughout the organisation by challenging behaviour, not people, and adequately chairing related meetings.

However, the experts stated critically that clinical governance occasionally became a tool for devolving risk from managers to the lowest possible staff level. They recommended introducing more international benchmarks to support individual decision-making, staff in England also thought that clinical governance supported decision-making. Further, financial incentives should be better designed to fulfil their purpose in fostering clinical governance. Staff in England more generally criticised a lack of hierarchical incentives to involve team members in clinical governance and suggested that these incentives should also be extended to lower levels of staff.

With regard to **involvement**, the experts opined that staff should have a better understanding of what clinical governance meant for their job. But this could become a problem, as they explained, in large organisations of around 3000 members of staff, such as within the NHS: as found in the other parts of this research, the employees often did not recognise the term. Staff could not relate, for instance, to financial aspects within it, as

they were not familiar with them in their daily activities. Nonetheless, they understood the components of clinical governance that had a practical impact on their work, such as risk management, clinical audit, improvement, ethics, standards and accountability.

Regarding the latter point, the experts, supported by staff responses in England, were convinced that staff showed more awareness of and accountability for consequences of their work because training, including that at university, emphasised these issues more than before. This is summarised in Table 89 below.

Table 89: Experts (E) – Involvement

INVOLVEMENT	Experts in D	Staff in D	Staff in E
More awareness			✓
Involvement increases with seniority			✓
Further develop involvement	✓	✓	✓

Source: the author

Nonetheless, they recommended further developing accountability- and clinical-governance-related training with more focus on improvement. In their view, record keeping and the publication of complaints were key to achieve more accountability and better risk analysis. Regarding complaints, the experts suggested involving clinicians more in their management – complaints were important to develop the organisation and should not be dealt with by very junior staff, as was said to be common practice.

Seniority also played a role in clinical governance involvement – in the view of the experts and of staff in England, staff were more involved with increasing seniority in the organisation. Unlike their German counterparts and staff across the countries, the experts in England perceived staff to be overall equally involved across the professions with slight differences in different specialities and personal interest, as supported by staff across the countries. However, they also admitted that the individual leading

clinical governance also influenced who got involved – if a nurse led clinical governance, nurses would be more involved.

The experts mentioned various forms of involvement, such as meetings, support groups, helpline, communications to inform staff about clinical governance (e.g. newsletters), which should be further developed. This was also demanded by the other experts as well as staff in both countries. The experts further suggest working groups to represent all staff groups within specific clinical governance aspects.

The experts further supported the research findings around **teamwork**. In their view, stroke service provision worked well because it followed a systems approach based on evidence, including research that confirmed the need for teamwork across the professional groups. Clinical governance recognised that teamwork was needed for the patients and created an expectation for it. However, they admitted that clinical governance was hard to implement in a dysfunctional group – it required good relationships and clinical governance alone could not create these.

Table 90: Experts (E) – Teamwork & Partnerships

TEAMWORK and PARTNERSHIPS	Experts in D	Staff in D	Staff in E
Stroke requires TW	✓	✓	✓
TW improves with academisation of N	✓		
Further develop TW between clinical and non-clinical staff			✓
Improve PS	✓		

Source: the author

In support of the experts from Germany, the experts from England explained that teamwork improved with the academisation of more confident nurses, even though communication between the different staff groups could still occasionally represent a problem. Nonetheless, the experts cautioned that too much delineation between the professions still persisted. Depending on the local personalities involved, they added, the responsibility for clinical governance was shared between the medical and

nursing director; staff cultivated more respectful inter-professional working relationships.

The experts suggested improving team approaches through team-based reporting. In terms of teamwork between administration and clinicians, the experts agreed with staff in England that non-clinical personnel should support clinicians with administrative tasks so that the latter could fully focus on the delivery and improvement of their clinical practice. This administrative support should also look at improving the patient experience in terms of the seven pillars.

In agreement with their counterparts in Germany, the experts recommended improvements of partnership approaches. This was rarely addressed by staff at the case-study organisations. The experts identified the need to bring social- and healthcare closer together by continuous improvement of care pathways, as suggested by the therapists at one organisation in England. The SHAs, however, represented a constraint in this regard, because SHA boundaries created pressures to work with certain providers, even though others might be geographically closer or better equipped to deal with certain diseases.

With regard to **cultural change**, the experts found it worrying that little had changed, even though serious incidents nationwide had underlined the need to learn from mistakes and had triggered the implementation of clinical governance, as discussed in Chapter 3. They admitted that new process structures helped to prevent mistakes but more changes were still needed. Alongside staff in both countries, risk management within a ‘no-blame’ culture and reducing the fear of staff to enable learning from mistakes were understood as key aspects within clinical governance, as displayed in Table 91 below.

Table 91: Experts (E) – Cultural Changes

CULTURAL CHANGES	Experts in D	Staff in D	Staff in E
'No-blame' culture is key		✓	✓
Reasons for resistance		✓	
Overcome resistance		✓	✓
Too much change in the NHS			✓

Source: the author

But culture, in their view, represented the main issue in implementing clinical governance. As mirrored by the experiences of staff in Germany, employees, who had worked in the NHS for a long time being loyal to what they knew, did not want to change. The experts additionally saw a general health service mentality of seeking to break new things down, as supported by Morgan and Murgatroyd (1994, p. 169). The experts explained further that staff did not understand clinical governance nor the need for it, as supported by this research. The experts agreed with staff in both countries that resistance was best overcome by focusing clinical governance, 'selling' the need for it to staff and explaining how and why it was implemented.

As it was not always worth spending 80% of time on 20% of people who were resisting change, the experts recommended involving practitioners in specific aspects of clinical governance, such as clinical audit, training staff in structural ways of thinking and finding enthusiastic leaders, who were popular with staff, to support clinical governance. However, the experts recognised that, because it was *"quite an intangible beast"*, the label clinical governance could often be blamed for various probably unrelated problems and issues. Further, they agreed with staff in England that the speed of change represented the main problem with all NHS initiatives – *"the NHS is an organisation which is all about change but yet it is always the same"*. The organisations, they explained, never had the chance to embed changes properly before the next initiative started. In their view, this resulted in initiative fatigue. Lewin's model of change (Senior & Fleming, 2006, pp. 349-351) describes the three phases of change, i.e.

unfreezing, moving and refreezing, which confirm these views of the experts.

With health being *"a really hot topic"* in politics, a rather cynical expert saw the NHS as a *"slave of the government and the DoH"* that suffered the latest management guru through minor reorganisations every three years and major ones every ten. More matter-of-factly, the experts cautioned that all of these changes unnecessarily took the focus off patient care. This leads to the discussions of **customer priority**. In the view of the experts, clinical governance should describe safe and effective ways of working with the patient at the centre. Table 92 below compares the findings around customer priority.

Table 92: Experts (E) – Customer Priority

CUSTOMER PRIORITY	Experts in D	Staff in D	Staff in E
Patients as main customer		✓	✓
Customer concept not well understood		✓	✓
CG improves safety to meet patient needs		✓	✓
Patients don't see effects of CG			✓
Difficult to realise patient choice	✓	✓	
CG takes time, less for patient		✓	✓
Need for more prevention	✓		

Source: the author

Unlike the experts in Germany and staff in Germany, the experts in England did not question the adequacy of the customer concept in a healthcare environment. As also understood by staff, the experts saw the patients as, *"hopefully"*, the main customer and service user with a right to comment on and critique the service they received. The main patient complaints, as experienced by the experts, did not aim at financial compensation but tried to prevent reoccurrence of similar events. Complaints often focused on bereavement. The experts advised that chaplains could help through open and honest communication. They cautioned, however, that the generally litigious society caused problems with regard to complaints.

Returning to the customer definition, the experts included internal customers and the PCT as the payer of the services. At the same time, they confirmed the findings of this research that the idea of the customer did not have a widespread understanding. In terms of effects, the experts agreed with staff across the countries that clinical governance ensured better risk assessment and, therefore, improved patient safety and hopefully the patient experience. Further, they explained that specific improvements in stroke care could be realised thanks to stroke prevention and care being a national priority.

In agreement with staff across the countries, the experts highlighted the crucial need within clinical governance of ensuring that patients received the services they needed, based on the right resources and the right equipment. However, the experts critically remarked that quality management and performance measurements were all about the system, excluding patient-level data despite a focus on patient and public involvement within clinical governance. Further, the experts confirmed the views of staff in England that most of the effects of clinical governance were invisible to the patients or that they would not necessarily attribute them to clinical governance, if they were aware of them.

Awareness was also identified as a barrier to realising patient choice to create more competition in the healthcare system. Agreeing with the experts in Germany and the QMBs, the experts in England explained that patients had to know about differences in treatment to make a reasonable choice about the hospital in which they wished to be treated. Thus, if clinical governance improved the quality of the service and the money followed patient choices, based on quality of the service, the organisation would achieve higher profits.

In terms of negative impacts, the experts agreed with staff in England and Germany that clinical governance could take staff away from the patients. But they also cautioned that this was using *“clinical governance as an excuse”*, as writing and recording of patient-related activities could be done together with the patient. This idea of patient involvement leads to

discussions of prevention as, in the view of staff in England, a manifestation of the responsibilities that patients had for their health, in addition to their rights. The experts in both countries concurred on the need for more support of prevention. The experts in England warned that hospitals tended to focus on the provision of more lucrative acute services. Finally, the experts agreed on the benefits of specialisation in smaller community hospitals for more individualised care, provided through simpler organisational structures rather than massive super hospitals.

With regard to themes that cut across the analytical categories of the case-studies, the experts agreed with their counterparts in Germany as well as staff at the hospitals across the countries that clinical governance increased **transparency**.

Further, the experts also supported the second theme of **looking good on paper instead of propelling real changes** based on prioritised action plans. In their view, most staff thought that clinical governance was a good thing and that often documentation looked great on paper. Yet, they questioned whether this was so in reality with regard to, for instance, audit. They had experienced that clinical governance was approached similarly at different hospitals in England, as supported by this research, and most attended to the key issues, while the question remained how advanced they were in doing so and how to measure this – some were more advanced on paper, others in operations.

Looking at it from a slightly different angle – clinical governance, the experts explained in agreement with their counterparts in Germany, increased monitoring and evaluating of services based on more paperwork but there were no standards as to how to record practice so the records were in danger of being meaningless. Additionally, the experts recommended, similar to their colleagues in Germany and staff across the countries, addressing issues identified through audit in prioritised action-plans that were clear in what they wanted to achieve and how achievements could be measured. Instead of getting lost in many initiatives, the experts further suggested focussing efforts on national and

local priorities. This focus should, in the view of the experts and staff in England, also extend to clinical governance meetings, pre-empted by agendas sent in advance. In agreement with staff in England and half of the experts in Germany, the experts did not see a need for management consultants to make clinical governance work, as there was enough internal knowledge.

With regard to the third theme, the experts critically remarked, alongside their counterparts in Germany and staff across the countries, that more time spent on recording activities and documentation might cause less time to be available for patient needs, as discussed above under customer priority. This **increased workload** should be more efficiently integrated to be less of a burden for staff. Comparable to the views of staff at the hospitals in both countries, the experts did not agree on the overall impact of clinical governance on the efficiency of the hospital operations. On the one hard, they were not sure about the value-for-money of clinical governance because of the above reasons. On the other hand, they highlighted increased efficiencies with reduced waiting lists. Therefore, they explained, money came in more quickly since more patients were being treated – or, at least, litigation caused less costs thanks to safer service provision.

Looking at the fourth theme of **clearer requirements and expectations** for staff, the experts in England agreed with their counterparts in Germany and staff at the hospitals across the countries that clinical governance made working more structured and staff more confident. They criticised, however, a mismatch between national standards and actual methods of delivery. Accordingly, they asked for improvements of quality by describing basic components of the service.

The experts in England developed similar views compared to the opinions of their counterparts in Germany and staff across the countries on the fifth theme – the **contentious role of consultants** in quality management and clinical governance. Unlike staff at the hospitals, the experts across the countries did not put any emphasis on the role of support staff within

quality management and clinical governance. Very generally, the experts explained that clinical governance did not work without the involvement of consultants, even though it was more difficult for consultants to integrate themselves. As explained by the experts, they were less ward-based than the other professions. In order to support the involvement of consultants in clinical governance, the experts recommended selecting them at an early age, if they showed leadership traits, to take over managerial responsibilities.

With regard to the sixth theme identified in the case-studies, the **'them versus us' phenomenon**, the experts in England alongside their colleagues in Germany advised the use of the right language to communicate clinical governance to staff.

In addition to the analytical categories and the themes identified in the case-studies, two new themes – politics and international comparisons – could be distinguished in the expert interviews. In terms of **politics**, the experts explained that implementation of clinical governance depended on organisational maturity.

With regard to **international comparison**, the experts in England, in contrast to their German colleagues, opined that the NHS had gone through a period of real growth in terms of investments over the past ten years. This had come to an end with real-terms cuts for healthcare because of the banking crisis, resulting in job freezes and no additional funds to renew hospitals. Considering the trends towards an elderly society with the population living longer and expensive treatments causing more healthcare costs, the experts questioned how many more funds could be taken from tax payers and whether the NHS could survive in its current form. Accordingly, they suggested *"change before its back is broken"*.

The experts considered privatising the NHS as a potential solution that would be, however, difficult to control. As it was seen to be an *"incredible*

system" that would become unaffordable if privatised, the experts recommended improvements and changes within the current NHS setting.

Similar to their counterparts in Germany, the experts in England further opined that more competition would be healthy for the NHS. Djellal and Gallouj (2008, pp. 66-67) support the positive impact of competition on innovation in the public sector and Section 3.3.2 further discussed the role of competitive elements in healthcare reforms. Comparing the NHS to alternative, insurance-based models in Europe, the experts suggested maintaining the national service for basic needs. Comparing the NHS to privately run healthcare models in the US, the experts supported the recommendation of increasing patient choice, discussed above under customer priority.

Similar to the expert interviews in Germany, questions of increased **competition** in healthcare run as a theme through the analysis of the expert interviews in England, namely customer priority (as in Germany) and international comparisons. **Risk management** represents an additional theme within the expert interviews in England under leadership, involvement and customer priority.

8.3 Florida

The analysis in this section applies the analytical categories and themes identified above. It is based on the interviews with the experts in Florida. With regard to **improvement**, the experts in Florida cautioned that quality, as a very nebulous concept[88], was difficult to measure but this measurement had been achieved by standardised outcome measures within evidence-based medicine[89]. Since 2003 federal law required the reporting of ten core measures for three main diseases (i.e. pneumonia, congestive heart failure and heart attack). Nonetheless, they were convinced that quality management in general reflected common sense and improvements were best achieved by taking a systems approach to

[88] See Section 2.1.
[89] Evidence-based medicine is understood as a key part of clinical governance in England.

search for bottlenecks in the hospital operations to enable faster access to appointments and track the patients through the hospital.

The experts supported the **leadership** findings of this research that national pressures had led to the implementation of quality management – but these had started slightly earlier than in Europe. Further, they also agreed with the experts in Germany, the QMBs and half of the experts in England that quality management, or at least part of it, formed part of strategic planning, whereas the focus was more on reputation. In order to prevent bad press because of quality issues, the hospitals worked with quality management standards. Linking the strategic approach to quality management to cultural changes discussed below, the experts cautioned: *"culture kills strategy"*. In support of the findings of this research, the experts added to this: *"management is the thing"* referring to the need for leadership commitment to quality management. They explained that this was often achieved by linking directors' bonuses to performance measures.

With regard to **involvement**, the experts supported the more detailed findings from this research that understanding, involvement and engagement of staff was generally very important for successful quality management. In Florida, as in England and Germany, this was or should be achieved, in their view, by relentless education about and reminders of what it meant, how it was done and why every staff group counted in implementing it. The latter point was especially addressed to support staff. The experts further explained that employee involvement in quality management and continuous improvement was also externally forced, as quality management accreditors only spoke to staff. One or two mock inspections per year were said to maintain the momentum. Finally, one of the experts could prove that thanks to quality management efforts at their organisation employee satisfaction had increased, which had resulted in decreasing staff turnover.

As with clinical governance in England and quality management in Germany, the experts confirmed for the US approaches to quality

management and continuous improvement that they supported **teamwork**, which, in turn, was seen to be important in delivering quality services to the patients. Nonetheless, the experts cautioned that this came with the danger of staff doing more other people's jobs rather than focusing on their own. Even though the experts did not perceive professional rivalries as a problem, they admitted that nurses approached care more holistically, while consultants focussed more on the actual cure of the disease. In agreement with the other experts, they saw a positive impact of academisation on the relationships between different groups of staff.

Further, the experts alongside their European colleagues appreciated the role of partnerships within quality management. In their view, several types of providers for elderly care (e.g. acute care, nursing homes, homecare, hospices) were well integrated. This was seen to be very important for this patient group. The experts attributed increased satisfaction of GPs with the services provided by the hospitals to quality management. The Institute for Healthcare Improvement[90] further supported partnerships for quality management and continuous improvement by cooperating with healthcare providers and leaders. However, the experts cautioned that Benchmarking in US healthcare represented a challenge, as different types of hospitals and private insurance systems required risk adjustments, in order to be comparable. This was also true for European hospitals even, if they seemed to be more similar on the surface.

In terms of **cultural changes**, the experts opined that quality management and continuous improvement were now culturally engrained. But, just as in Europe, the experts recommended that this change had to be managed in order to be successful. Both staff and management personalities were seen to have a significant impact on a culture for quality. In their view, it was *"easy to pave the road towards the change"* but a lot more difficult to change people's habits – *"they say yes to it but mean no"*. Supporting the findings of this research, the experts explained that staff tended to be afraid of change and resisted it, because they had worked the same way for a long time without any problems. Accordingly, managers needed to

[90] See http://www.ihi.org/ihi.

communicate the reasons, vision and mission of the project and achieve staff buy-in by showing how they would profit from the changes.

As summarised in Table 93 below, the experts explained the development of **customer priority** in hospitals. Around the implementation start for formal quality management, the patients had become numbers and the concept of a customer was introduced to change this. Therefore, it did not have a negative connotation, as amongst staff at the hospitals in Germany and among the experts in Germany. In addition to the patients as the main customers, the experts included staff, GPs, insurance companies, regulators, vendors, volunteers, neighbours and visitors to the city among others in their customer understanding – this extended the customer understanding from the majority of the respondents in Europe.

Table 93: Experts (FL) – Customer Priority

CUSTOMER PRIORITY	Experts in D	Experts in E	Staff in D	Staff in E
Patients as main customer		✓	✓	✓
QM improves safety to meet patient needs		✓	✓	✓
Patients don't see QM effects		✓		✓
Need for patient choice	✓	✓	✓	
Scarce resources prevent CP			✓	✓

Source: the author

Further, the experts supported the findings of this research with regard to quality management improving patient safety. Patient satisfaction was said to have increased with safety (e.g. less patient falls) and more friendly staff through quality management. For further improvements of the patient experience, the experts suggested developing this idea to a new focus on documenting pain and the remedies taken, as well as screening for the main issues among the elderly (i.e. memory, mood, mobility and medication). In agreement with staff opinions in Europe, the experts defined high quality of care by doing the right thing for the patient regardless of background and ability to pay. Nonetheless, the experts warned that the risk to die of hospital-acquired infection was higher than of

breast cancer, Aids and car accidents together. This would equal, they explained, to one jumbo-jet crashing every day in the US.

Because of this and because patients could only in part evaluate the quality of care, as discussed by experts and staff in England, they saw a need for more public scrutiny of healthcare. In agreement with the experts in Europe, they recommended more patient choice in healthcare. Insurance carriers tended to have specialised contracts and tried to force patients to consult certain providers, even though they should realise that patients had a choice and listen to their needs. Accordingly, the experts agreed with their European colleagues that the government needed to educate the public more, so that they could make more informed choices, and focus more on prevention. Similar to the situation in Europe, the latter point became ever more important, as the experts explained, taking into account the funding problems, especially for elderly care, across the US. The experts highlighted the irony of not enough funding for specialist care that then resulted in higher costs, when the patients were admitted into emergency care. As in Europe, scarce resources were blamed for decreasing quality and losing true insight into patient care.

With regard to themes that cut across the analytical categories of the case-studies, the experts agreed with their counterparts in Europe, as well as staff at the hospitals, that quality management increased **transparency** to verify the reputation of the hospitals by measuring and reporting data. This data was published, for instance, in the ranking of hospitals in Florida[91] on mortality rate by condition, infection rates and poor care condition rates (e.g. bed sores). The experts criticised the new state governor, however, for having lost the focus on healthcare transparency, while it was still present in the political discussions at federal level. With regard to consistency and standards, the experts advised not to change processes every day – this supported the criticism in England that the speed of change was too high in the NHS. The experts further advocated consistency of treatment because they were convinced that patients felt

[91] See based http://www.floridahealthfinder.gov/.

better, if the same consultant treated them with the same team throughout their stay in hospital.

The experts also provided evidence for the second theme of **looking good on paper** instead of propelling real changes based on prioritised action plans. In agreement with their colleagues in Germany, they remarked critically that quality management required too much bureaucracy and that this did not enhance quality. Before the implementation of formal quality management, they further explained, the problem of just looking good on paper had been even more important: *"you just reported what Washington wanted to hear"*. Agreeing with the QMBs and half of the experts in Germany and disagreeing with the experts in England and the other half of the experts in Germany, the experts in Florida recommended hiring external management consultants to help improving this by implementing quality performance measures. Moreover, they added that accreditation visits were unannounced with just fifteen minutes notice to counter this. Finally, they supported the findings of this research that a hands-on business orientation should be applied to quality management, manifesting itself in concrete action-plans and avoiding too high-level projects.

Even though this research did not yield clear results with regard to the third theme of **impact on efficiency and workload**, the experts explained that streamlined processes reduced lead-times. This, in their view, had a positive impact on efficiency and return on investment. However, they remarked critically, alongside the respondents in Europe, that quality management became more complicated every year and, therefore, required more resources in terms of time and money. In spite of supporting the findings of this research that quality management increased paperwork, the experts were still in favour of it because it supported organisational learning and education for the induction of new staff. Managerial and clinical staff at two organisations in Germany also mentioned this latter point.

The experts linked the fourth theme of **clearer expectations and requirements** to managing cultural changes in favour of quality management. In order to achieve the latter, they advised managers to be clear on which targets and outcomes were expected from employees.

The experts in Florida developed similar views as their counterparts in Europe and staff across the countries on the fifth theme – the **contentious role of consultants** in quality management and continuous improvement. Unlike staff at the hospitals, however, the experts across the countries did not put any emphasis on the role of support staff within quality management and continuous improvement. The experts remarked critically that plenty of literature on good medical practice existed without consultants using them, because they had *"always done otherwise so won't change now"* – if this was made public, there would be more pressures to convince them. On the one hand, they put hope with the younger generation of consultants. On the other hand, they had experienced the involvement of consultants to be easier in government related settings of healthcare than in completely private ones. Nonetheless, they added that quality management was significantly consultant driven.

With regard to the sixth theme identified in the case-studies, the **'them versus us'** phenomenon, the experts in Florida, alongside their colleagues in Europe, admitted that finding the right language to communicate with staff about quality management and continuous improvement could be difficult. Furthermore, they criticised the accreditors for inconsistently interpreting standards that should be written in a more concrete and tangible style, in order to avoid this.

In addition to the analytical categories and the themes identified in the case-studies, two additional themes – politics and international comparisons – could be distinguished in the expert interviews. In terms of **politics**, the experts explained that the state played an important role in forcing the implementation of quality management through regulations and licences to run healthcare, requiring formalised risk, safety and project

management among others. Additionally, they highlighted political pressures fostering the obligation to treat emergency cases, palliative care and hospices. The AARP[92] was seen as a strong lobby for elderly patients.

One expert explained critically that law interpretations changed from government via regulators to the application at hospitals. Having successively worked for the government, a healthcare regulatory body and as advisor to a hospital, he had seen how the law on reportable adverse events had changed from the original legislative intention to the actual operationalisation. If patients had been warned that they might lose the wrong leg through surgery and this really happened, it would not be a reportable adverse event, because the patients had been warned. Therefore, he asked for more consistent interpretations from law to regulators to hospitals.

In terms of **international comparisons**, the experts espoused critical views about their country. Even though they admitted the general US mentality of being superior, they confronted this with the reality in healthcare – the US did not even rank within the top ten comparing healthcare measurements and outcomes. Quite cynically, one expert summarised: *"the US are great at saving the rest of the world but forget about their own patients"*. As discussed under customer priority above, the system was not prepared for more elderly care needs. The experts further explained the need to nationally force quality management to counter the problem of the healthcare system being too expensive in international comparison. They attributed this, among other reasons, to liability problems within a litigious society, as also pointed out by the experts in England under customer priority.

Finally, the experts supported the additional themes of **competition** and **risk management** identified to run through the expert interviews in Germany and, or England. In Florida, the experts explained, the insurance carrier required best practices to be applied by hospitals to contract them and, thus, provided financial incentives to make healthcare more

[92] AARP stands for American Association of Retired Persons, see http://www.aarp.org/.

competitive. In spite of a political intention to let the market regulate healthcare, the experts underlined the need for standards to guarantee safe service provision. As discussed under politics above, risk management played a similar role as in England. Resulting from stronger market pressures in a private system, a focus on organisational reputation emerged as a new theme under leadership and transparency for the interviews in Florida.

8.4 Summary

The analysis of the international expert interviews in this section largely confirms the findings of this research, prepares the conclusions drawn in the following chapter and the recommendations in the final chapter. In addition to the organisationally focused analytical categories and themes applied to and developed from the case-studies, the expert interviews included two additional, more general themes that were used at the data coding stage already: the role of politics and international comparisons. Further, the analysis yielded three more themes that run through the expert interviews in at least one country: the importance of competition to improve healthcare across all countries, risk management in the Anglo-Saxon countries and a focus on organisational reputation in the US.

9 Conclusion

This chapter concludes the findings to answer the research questions and to develop the contribution to knowledge made by this research.

9.1 Overall Aim

The aim of this research was to analyse and compare clinical governance and quality management initiatives at hospitals in England and Germany in terms of **content**, **effects** and **implementation issues** as perceived by managerial, clinical and non-clinical staff working in elderly-related and acute stroke care in order to identify **'valued' practice** approaches and develop **recommendations for improvement** of these initiatives. The research addressed this aim by investigating five research questions, as developed in Section 1.2.

9.2 Approaches to Clinical Governance and Quality Management

The first research question concerns the main differences and similarities between and within approaches to clinical governance and quality management in elderly-related and acute stroke care, as implemented at the hospitals in England and Germany. This question helps to answer parts of the research aim, i.e. the **content** and **implementation** of clinical governance and quality management.

The comparison of the clinical governance and quality management models, predominantly applied at the hospitals in England and Germany[93], shows that these two models are composed of similar concepts. The interviews with the clinical governance managers and the QMBs further confirmed that clinical governance and quality management were approached similarly at the hospitals and had a comparably stable tradition. Even though for different reasons, the related initiatives had started between 1998 and 2000 in both countries and, at least officially, were of strategic importance, as suggested in the literature (e.g. Oakland, 2001, p. 2).

[93] See Section 3.3.2.

The main differences discovered did not relate to the models of clinical governance and quality management, but rather to how their implementation was dealt with regarding management consultants, ownership and ICT. While the organisations in Germany relied on the help of management consultants to implement quality management, they did not play a role in the organisations in England. The role of corporate ownership also only had an effect in Germany, resulting from the different structures of public healthcare delivery. Nonetheless, even within the organisations in Germany there was no agreement as to whether corporate ownership influenced quality management approaches. Heringshausen (2008, p. 2) clarifies that the successful implementation of quality management values is not a question of the ownership, but rather of the organisational culture.

Finally, only two of the clinical governance managers agreed with all of their colleagues in Germany on the importance of ICT in healthcare quality management. The origin of this difference remained unclear and should be further researched[94]. The controversy about ICT in healthcare is also mirrored in the academic literature: OECD (2009d) explains the importance of ICT to monitor and improve quality in healthcare, whereas Djellal and Gallouj (2008, pp. 74-78) question the impact of ICT on innovation in healthcare.

9.3 Staff Understanding

The second research question concerns the meaning staff, working in elderly-related and acute stroke care at the hospitals in England and Germany, attributed to clinical governance and quality management. This addresses another part of the research aim, i.e. the **content** of clinical governance and quality management as understood by clinical and non-clinical staff at the hospitals.

[94] See Chapter 10.

All staff groups at three organisations in Germany and 47% of the staff groups in England[95] cautioned, about themselves or the staff they worked with, that they might not fully understand clinical governance and quality management. Nonetheless, staff from all professional groups in both countries showed a general understanding of clinical governance and quality management, appreciating aspects of the six elements of TQM, used as analytical categories in this research[96]. This further supports the conclusion to the first research question – quality management and clinical governance are umbrella terms for similar concepts.

The main agreement across the countries focused on improvement, leadership and teamwork. Staff understood that clinical governance and quality management positively impacted on the performance of the organisation through planning, benchmarking and continuous professional development so that staff were always 'up-to-date'. With regard to leadership, staff saw clinical governance and quality management as forms of control but also as frameworks to orientate staff. Multidisciplinary teamwork was commonly accepted as an important element of clinical governance and quality management but staff did not develop this further to extend to external partnerships. OECD (2009d, pp.79-95) addresses this latter point and suggests better coordination of care within and between different health and social care providers to improve healthcare system performance, this is discussed further in the recommendations from this research[97].

The main disagreement across the countries focused on involvement and cultural changes. Staff from less than half of the organisations included training in their understanding of involvement in clinical governance and quality management. Yet, staff from three out of four organisations in England agreed on individual accountability as an important element of clinical governance. Cultural changes were not mentioned at all at three out of five organisations in Germany. Staff from half of the organisations in

[95] Managers at two organisations, consultants at one, nursing staff at three, therapists at one and support staff at two.
[96] See Section 4.2.3.
[97] See Chapter 10.

England thought that clinical governance created a cultural openness to learn from mistakes and staff at three out of four organisations agreed that evidence-based practice was a key aspect of clinical governance.

With regard to customer priority, staff across the countries agreed on a similar definition of their customers with the patients at the heart, although 25% of the staff groups in Germany did not like this concept[98]. In spite of this, customer priority found different appreciation within staff understanding of clinical governance and quality management. Staff at all organisations in England concurred that clinical governance was intended to ensure patient satisfaction by meeting their needs, while only staff at one organisation in Germany mentioned this as part of quality management.

9.4 Perceived Effects and Implementation Issues

The third research question deals with the effects and implementation issues staff perceived in dealing with clinical governance and quality management on their wards. This addresses another part of the research aim, i.e. the **effects** and **implementation issues** of the clinical governance and quality management initiatives.

Staff in both countries perceived similar **effects** of quality management and clinical governance on improvement, teamwork and customer priority. Effects on leadership, involvement and cultural changes found very little appreciation. There was, however, no agreement, either nationally or internationally, as to whether the effects were positive, negative or neutral.

Effects on improvement were the most controversial. All QMBs in Germany and three out of four clinical governance managers in England agreed that quality management and clinical governance increased transparency. Nursing staff at three out of four organisations in England supported this, but it found no support of the nurses in Germany or

[98] See Section 2.2.3 for the theoretical background about the difficulties around defining customers in healthcare.

consultants in either country. Further, staff controversially discussed the impact on efficiency. Therapists and support staff did not mention this at all. Three out of five QMBs in Germany and two out of four clinical governance managers in England had experienced efficiency gains. Two out of five QMBs in Germany, however, thought that quality management had not impacted on efficiency. Very few nursing staff and consultants contributed their opinion in this regard, but amongst those who did there was no agreement. This disagreement is consistent with the dissent in the academic literature[99].

With regard to teamwork, 84% of the staff groups in England agreed that stroke care required teamwork. This agreement spread across all staff groups in England, but only found the support of consultants and support staff at one and nursing staff at two organisations in Germany. Further, nursing staff at one organisation in Germany and consultants at all organisations in England added that teamwork also depended on local personalities. Mainly nursing staff and therapists in both countries, but also three out of five QMBs in Germany, perceived a positive effect of clinical governance and quality management to be supporting teamwork.

In terms of customer priority, staff from all staff groups, apart from support staff in England, saw safer care as a positive effect of quality management and clinical governance on the patients. Clinical staff groups across the countries explained this increase in safety as being associated with more consistent care. Nonetheless, clinical staff in both countries and one QMB in Germany cautioned that staff could spend less time with the patients due to increased administrative burden resulting from quality management and clinical governance.

Staff agreed and disagreed about various **implementation issues** of clinical governance and quality management, apart from improvement. Staff at three out of five organisations in Germany and all organisations in England agreed that teamwork was not an issue at their organisation. The contentious role of consultants was mentioned as an issue under

[99] See Section 2.2.1.

teamwork and involvement. As this was an emerging theme that cut through various categories, it is discussed with the other emerging themes below[100]. This also applies to the criticism of quality management and clinical governance as 'tick-box' exercises, which was an issue under cultural changes. There was no other agreement between the countries about cultural changes. All clinical governance managers and a minority of consultants, nursing staff and support staff at one organisation in England complained about too much change in the NHS.

With regard to leadership issues, 8% of the staff groups in Germany and 37% of the staff groups in England agreed that leadership depended on the personal interest of the leader. Personal interest was also important under involvement issues, which represented the main issues perceived by staff. Across all staff groups, 42% in Germany and 58% in England cautioned that involvement depended on personal interest. Nursing staff at two organisations in each country and one QMB in Germany further explained that nurses played a special role in clinical governance and quality management. Because of professional traditions in this regard, they were seen to be more involved in clinical governance and quality management. Finally, staff across the professions and in both countries, apart from consultants in Germany, complained that they did not have enough resources to realise a true customer priority in their daily activities.

9.5 'Valued' Practice and Suggested Improvements

The fourth research question addresses the 'valued' practices and improvements for implementing, maintaining and further developing clinical governance and quality management initiatives suggested by staff. This addresses the last part of the research aim, i.e. **'valued' practice** and **suggested improvements** for clinical governance and quality management.

The main **'valued' practices** identified by staff related to leadership, involvement and cultural changes. The contributions covered various

[100] See Section 9.6.

aspects of teamwork, but there was no agreement across the countries. Very little was mentioned with regard to improvement and customer priority.

For leadership, mainly managerial staff, i.e. three out of five QMBs in Germany and two out of four clinical governance managers in England, agreed that management support and commitment to quality management and clinical governance fostered these initiatives. Non-managerial staff, excluding consultants, at one organisation in Germany, two clinical governance managers and the therapists at one organisation in England had experienced that visibility of managers throughout the organisation supported quality management and clinical governance leadership. Finally, almost all managers in both countries, apart from one clinical governance manager in England, agreed that a clinical background helped leaders in quality management and clinical governance.

With regard to involvement, mainly managerial staff agreed on the importance of enthusiastic communication and training about clinical governance and quality management. A majority across all staff groups in Germany confirmed the local approaches to quality management, stating that *"involvement is ok"* (*"wir sind gut involviert"*). 'Valued' practice for cultural changes focused on dealing with resistance. Two out of five QMBs and two out of four clinical governance managers had overcome resistance by working with enthusiasts to convince resisters.

There was least agreement by staff across the countries about **suggested improveme**nts for teamwork including partnerships and cultural changes. Throughout the research, staff rarely addressed issues of partnerships in healthcare. Nursing staff and therapists at two organisations in Germany suggested improving communication with external partners, while therapists at one organisation in England saw pathways throughout the NHS as an area for improvement. Accordingly, the findings of this research suggest the need to further develop partnership approaches in healthcare.

In terms of cultural changes, two clinical governance managers, as well as therapists and support staff at one organisation in England, demanded a decrease in the level of change within the NHS. In Germany, however, staff at three out of five organisations did not suggest any improvements for cultural changes, while staff at one organisation asked for less change and staff at another would have liked to see an increase in real changes, for example an increase in staff involvement in decision-making. The origin of these differences remained unclear.

Managerial and non-managerial staff at one organisation in Germany agreed that improvements were always possible. Further, different staff groups across the countries suggested streamlining and consolidating documentation to reduce the increase in workload due to clinical governance and quality management. Even though staff in Germany were satisfied about involvement in quality management at their organisation, different staff groups across the countries would like to be more involved and suggested an increase in training, information and communication about quality management and clinical governance. Across the staff groups in Germany, apart from consultants, 25% asked for more positive feedback and rewards to support clinical governance and quality management leadership. Finally, 58% of the staff groups in Germany and 47% in England underlined the need for more resources to provide quality services to the patients and realise customer priority in their organisations.

9.6 Emerged Themes and Mitigated Limitations

In addition to the findings about staff understanding, perceived effects and issues, ‘valued’ practice and suggested improvements, the research yielded six themes that cut across the other findings in the case-study analysis. Quality management and clinical governance were seen to increase transparency. This occasionally caused resistance. Further, staff cautioned that quality management and clinical governance could look great on paper without any real changes in the daily operations and, therefore, became ‘tick-box’ exercises. There was no agreement whether clinical governance and quality management increased or decreased the workload and impacted on efficiency or not. Nonetheless, staff appreciated

that clinical governance and quality management clarified expectations and requirements for their jobs. This also supported teamwork. Overall, staff criticised the contentious role consultants played in various aspects of quality management and clinical governance. Yet, issues of 'them versus us' influenced the general relationship between staff on the ward and staff responsible for clinical governance and quality management.

The international experts largely confirmed these emerged themes and the other findings, discussed above. Five additional themes could be identified in the expert interviews. First, the experts agreed that political pressures could and should further strengthen the implementation and application of quality management and clinical governance in healthcare. Secondly, there was no agreement around international comparisons of healthcare. Thirdly, the experts underlined the positive impact of increased competition on quality management and quality service provision in healthcare. Fourthly, the experts in England and Florida attributed importance to risk management within leadership, involvement and customer priority. Finally, the experts in Florida explained that quality management could help to improve the organisational reputation and, with this, improve the organisational standing in the market.

9.7 Contribution to Knowledge

By answering the research aim and the related question, as concluded above, the research has made the contribution to knowledge expected in Section 2.3.3. The findings contribute staff perceptions about various aspects of clinical governance and quality management from managerial, clinical and non-clinical perspectives focused on acute elderly-related and stroke care in England and Germany. The analysis of these perceptions has identified issues, 'valued' practice and suggested improvements for successful implementation, maintenance and further development of clinical governance and quality management initiatives.

This widens the scope of previous research in two senses. First, the researcher applied a qualitative research design to an international comparison of quality management in healthcare and interviewed a wider

spread of different professions, including managers, consultants, nurses, therapists and support staff, than has been done in previous related research[101]. Yet, there were no clear differences between the perceptions of these staff groups. Secondly, the interview questions focused not only on the quality understanding or quality management implementation issues, discussed in research by Hudelson *et al.* (2008) and François and Pomey (2005), but also extended the areas of discussion to include 'valued' practice and suggested improvements.

The findings of the case-study analysis highlight six emerging themes, which confirm general issues from the quality management literature, such as an unclear impact on efficiency or the 'them versus us' phenomenon, for the hospitals. Apart from this, these themes and general findings from the research confirm and develop more detail about hospital specific issues of quality management and clinical governance. Examples include the contentious role of consultants, the need for more partnerships in healthcare and scarcity of resources. Most importantly, staff confirmed that clinical governance and quality management resulted in safer, more consistent care to better meet patient needs.

The final chapter develops recommendations for the hospitals to improve their approaches to clinical governance and quality management. These recommendations are based on the issues, 'valued' practice, suggested improvements and emerging themes, identified in the cross-case analysis and the expert interviews. Further, the findings suggest the need for political impulses to foster clinical governance and quality management application at the hospitals throughout the healthcare system. Finally, even though the limitations of the research have been mitigated by the expert interviews and the comparison of the findings with the literature, further research should address these limitations and aim to explain remaining questions.

[101] Hudelson *et al*. (2008) interview doctors and nurses at a Swiss case-study. François and Pomey (2005) base their research on interviews with administrative staff, physicians and chief nurses.

10 Recommendations

This chapter develops recommendations for the hospitals, for political and systems aspects and suggests further research, before it closes the thesis with final remarks.

10.1 Organisational Focus

The research yields two areas of recommendations for the hospitals focussing on organisation-wide aspects, on the one hand, and staff-specific issues, on the other. At the **organisational level**, documentation should be more focused and streamlined, as also suggested by staff. Improvements and efficiency gains resulting from clinical governance and quality management should be measured to address three of the themes that cut across the analytical categories in the cross-case analysis: to further increase transparency and consistency of the service provision, to prevent clinical governance and quality management from becoming a tick-box exercise and to clarify their impact on workload and efficiency. It is important that these measurements are meaningful for both managers and staff. During the interviews, staff appreciated that hand-hygiene was important but thought that ticking boxes for each time they washed their hands was not an effective measurement. They suggested the inclusion of outcome measures, such as a reduction in MRSA rates.

Kaye and Anderson (1999, p. 502), Huq and Martin (2000, p. 80) and Øvretveit (2000, p. 79) support the need for more effective measurements to achieve continuous improvement in general and at hospitals in particular. ICT has the potential to facilitate the measurements, improve the data quality of these measurements and foster general quality improvements in healthcare (OECD, 2004, p. 30; OECD, 2009d, pp. 129-149). The QMBs in Germany agreed that ICT supported the quality management at their organisation, while there was no agreement among the clinical governance managers in England. The organisations should revise their use of ICT as a tool for measurement and communication in order to share knowledge and foster the efficient use of scarce resources in healthcare.

To address this scarcity of resources, the findings of this research further support the need to develop closer partnerships with different service providers. This should also be addressed politically, as discussed in the following section. OECD (2009d, pp. 79-95) explains the positive impact of better coordination of care on healthcare systems performance. ICT should be used to improve information sharing across different service providers (OECD, 2009d, p. 90). More concretely, nursing staff and therapists at two organisations in Germany suggested improving and extending the communication with external partners, for instance, to prepare nursing homes for the special needs of a patient after stroke. The organisations should manage these partnerships more proactively and share the information needed for a seamless service provision to the patients across different providers.

At the **staff level**, the organisations need to address two of the emerged themes for successful quality management and clinical governance – the 'them versus us phenomenon' and the contentious role of consultants. Staff contributed various suggestions for this, which are supported by Huq and Martin (2000), Øvretveit (2000) and Kaye and Anderson (1999). Top and general management need to show commitment to and support for clinical governance and quality management. They should be known throughout the organisation and should get a better understanding for the operations on the ward by walk-rounds through both clinical and non-clinical areas. Clinical and non-clinical managers should show appreciation for the work of staff by positive, constructive feedback and rewards. Further, staff should be more involved in decision-making. The organisations should train staff more specifically in clinical governance and quality management. Communications about the related initiatives and results should apply a common language to continuously realise the last of the six emerged themes – to further orientate staff about expectations and requirements within clinical governance and quality management.

In the view of staff, this clarification of responsibilities improved teamwork between different professional groups. The findings of this research suggest the need to provide more incentives for teamwork, such as team-

based reporting, that should not only involve clinical staff but should also include support staff. 'Valued' practice and lessons-learned at the organisations highlight the need to address the contentious role of consultants in this regard, as supported by Øvretveit (2000), Zabada *et al.* (1998) and François and Pomey (2005). Managerial experiences at the case-study organisations suggest working with the younger generation of consultants to improve their involvement in clinical governance and quality management, as well as to create more respect between the different professions in support of teamwork. The following section addresses the contentious role of consultants at the political level.

10.2 Political and Systems Aspects

The findings from the case-study analysis lead to some more general recommendations for improvement of political and systems aspects in healthcare. Clinical governance and quality management should be more embedded in the training of all professional groups involved in healthcare provision. This is already the case, according to the findings from the case-study organisations, for nursing and therapist training and should be extended to the other professional groups, especially consultants. Staff in England and the international experts positively appreciated academic training for nurses. In Germany, nurses do not receive academic training. The political debate should consider whether nursing training should become more academic in Germany to strengthen mutual respect between staff groups and, thus, improve teamwork within flatter hierarchies.

Finding the right language to communicate quality management and clinical governance should also be supported system-wide. Even though KTQ has been specifically designed for quality management at German hospitals, users at the case-study organisations in Germany complained that its linguistic style was not easy to understand for non-managerial practitioners. A revision of the standard should take this into account. In the case of England, respondents explained that quality management and improvement were more tangible for staff than clinical governance. A change in terminology should also be considered. The most recent white

paper for the future development of the NHS (DoH, 2010c) seems to address this, in part. Clinical governance is not mentioned. The focus lies on achieving excellence and equity through quality and general improvements.

Staff across the organisations demanded an increase in resources to deliver good quality services to the patients. With regard to the current financial climate, higher investments in healthcare appear to be unrealistic. Therefore, scarce resources should be managed more efficiently. The findings of this research suggest three areas for improvement to support this.

First, cooperation and partnerships in healthcare should increase and should be supported by ICT. Starting in 2000, healthcare reforms in Germany have created incentives for integrated care structures[102]. Nonetheless, the two most recent reports about the future development of healthcare in Germany (SVR, 2007 & 2009) underline the need to further improve coordination and cooperation in healthcare across the system. The most recent white paper for the future development of the NHS builds on partnerships to achieve excellence in the NHS (DoH, 2010c). These political impulses should be continuously pursued and their effects should be assessed at national level.

Secondly, the international experts agreed on the importance of competitive forces and patient choice, in particular, to foster clinical governance and quality management in healthcare. OECD (2009d, p. 70) support this. The introduction of market elements in the healthcare system of both England and Germany is discussed in Section 3.3.1. The recent reports about healthcare development in both countries (SVR, 2009; DoH, 2010c) continue to emphasise the role of competition in healthcare. The effect of the related measures should be closely monitored and adjusted if necessary. However, the experience of the experts in Florida cautioned that the state should play an important role of setting quality standards for

[102] See Section 3.3.1.

the healthcare service provision without giving all the control to the market, as also supported by OECD (2009d, p. 71).

Thirdly, participants in England criticised the speed of change in the NHS that prevented new initiatives from becoming embedded before another change was implemented. Initiatives should be dealt with more consistently. Further, the experts questioned the future sustainability of the NHS. The most recent white paper about the future development of the NHS (DoH, 2010c) addresses sustainability issues. Further, the similar findings across the countries suggest the potential for more political cooperation at the European level to exchange ideas and experiences with regard to healthcare improvement and enable mutual learning.

10.3 Further Research

The findings, conclusions and recommendations suggest two areas for further research. On the one hand, it should **address the limitations**[103] **and open questions** of the research. Further research should quantitatively replicate the findings to test their applicability to other hospitals, nationally and internationally. This research did not find clear patterns of differences between staff groups. Further research should investigate this in more detail and could, for instance, look at staff differences with regard to the 'them versus us' phenomenon.

This research could not explain the different views on speed of change and on the adequacy of the customer concept in healthcare within and between the countries. It remains unclear why staff did not identify any issues around improvement and why the participants in England usually gave longer responses that resulted in longer interview notes and a richer data set for analysis. These aspects should form part of further research.

Finally, a longitudinal study should investigate the direct impact of quality management and clinical governance on patient satisfaction. The question of patient satisfaction is already generally addressed in both research and

[103] See Section 4.3.1.

politics (OECD, 2004, p. 70). But further research should look at actual causality between an increase in patient satisfaction in response to successful clinical governance and quality management.

On the other hand, further research should **clarify and follow-up on the practical and political recommendations** developed above. Most importantly, the impact of quality management and clinical governance on workload and efficiency requires clarification. First, there is no academic agreement in this regard[104]. Secondly, previous research is based on the assumption that winning a quality award proves that an organisation has an effective quality management or clinical governance system in place (e.g. Hendricks & Singhal, 2001a). The findings of this research, however, caution that quality management and clinical governance might as well just look good on paper without any real changes. Therefore, further research should first assess the implementation of quality management and clinical governance to then investigate whether the initiatives have an impact on workload and efficiency.

With regard to the political recommendations, further research should play three roles. First, it should help to make a decision whether an idea, e.g. an increase in academic training for nurses in Germany, is worth pursuing and implementing. Secondly, it should support the design of the related initiatives, i.e. to find a clearer language for KTQ and clinical governance and to further develop partnerships, ICT application and competition in healthcare. Thirdly, further research is needed to evaluate the effect of these initiatives and suggest further improvements.

10.4 Final Remarks

This research set out to analyse and compare clinical governance and quality management initiatives at hospitals in England and Germany in terms of content, effects and implementation issues as perceived by managerial, clinical and non-clinical staff working in elderly-related and acute stroke care in order to identify ‘valued’ practice approaches and

[104] See Section 2.2.1.

develop recommendations for overall improvement. If these recommendations are successfully implemented, they will enable better use of scarce resources to provide safer care and better meet patient needs. This is, after all, the holy grail of healthcare.

References

Adamson, J. (2005). Combined qualitative and quantitative designs. In A. Bowling, & S. Ebrahim (Eds.). *Handbook of Health Research Methods – Investigation, Measurement and Analysis* (pp. 230-245). Maidenhead: Open University Press.

AHCA (2010a). *About the Agency for Health Care Administration (AHCA).* Retrieved July 22, 2010, from http://ahca.myflorida.com/#.

AHCA (2010b). *Florida Center for Health Information and Policy Analysis (Florida Center).* Retrieved July 22, 2010, from http://ahca.myflorida.com /SCHS/.

AHCA (2010c). *Health Quality Assurance.* Retrieved July 22, 2010, from http://ahca.myflorida.com/MCHQ/index.shtml.

AHRQ (2010). *AHRQ Profile: Advancing Excellence in Healthcare.* Retrieved July 22, 2010, from http://www.ahrq.gov/about/profile.htm.

Amelung, V.E., & Schumacher, H. (2004). *Managed Care – Neue Wege im Gesundheitsmanagement* (3rd ed.) [Managed Care – New Ways of Healthcare Management]. Wiesbaden: Gabler Verlag.

Antunes, G., Pires, A., & Machado, V. (2008). Economics aspects of quality and organizational performance – a study in Setúbal care homes for elderly persons [Electronic Version]. *Total Quality Management,* 19(1-2), 79-88.

Arah, O.A., Westert, G.P., Hurst, J., & Klazinga, N.S. (2006). A conceptual framework for the OECD Health Care Quality Indicators Project [Electronic Version]. *International Journal for Quality in Health Care*, 2006(September), 5-13.

Arasli, H. (2008). Gearing service quality into public and private hospitals in small islands – Empirical evidence from Cyprus [Electronic Version]. *International Journal of Health Care Quality Assurance*, 21(1), 8-23.

Baggott, R. (2004). *Health and Health Care in Britain* (3rd ed.). Basingstoke: Palgrave MacMillan.

Bailey, D.M. (1991). *Research for the Health Professional – A Practical Guide.* Philadelphia: F.A. Davis.

Barrett, G., & Coleman, M.P. (2005). Ethical and political issues in the conduct of research. In A. Bowling, & S. Ebrahim (Eds.). *Handbook of Health Research Methods – Investigation, Measurement and Analysis* (pp. 555-583). Maidenhead: Open University Press.

Bin Saeed, K. S. (1999). Perceptions on the influence of cost issues on quality improvement initiatives: a survey of Saudi health care managers [Electronic Version]. *International Journal for Quality in Health Care,* 11(1), 59-65.

Blodgett, J.G., Bakir, A., & Rose, G.M. (2008). A test of the validity of Hofstede's cultural framework [Electronic Version]. *Journal of Consumer Marketing,* 25(6), 339-349.

BMG (2010a). *Entwicklung nationaler Gesundheitsziele* [The development of national health objectives]. Retrieved July 22, 2010, from http://www.bmg.bund.de/cln_169/nn_1168258/SharedDocs/Standardartikel/DE/AZ/G/Glossarbegriff-Gesundheitsziele.html?__nnn=true.

BMG (2010b). *Primärprävention von Schlaganfällen bei Frauen verbessern* [To improve primary prevention of stroke for women]. Retrieved July 22, 2010, from http://www.bmg.bund.de/SharedDocs/Standardartikel/DE/AZ/F/Glossar-Frauen-und-Gesundheit/Primaerpraevention-von-Schlaganfaellen-bei-Frauen.html.

BMG (2010c). *Für ein gerechtes, soziales, stabiles, wettbewerbliches und transparentes Gesundheitssystem* [For a fair, social, stabile, competitive and transparent healthcare system]. Retrieved July 22, 2010, from http://www.bmg.bund.de/cln_160/SharedDocs/Downloads/DE/Presse/Presse-2010/pm-10-07-06-gesundheitsreform-eckpunkte-anhang,templateId=raw,property=publicationFile.pdf/pm-10-07-06-gesundheitsreform-eckpunkte-anhang.pdf.

BMG (2010d). *Qualitätsmanagement* [Quality management]. Retrieved July 21, 2010, from http://www.bmg.bund.de/cln_169/nn_1168248/SharedDocs/Standardartikel/DE/AZ/Q/Glossarbegriff-Qualit_C3_A4tsmanagement.html.

BMG (2009a). *Pressemitteilung Nr. 33: Deutscher Bädertag 2009 – Caspers-Merk "Prävention wirkt – Wir brauchen ein Präventionsgesetz"* [Press release Nr. 33: German Bath Day 2009 – Caspers-Merk "Prevention works – We need a prevention bill, Electronic Version]. Retrieved June 1, 2010, from http://www.bmg.bund.de/cln_169/nn_1168258/SharedDocs/Pressemitteilungen/DE/2009/Presse-2-2009/pm-24-04-09-3.html?__nnn=true.

BMG (2009b). *Gemeinsame Pressemitteilung des BMG und des BMF: Gutachten bekräftigt Gesundheitspolitik der Bundesregierung – Mehr Wettbewerb unterstützt tragfähige öffentliche Finanzen* [Joint press release BMG and BMF: report supports the healthcare policy of the government – more competition fosters sustainable public finances]. Retrieved July 22, 2010, from http://www.bmg.bund.de/cln_160/nn_1168258/SharedDocs/Pressemitteilungen/DE/2009/Presse_3_2009/pm-21-07-09-gutachten__gesundheitspolitik.html?__nnn=true.

BMG (2008). *Gesundheitsbericht* [Health report].Retrieved July 22, 2010, from http://www.bmg.bund.de/cln_169/nn_1168258/sid_F5D8C79A98BFD66B2789C35E3B0B7BB1/SharedDocs/Standardartikel/DE/AZ/G/Glossar-Gesundheitsberichterstattung/gesundheitsbericht.html?__nnn=true.

BMG (2007). *Die neue Gesundheitsversicherung – Das bringt die Gesundheitsreform den Versicherten* [The new health insurance – This is in the health reform for the patients, Electronic Version] (2nd ed.). Berlin: BMG.

BMG (2006). *Sicherung der Qualität im Gesundheitswesen* [Quality Assurance in the Health Care System, Electronic Version]. Berlin: BMG.

Bok, S. (2004). Rethinking the WHO Definition of Health [Electronic Version]. *Harvard Center for Population and Development Studies Working Paper Series*, 14(7), 1-16.

Bounds, G. *et al.* (1994). *Beyond Total Quality Management – Toward the emerging paradigm.* London: McGraw-Hill.

Bowling, A. (2005). Quantitative social science: the survey. In A. Bowling, & S. Ebrahim (Eds.). *Handbook of Health Research Methods – Investigation, Measurement and Analysis* (pp. 190-214). Maidenhead: Open University Press.

BQS (2010a). *Über das BQS-Institute* [About the BQS-Institute]. Retrieved July 22, 2010, from http://www.bqs-institut.de/bqs-institut.html.

BQS (2010b). *Archiv* [Archive]. Retrieved July 22, 2010, from http://www.bqs-institut.de/archiv.html.

BQS (2007). *Qualität sichtbar machen. BQS-Qualitätsreport 2006* [Making quality visible. BQS-Qualityreport 2006, Electronic Version]. Düsseldorf: BQS.

Brandeau, M.L., Sainfort, F., & Pierskalla, W.P. (2004). Health Care Delivery: Current Problems and Future Challenges. In M.L. Brandeau, F. Saintfort, & W.P. Pierskalla (Eds.), *Operations Research and Health Care – A Handbook of Methods and Applications* (pp. 2-14). London: Kluwer Academic Publishers.

Bryman, A. (1992). Quantitative and qualitative research: further reflections on their integration. In J. Brannen (Ed.), *Mixing Methods: qualitative and quantitative research* (pp. 57-78). Aldershot: Avebury.

Bryman, A. (1988). *Quantity and Quality in Social Research.* London: Unwin Hyman.

BSI (2005). *BS EN ISO 9000:2005 Quality Management systems – Fundamentals and vocabulary* [Electronic Version]. London: BSI.

Buchanan, D., & Huczynski, A. (2004). *Organizational Behaviour – An Introductory Text* (5th ed.). Harlow: Financial Times Prentice Hall.

Busse, R. (2006). Europäische Gesundheitssysteme – Grundfragen und Vergleich [European healthcare systems – Basic questions and comparision, Electronic Version]. *Die Volkswirtschaft – Das Magazin für Wirtschaftspolitik,* 2006(12), 10-13.

Busse, R., & Riesberg, A. (2005). *Gesundheitssysteme im Wandel: Deutschland* [Health care systems in transition: Germany]. Copenhague: WHO regional office Europe for the European Observatory on Health Systems and Policies.

Cadilhac, D.A., Pearce, D.C., Levi, C.R., & Donnan, G.A. (2008). Improvements in the quality of care and health outcomes with new stroke care units following implementation of a clinician-led, health system redesign programme in New South Wales, Australia [Electronic Version]. *Quality and Safety in Health Care,* 2008(17), 329-333.

Carter, S., & Henderson, L. (2005). Approaches to qualitative data collection in social science. In A. Bowling, & S. Ebrahim (Eds.). *Handbook of Health Research Methods – Investigation, Measurement and Analysis* (pp. 215-229). Maidenhead: Open University Press.

Cauchick Miguel, P.A. (2006). Quality management through a national quality award framework – The experience of a hospital in Brazil [Electronic Version]. *The TQM Magazine,* 18(6), 626-637.

Chassin, M.R., & Galvin, R.W. (1998). The Urgent Need to Improve Health Care Quality [Electronic Version]. *JAMA*, 280(11), 1000-1005.

Chen, C.-K., Yu, C.-H., & Chang, H.-C. (2005). An Empirical Analysis of Customer-oriented Service Activities in the Taiwanese Public Sector [Electronic Version]. *Total Quality Management,* 16(7), 887-901.

Corbin, J., & Strauss, A. (2008). *Basics of Qualitative Research – Techniques and Procedures for developing Grounded Theory* (3rd ed.). London: Sage Publications.

CQC (2009). *Making sure people get better care – Our Strategy for 2010-2015* [Electronic Version]. London: CQC.

Cramer, S.C. (2010). Brain Repair after Stroke [Electronic Version]. *The New England Journal of Medicine*, April 2010, 1-3.

Crosby, P.B. (1979). *Quality is free.* London: MacGraw-Hill.

Dale, B.G. (2003). *Managing Quality* (4th ed.). Oxford: Blackwell Publishing.

Daniel, A. (1993). Politicians, bureaucrats and the doctors: researching in the crossfire. In D. Colquhoun, & A. Kellehear (Eds.), *Health Research in Practice - Political, ethical and methodological issues* (pp. 1-15). London: Chapman & Hall.

Davies, P. (2007). *The NHS in the UK 2007/08: a pocket guide* (9th ed.). London: The NHS Confederation.

Deming, W.E. (1982). *Out of the crisis – Quality, productivity and competitive position.* Cambridge: Cambridge University Press.

Deutscher Bundestag (2009). *Anteil der Krankenhäuser in privater Trägerschaft deutlich gestiegen* [Marked increase of private ownership for hospitals]. Retrieved July 21, 2010, from http://www.bundestag.de/presse/hib/2009_09/2009_248/03.html.

Dey, P.K., & Hariharan, S. (2006). Integrated approach to healthcare quality management: a case study [Electronic Version]. *The TQM Magazine,* 18(6), 583-605.

Dick, P. (2004). Discourse analysis. In C. Cassell, & G. Symon (Eds.), *Essential Guide to Qualitative Methods in Organizational Research* (pp. 203-213). London: Sage Publications.

Dieppe, P. (2005). Research on health and health care. In A. Bowling, & S. Ebrahim (Eds.). *Handbook of Health Research Methods – Investigation, Measurement and Analysis* (pp. 2-11). Maidenhead: Open University Press.

Djellal, F., & Gallouj, F. (2008). Survey of research on health sector innovation. In P. Windrum, & P. Koch (Eds.), *Innovation in Public Sector Services – Entrepreneurship, Creativity and Management* (pp. 64-86). Cheltenham: Edward Elgar.

DoH (2010a). *Quality Accounts.* Retrieved July 30, 2010, from http://www.dh.gov.uk/en/Healthcare/Qualityaccounts/index.htm.

DoH (2010b). *Quality Accounts Survey 2009-2010*. Retrieved July 30, 2010, from http://www.dh.gov.uk/en/Healthcare/Qualityaccounts/DH_117420.

DoH (2010c). *Equity and excellence: Liberating the NHS* [Electronic Version]. London: The Stationery Office.

DoH (2009). *World class commissioning – an introduction*. Retrieved July 28, 2010, from http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_107080.pdf.

DoH (2007). *National Stroke Strategy* [Electronic Version]. London: DH Publications Orderline.

DoH (2006a). *Standards for Better Health* [Electronic Version]. London: DoH.

DoH (2006b). *NHS – Integrated Governance Handbook, A handbook for executives and non-executives in healthcare organisations* [Electronic Version]. London: DoH.

DoH (2005). *Reducing brain damage: Faster access to better stroke care* [Electronic Version]. London: Her Majesty's Stationery Office.

DoH (2004). *Choosing health – making healthy choices easier* [Electronic Version]. Norwich: Her Majesty's Stationery Office.

DoH (1998). *A First Class Service – Quality in the New NHS* [Electronic Version]. London: DoH.

Donabedian, A. (1980). *Explorations in Quality Assessment and Monitoring, Volume I, The Definition of Quality and Approaches to its Assessment*. Ann Arbor, Michigan: Health Administration Press.

Donovan, J., & Sanders, C. (2005). Key issues in the analysis of qualitative data in health services research. In A. Bowling, & S. Ebrahim (Eds.). *Handbook of Health Research Methods – Investigation, Measurement and Analysis* (pp. 515-532). Maidenhead: Open University Press.

Duclos, A. *et al.* (2008). Health staff perception regarding quality of delivered information to inpatients [Electronic Version]. *International Journal for Quality in Health Care*, 20(1), 13-21.

EFQM (2003). *Introducing Excellence.* Brussels: EFQM.

Eichhorn, S., & Schmidt-Rettig, B. (1998). Managed Care-Strategien zur Verbesserung der Effektivität, der Wirtschaftlichkeit und der Qualität der Gesundheitsversorgung, insbesondere der Krankenhausversorgung [Managed Care Strategies to improve Effectiveness, Efficiency and Quality of Health Care, especially Hospital Care]. In S. Eichhorn, & B. Schmidt-Rettig (Eds.). *Chancen und Risiken von Managed Care – Perspektiven der Vernetzung des Krankenhauses mit Arztpraxen, Rehabilitationskliniken und Krankenkassen* [Opportunities and risks of managed care – Perspectives of networks between hospitals and surgeries, rehabilitation clinics and health insurers] (pp. 3-40). Stuttgart: Verlag Kohlhammer.

Eisenhardt, K.M. (1989). Building Theories from Case Study Research [Electronic Version]. *The Academy of Management Review,* 14(4), 532-550.

Eriksson, P., & Kovalainen, A. (2008). *Qualitative Methods in Business Research*. London: Sage Publications.

Erzberger, C., & Kelle, U. (2003). Making Inferences in Mixed Methods: The Rules of Integration. In A. Tashakkori, & C. Teddlie (Eds.), *Handbook of Mixed Methods in Social and Behavioural Research* (pp. 457-488). London: Sage Publications.

Ferlie, E. (2001). Organisational studies. In N. Fulop, *et al.* (Eds.). *Studying the organisation and delivery of health services – Research Methods* (pp. 24-39). London: Routledge.

Flenker, I., & Bredehöft, J. (2001). KTQ – ein krankenhausspezifisches Zertifizierungsverfahren. *Aktuelle Neurologie*, 28(9), 404-408.

Flick, U. (2004). Triangulation in Qualitative Research. In U. Flick, E. von Kardoff, & I. Steinke (Eds.). *A Companion to Qualitative Research* (pp. 178-183). London: Sage Publications.

Florida Department of Health (2010). *Heart Disease and Stroke Prevention Program.* Retrieved July 22, 2010, from http://www.doh.state.fl.us/Family/heart/index.html.

Florida Hospital Association (2009). *Facts About Florida's Health Care System ~ Updated November 2009*. Retrieved July 22, 2010, from http://www.fha.org/facts.html#healthcoverage.

Flynn, B.B., & Saladin, B. (2006). Relevance of Baldrige constructs in an international context: A study of national culture [Electronic Version]. *Journal of Operations Management,* 24(2006), 583-603.

Forster, R., & Gabe, J. (2008). Voice or choice? Patient and public involvement in the National Health Service in England under New Labour [Electronic Version]. *International Journal of Health Services*, 38(2), 333-356.

Forthofer, M.S. (2003). Status of Mixed Methods in the Health Sciences. In A. Tashakkori, & C. Teddlie (Eds.), *Handbook of Mixed Methods in Social and Behavioural Research* (pp. 527-540). London: Sage Publications.

François, P., & Pomey, M.-P. (2005). Implementation of quality management in French hospitals: staff interplay and induced changes [Electronic Version]. *Revue d'Epidemiologie et de Santé Publique*, 53(Supplement1), 4-11.

Freeman, R. (2000). *The politics of health in Europe*. Manchester: Manchester University Press.

Fulop, N., *et al.* (2001). Issues in studying the organisation and delivery of health services. In N. Fulop, *et al.* (Eds.). *Studying the organisation and*

delivery of health services – Research Methods (pp. 1-23). London: Routledge.

Gaa, J. *et al.* (2005). *South-African and German healthcare systems: lessons to be learned*. University of Applied Sciences Münster: Unpublished Presentation.

Gaster, L., & Squires, A. (2003). Conclusions and reflections. In L. Gaster, & A. Squires (Eds.), *Providing Quality in the Public Sector – A practical approach to improving public services* (pp. 245-258). Maidenhead: Open University Press.

Glaser, B.G., & Strauss, A.L. (1967). *The Discovery of Grounded Theory: Strategies for Qualitative Research.* New York: Aldine Publishing Company.

Glattacker, M., & Jäckel, W.H. (2007). Evaluation der Qualitätssicherung – aktuelle Datenlage und Konsequenz für die Forschung [Evaluation of Quality Assurance – Current Data and Consequences for Research, Electronic Version]. *Gesundheitswesen*, 2007(69), 277-283.

Goetsch, D.L., & Davis, S.B. (2006). *Quality Management – Introduction to Total Quality Management for Production, Processing, and Services* (5th ed.). Upper Saddle River: Pearson Education.

Gooderham, P.N., & Nordhaug, O. (2003). *International management: cross-boundary challenges.* Oxford: Blackwell Publishing.

Goodwin, D. (2006). Ethical issues. In C. Pope, & N. Mays (Eds.), *Qualitative research in health care* (3rd ed., pp. 53-62). Oxford: Blackwell Publishing.

Green, D.G. *et al.* (2002). For and against: social insurance – the right way forward for health care in the United Kingdom? [Electronic Version]. *British Medical Journal,* 325, 488-490.

Green, J., & Thorogood, N. (2004). *Qualitative Methods for Health Research.* London: Sage Publications.

Groene, O. *et al.* (2009). Is patient-centredness in European hospitals related to existing quality improvement strategies? Analysis of a cross-sectional survey (MARQuIS study) [Electronic Version]. *Quality and Safety in Health Care,* 18(Suppl I), i44-i50.

Grundgesetz für die Bundesrepublik Deutschland [The Constitution of the Federal Republic of Germany]: May 23, 1949 (BGBI. I p.1), last change by law July 26, 2002 (BGBI. I p.2863).

Güssow, J. (2007). *Vergütung integrierter Versorgungsstrukturen im Gesundheitswesen* [Payment for integrated care structures in the healthcare system]. Wiesbaden: Deutscher Universitäts-Verlag.

Gupta, A., McDaniel, J.C. & Herath, S.K. (2005). Quality management in service firms: sustaining structures of total quality service [Electronic Version]. *Managing Service Quality,* 15(4), 389-402.

GVG (2009). *Gesundheitsziele* [Health Objectives]. Retrieved June 15, 2009, from http://www.gesundheitsziele.de/.

Halank, A. (2008). *Quality in the German Health Care System – An Analysis based on the Concepts of Excellence*. UoP: Dissertation to complete the MSc Strategic Quality Management.

Halank, A. (2007a). *Change Management in a German chain of rehabilitation hospitals: Implementation of an Enterprise Resource Planning system.* UoP: Unpublished assignment in Change Management.

Halank, A. (2007b). *Implementation of Enterprise Resource Planning: Lessons-learned from a chain of rehabilitation hospitals in Germany.* UoP: Unpublished assignment in Business Systems.

Halank, A. (2006). *Integrierte Versorgung von Schlaganfallpatienten – Ein Konzept für das Versorgungsgebiet 15* [Integrated Care for Stroke Patients – A Concept for the Service Area 15]. University of Applied Sciences Münster: Unpublished undergraduate dissertation.

Hall, M., & Holt, R. (2008). New Public Management and cultural change: the case of UK public sector project sponsors as leaders. In P. Windrum, & P. Koch (Eds.), *Innovation in Public Sector Services – Entrepreneurship, Creativity and Management* (pp. 21-40). Cheltenham: Edward Elgar.

Hartley, J. (2004). Case Study Research. In C. Cassell, & G. Symon (Eds.), *Essential Guide to Qualitative Methods in Organizational Research* (pp. 256-270). London: Sage Publications.

Hearld, L.R., Alexander, J.A., Fraser, I., & Jiang, H.J. (2008). How Do Hospital Organizational Structure and Processes Affect Quality of Care? A Critical Review of Research Methods [Electronic Version]. *Medical Care Research and Review,* 65(3), 259-299.

Hendricks, K.B., & Singhal, V.R. (2001a). The Long-Run Stock Price Performance of Firms with Effective TQM Programs [Electronic Version]. *Management Science*, 47(3), 359-368.

Hendricks, K.B., & Singhal, V.R. (2001b). Firm characteristics, total quality management, and financial performance [Electronic Version]. *Journal of Operations Management*, 19(2001), 269-285.

Hensen, P. *et al.* (2008). Evaluating hospital service quality from a physician viewpoint [Electronic Version]. *International Journal of Health Care Quality Assurance*, 21(1), 75-86.

Heras, I., Cilleruelo, E., & Iradi, J. (2008a). ISO 9001 and residential homes for the elderly: a Delphi study [Electronic Version]. *Managing Service Quality*, 18(3), 272-288.

Heras, I., Cilleruelo, E., & Iradi, J. (2008b). Quality management and quality of care in nursing homes [Electronic Version]. *International Journal of Health Care Quality Assurance*, 21(7), 659-670.

Heras, I., Cilleruelo, E., & Iradi, J. (2008c). Standardization of management systems in Spanish care homes [Electronic Version]. *Leadership in Health Services,* 21(2), 111-119.

Heras Saizarbitoria, I. (2006). How Quality Management Models Influence Company Results – Conclusions of an Empirical Study Based on the Delphi Method [Electronic Version]. *Total Quality Management,* 17(6), 775-794.

Heringshausen, G. (2008). *Qualitätsmanagement im konfessionellen Krankenhaus – Das Krankenhaus als modernes Dienstleistungsunternehmen der Zukunft* [Quality management in the denominational hospital – The hospital as a modern service enterprise of the future]. Munich: GRIN.

Himmelstein, D.U., & Woolhandler, S. (2008). Privatization in a publicly funded health care system: the US experience [Electronic Version]. *International Journal of Health Services,* 38(3), 407-419.

Hoffman, A. *et al.* (2009). *National Sentinel Stroke Audit Phase II (clinical audit) 2008 – Report for England, Wales and Northern Ireland* [Electronic Version]. London: Clinical Effectiveness and Evaluation Unit, Royal College of Physicians.

Hofstede, G. (2003). *Cultures and Organizations: Intercultural Cooperation and Its Importance for Survival – Software of the Mind.* London: Profile Books.

Holden, M.T., & Lynch, P. (2004). Choosing the appropriate methodology: Understanding Research Philosophy [Electronic Version]. *The Marketing Review,* 2004(4), 397-409.

Hollick, J., & Kerres, A. (2002). *Pflege im DRG-System: DRGs – Pflege – Pflegediagnosen* [Care in the DRG system: DRGs – Care – Care Diagnoses]. Balingen: Spitta Verlag.

Hope (2008). *Hospitals in the 27 Member States of the European Union* [Electronic Version]. La Défense: Dexia Editions.

Hu, Z., Liebens, J., & Rao, K.R. (2008). Linking stroke mortality with air pollution, income, and greenness in northwest Florida: an ecological geographical study [Electronic Version]. *International Journal of Health Geographics*, 7(2), 1-34.

Hudelson, P. *et al.* (2008). What is quality and how is it achieved? Practitioners' views versus quality models [Electronic Version]. *Quality and Safety in Health Care*, 17(1), 31-36.

Huq, Z., & Martin, T.N. (2000). Workforce Cultural Factors in TQM/CQI Implementation in Hospitals [Electronic Version]. *Health Care Management Review,* 25(3), 80-93.

Initiativkreis Ruhrgebiet (2007). *Klinikführer Rhein-Ruhr 2008/2009*. Essen: Klartext.

Institute of Medicine (2009). *America's Uninsured Crisis: Consequences for Health and Health Care, Report Brief* [Electronic Version]. Washington: National Academies Press.

Jacob, R., Madu, C.N., & Tang, C. (2004). Quality and Reliability Corner – An empirical assessment of the financial performance of Malcolm Baldrige Award winners [Electronic Version]. *International Journal of Quality and Reliability Management,* 21(8), 897-914.

Jones, M.L. (2007). *Hofstede – culturally questionable?* [Electronic Version]. Paper presented at Oxford Business & Economics Conference.

Oxford, UK, 24-26 June, 2007. Retrieved May 15, 2009, from http://ro.uow.edu.au/commpapers/370/.

Jones, S. (2006). Care pathways: Improving the patient journey. In M. Lugon, & J. Secker-Walker (Eds.), *Clinical Governance in a Changing NHS* (pp. 49-66). London: Royal Society of Medicine Press.

Jung, J., Su, X., Baeza, M., & Hong, S. (2008). The effect of organizational culture stemming from national culture towards quality management deployment [Electronic Version]. *The TQM Magazine*, 20(6), 622-635.

Kajdan, V. (2007). Why Quality, Cost and Business Excellence are Inseparable [Electronic Version]. *Total Quality Management & Business Excellence,* 18(1), 147-152.

Kang, G.-D., & James, J. (2004). Service quality dimensions: an examination of Grönroos' service quality model [Electronic Version]. *Managing Service Quality,* 14(4), 266-277.

Kaye, M., & Anderson, R. (1999). Continuous improvement: the ten essential criteria [Electronic version]. *International Journal of Quality and Reliability Management*, 16(5), 485-506.

Kayser, B., & Schwefing, B. (1998). *Managed Care und HMO's – Lösung für die Finanzkrise der Krankenversicherung?* [Managed Care and HMOs – A solution for the financial crisis of the health insurance?]. Bern: Verlag Hans Huber.

Keen, J. (2006). Case studies. In C. Pope, & N. Mays (Eds.), *Qualitative research in health care* (3rd ed., pp. 112-120). Oxford: Blackwell Publishing.

Kelemen, M.L. (2003). *Managing Quality – Managerial and Critical Perspectives.* London: Sage Publications.

Kemper, E.A., Stringfield, S., & Teddlie, C. (2003). Mixed Methods Sampling Strategies in Social Science Research. In A. Tashakkori, & C. Teddlie (Eds.), *Handbook of Mixed Methods in Social and Behavioural Research* (pp. 273-296). London: Sage Publications.

King, N. (2004). Using templates in the thematic analysis of text. In C. Cassell, & G. Symon (Eds.), *Essential Guide to Qualitative Methods in Organizational Research* (pp. 256-270). London: Sage Publications.

Kirkpatrick, I., Ackroyd, S., & Walker, R. (2005). *The New Managerialism and Public Service Professions – Change in Health, Social Services and Housing*. Basingstoke: Palgrave MacMillan.

Koch, H. (1991). *Total Quality Management in Health Care*. Harlow: Longman.

Komashie, A., Mousavi, A., & Gore, J. (2007). Quality management in healthcare and industry – A comparative review and emerging trends [Electronic Version]. *Journal of Management History,* 13(4), 359-370.

KTQ (2004). *KTQ-Manual*. Düsseldorf: Deutsche Krankenhaus Verlagsgesellschaft mbH.

KTQ (2003). *Das krankenhausspezifische Zertifizierungsverfahren der Kooperation für Transparenz und Qualität im Krankenhaus (KTQ) – Eine Verfahrensbeschreibung* [The hospital specific certification process of the cooperation for transparency and quality in hospitals (KTQ) – A procedural description, Electronic Version]. Siegburg: KTQ.

Kumar, V., Choisne, F., de Grosbois, D., & Kumar, U. (2009). Impact of TQM on company's performance [Electronic Version]. *International Journal of Quality and Reliability Management,* 26(1), 23-37.

Kunst, P., & Lemmink, J. (2000). Quality management and business performance in hospitals: A search for success parameters [Electronic Version]. *Total Quality Management,* 11(8), 1123-1133.

Lagrosen, S. (2003). Exploring the impact of culture on quality management [Electronic Version]. *International Journal of Quality & Reliability Management,* 20(4), 473-487.

Lee, P.-M., Khong, P.W., & Ghista, D.N. (2006). Impact of deficient healthcare service quality [Electronic Version]. *The TQM Magazine,* 18(6), 563-571.

Lombarts, M.J.M.H., *et al.* (2009). Application of quality improvement strategies in 389 European hospitals: results of the MARQuIS project [Electronic Version]. *Quality and Safety in Health Care,* 18(Suppl I), i28-i37.

Lord Darzi (2008). *High Quality Care For All – NHS Next Stage Review Final Report – Summary* [Electronic Version]. London: DoH.

Luce, J.M., Bindman, A.B., & Lee, P.R. (1994). A Brief History of Health Care Quality Assessment and Improvement in the United States [Electronic Version]. *WJM*, 160(3), 263-268.

Lutfiyya, M.N. *et al.* (2007). A comparison of quality of care indicators in urban acute care hospitals and rural critical access hospitals in the United States [Electronic Version]. *International Journal for Quality in Health Care*, 19(3), 141-149.

Macinati, M.S. (2008). The relationship between quality management systems and organizational performance in the Italian National Health System [Electronic Version]. *Health Policy,* 85(2008), 228-241.

Maguad, B.A. (2006). The Modern Quality Movement: Origins, Development and Trends [Electronic Version]. *Total Quality Management,* 17(2), 179-203.

Mannion, R., Konteh, F.H., & Davies, H.T.O. (2009). Assessing organisational culture for quality and safety improvement: a national survey of tools and tool use [Electronic Version]. *Quality and Safety in Health Care,* 18(2), 153-156.

Mathews, B.P. *et al.* (2001). European quality management practices – The impact of national culture [Electronic Version]. *International Journal of Quality & Reliability Management,* 18(7), 692-707.

Mays, N., & Pope, C. (2006). Quality in qualitative health research. In C. Pope, & N. Mays (Eds.), *Qualitative research in health care* (3rd ed., pp. 82-101). Oxford: Blackwell Publishing.

Medicare HMO (2010). *What is a Medicare HMO?.* Retrieved July 22, 2010, from http://www.medicarehmo.com/mchmwhat.htm.

Merry, P. (2007). *Wellard's NHS Guide 2007* (10th ed.). Wadhurst: JMH Publishing.

Miles, M.B., & Huberman, A.M. (1994). *An Expanded Sourcebook - Qualitative Data Analysis* (2nd ed.). London: Sage Publications.

Mills, A., Engelhard, C.L., & Tereskerz, P.M. (2010). Truth and Consequences – Insurance-Premium Regulation and the ACA [Electronic Version]. *The New England Journal of Medicine,* July 2010, 1-3.

Minkman, M., Ahaus, K., & Huijsman, R. (2007). Performance improvement based on integrated quality management models: what evidence do we have? A systematic literature review [Electronic Version]. *International Journal for Quality in Health Care,* 19(2), 90-104.

Moeller, J., Breinlinger-O'Reilly, J., & Elser, J. (2000). Quality management in German health care – the EFQM excellence model [Electronic Version]. *International Journal of Health Care Quality Assurance*, 13(6), 254-258.

Morgan, C., & Murgatroyd, S. (1994). *Total Quality Management in the Public Sector*. Buckingham: Open University Press.

Morgan, P., & Potter, C. (1995). Professional cultures and paradigms of quality in health care. In I. Kirkpatrick, & M. Martinez Lucio (Eds.). *The politics of quality in the public sector* (pp. 166-189). London: Routledge.

Morris, R., Payne, O. & Lambert, A. (2007). Patient, carer and staff experience of a hospital-based stroke service [Electronic Version]. *International Journal for Quality in Health Care,* 19(2), 105-112.

Moulettes, A. (2007). The absence of women's voices in Hofstede's *Cultural Consequences* – A postcolonial reading [Electronic Version]. *Women in Management Review,* 22(6), 443-455.

Moullin, M. (2002). *Delivering Excellence in Health and Social Care.* Buckingham: Open University Press.

Mühlbauer, B.H. (2002). Qualitätsmanagement im Krankenhaus zwischen Akkreditierung, Zertifizierung und Total Quality Management [Quality management in hospitals between accreditation, certification and Total Quality Management]. In R. Geisen, & B.H. Mühlbauer (Eds.), *Qualitätsmanagement im Krankenhaus – Praxis und aktuelle Entwicklungen* [Quality Management in hospitals – Practical application and current developments] (pp. 1-34). Münster: LIT.

Natarajan, R.N. (2006). Transferring best practices to healthcare: opportunities and challenges [Electronic Version]. *The TQM Magazine,* 18(6), 572-582.

National Commission for the Protection of Human Subjects of Biomedical and Behavioural Research (1979). *The Belmont Report – Ethical Principles and Guidelines for the Protection of Human Subjects of Research.* Washington DC: Department of Health, Education, and Welfare.

Naveh, E., Katz-Navon, T., & Stern, Z. (2006). Readiness to Report Medical Treatment Errors – The Effects of Safety Procedures, Safety Information, and Priority of Safety [Electronic Version]. *Medical Care*, 44(2), 117-123.

NCQA (2010). *About NCQA*. Retrieved July 22, 2010, from http://www.ncqa.org/tabid/675/Default.aspx.

Newdick, C. (2005). *Who should we treat? Rights, Rationing and Resources in the NHS* (2nd ed.). Oxford: Oxford University Press.

Newhouse, J.P. (2002). Why is there a quality chasm? [Electronic Version]. *Health Affairs,* 21(4), 13-25.

NGC (2010). *National Guideline Clearinghouse – Welcome!.* Retrieved July 22, 2010, from http://www.guideline.gov/.

NHS (2010a). *The NHS Constitution – The NHS belongs to us all.* Retrieved March 30, 2010, from http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_113645.pdf.

NHS (2010b). *About the NHS – NHS Structure.* Retrieved June 25, 2010, from http://www.nhs.uk/NHSEngland/thenhs/about/Pages/nhsstructure.aspx.

NHS (2010c). *Stroke – Act F.A.S.T..* Retrieved July 21, 2010, from http://www.nhs.uk/actfast/Pages/stroke.aspx.

NHS (2009). *NHS Core Principles*. Retrieved June 25, 2010, from http://www.nhs.uk/NHSEngland/thenhs/about/Pages/nhscoreprinciples.aspx.

NHS Clinical Governance Support Team (1999). *Seven Pillars of Clinical Governance Model*. Retrieved November 5, 2008, from http://www.cgsupport.nhs.uk.

NHS Institute for Innovation and Improvement (2010). *About the NHS Institute for Innovation and Improvement*. Retrieved July 18, 2010, from http://www.institute.nhs.uk/organisation/about_nhsi/about_the_nhs_institute.html.

NICE (2010). *About NICE – Who we are.* Retrieved July 18, 2010, from http://www.nice.org.uk/aboutnice/.

Nielsen, D.M., *et al.* (2004). Can the Gurus' Concepts cure Healthcare [Electronic Version]. *Quality Progress*, 2004(September), 25-34.

Nolan, T., & Bisognano, M. (2006). Finding the balance between quality and cost [Electronic Version]. *Healthcare Financial Management,* 2006(April), 67-72.

Nolte, E., McKee, M., & Wait, S. (2005). Describing and evaluating health systems. In A. Bowling, & S. Ebrahim (Eds.). *Handbook of Health Research Methods – Investigation, Measurement and Analysis* (pp. 12-43). Maidenhead: Open University Press.

Ntungo, C. (2007). Quality Culture in Government: The Pursuit of a Quality Management Model [Electronic Version]. *Total Quality Management,* 18(1-2), 135-145.

Oakland, J.S., & Tanner, S.J. (2008). The relationship between Business Excellence and Performance – An empirical study using Kanji's

Leadership Excellence Model [Electronic Version]. *Total Quality Management,* 19(7-8), 733-749.

Oakland, J.S. (2001). *Total Organizational Excellence – Achieving world-class performance*. London: Elsevier.

Oberender, P.O., Hebborn, A., & Zerth, J. (2006). *Wachstumsmarkt Gesundheit* [Health as a growing market] (2nd ed.). Stuttgart: Lucius & Lucius.

O'Cathain, A., & Thomas, K. (2006). Combining qualitative and quantitative methods. In C. Pope, & N. Mays (Eds.), *Qualitative research in health care* (3rd ed., pp. 102-111). Oxford: Blackwell Publishing.

OECD (2010a). *Public's satisfaction with availability of quality health care, 2008*. Retrieved June 28, 2010, from http://www.ecosante.org/OCDE ENG/66.html.

OECD (2010b). *Public's satisfaction with health care system, selected European and non-European countries, 1988-2007.* Retrieved June 28, 2010, from http://www.ecosante.org/OCDEENG/65.html.

OECD (2009a). *Health at a Glance 2009 – OECD Indicators.* Paris: OECD Publishing.

OECD (2009b). *Germany: Financing of Healthcare.* Retrieved June 28, 2009, from http://www.ecosante.org/index2.php?base=OCDE&langs=ENG&langh=ENG&ref=YES&sessionid=b0b9b7b080b4e729ab7a8cc116233d08.

OECD (2009c). *United States: Financing of Healthcare*. Retrieved June 28, 2009, from http://www.ecosante.org/index2.php?base=OCDE&langs=ENG&langh=ENG&ref=YES&sessionid=b0b9b7b080b4e729ab7a8cc116233d08.

OECD (2009d). *OECD Health Policy Studies – Achieving Better Value for Money in Health Care*. Paris: OECD Publishing.

OECD (2007). *Health Care Quality Indicators Project – Patient Safety Data Systems in the OECD: A Report of a Joint Irish Department of Health – OECD Conference* [Electronic Version]. Dublin: OECD.

OECD (2004). *The OECD Health Project: Towards High-Performing Health Systems* [Electronic Version]. Paris: OECD Publication Service.

OECD (2003a). *A Disease-based Comparison of Health Systems – What is best and at what cost?* [Electronic Version]. Paris: OECD Publication Service.

OECD (2003b). *Health-Care Systems: Lessons from the Reform Experience* [Electronic Version]. Paris: OECD Publication Service.

Oliver, P. (2003). *The Student's Guide to Research Ethics.* Maidenhead: Open University Press.

Øvretveit, J. (2000). Total Quality Management in European healthcare [Electronic Version]. *International Journal of Health Care Quality Assurance,* 13(2), 74-49.

Øvretveit, J. (1992). *Health Service Quality – An introduction to quality methods for Health Services.* Cambridge: Blackwell Science.

PAF (2010). *Our Mission*. Retrieved July 22, 2010, from http://www.patientadvocate.org/.

Parasuraman, A., Zeithaml, V.A., & Berry, L.L. (1985). A Conceptual Model of Service Quality and Its Implications for Future Research [Electronic Version]. *Journal of Marketing,* 49(4), 41-50.

Parliamentary and Health Service Ombudsman (2008). *Improving public service: a matter of principle* [Electronic Version]. London: The Stationery Office.

Patientenbeauftragter (2010). *Das Amt* [The function]. Retrieved July 22, 2010, from http://www.patientenbeauftragter.de/front_content.php?idcat=4&lang=1.

Patton, M.Q. (2002). *Qualitative Research & Evaluation Methods* (3rd ed.). London: Sage Publications.

Peters, T., & Austin, N. (1985). *A Passion for Excellence – The Leadership Difference*. London: Collins.

Pitta, D.A., & Laric, M.V. (2004). Value chains in health care [Electronic Version]. *Journal of Consumer Marketing,* 21(7), 451-464.

Pongpirul, K. *et al.* (2006). Comparison of health care professionals' and surveyors' opinions on obstacles and problems in implementing quality management system in Thailand: a national survey [Electronic Version]. International Journal for Quality in Health Care, 18(5), 346-351.

Pope, C., Mays, N., & Popay, J. (2007). *Synthesizing Qualitative and Quantitative Health Evidence – A guide to methods.* Maidenhead: Open University Press.

Pope, C., Ziebland, S., & Mays, N. (2006). Analysing qualitative data. In C. Pope, & N. Mays (Eds.), *Qualitative research in health care* (3rd ed., pp. 63-81). Oxford: Blackwell Publishing.

Pope, C., Ziebland, S., & Mays, N. (2000). Analysing qualitative data [Electronic Version]. *British Medical Journal,* 2000(320), 114-116.

Price, S.A., Koch, M.W., & Bassett, S. (1998). *Health Care Resources Management – Present and Future Challenges.* St. Louis, Missouri: Mosby.

Rachold, U. (2000). *Neue Versorgungsformen und Managed Care – Ökonomische Steuerungsmaßnahmen der Gesundheitsversorgung* [New Forms of Healthcare Provision and Managed Care – Economic Measures of Control for Healthcare]. Stuttgart: Verlag Kohlhammer.

Redfern, J., McKevitt, C., & Wolfe, C.D.A. (2006). Risk management after stroke: The limits of a patient-centred approach [Electronic Version]. *Health, Risk & Society*, 8(2), 123-141.

Riege, A.M. (2003). Validity and reliability test in case study research: a literature review with "hands-on" applications for each research phase. *Qualitative Market Research: An International Journal,* 6(2), 75-86.

Riesberg, A., Weinbrenner, S., & Busse, R. (2003). Gesundheitspolitik im europäischen Vergleich – Was kann Deutschland lernen? [HC policy compared in Europe – Which lessons can Germany learn?, Electronic Version]. *Aus Politik und Zeitgeschichte – Beilage zur Wochenzeitung Das Parlament,* 2003(33-34), 29-38.

Rihoux, B., & Ragin, C.C. (2009). *Configurational Comparative Methods – Qualitative Comparative Analysis (QCA) and Related Techniques.* London: Sage.

Rudd, A.G. *et al.* (2001). National stroke audit: a tool for change? [Electronic Version]. *Quality in Health Care,* 2001(10), 141-151.

Ruiz, U. *et al.* (1999). A two-level integrated approach to self-assessment in healthcare organisations [Electronic Version]. *International Journal of Health Care Quality Assurance,* 12(4), 135-142.

Ruiz, U., & Simón, J. (2004). Quality management in health care: a 20-year journey [Electronic Version]. *International Journal of Health Care Quality Assurance*, 17(3), 323-333.

Ruiz, U., & Simón, J. (1994). La mejora contínua en el sistema sanitario: Resultados de la primera fase de implantación del plan de calidad en España (1986-1992) [Continuous improvement in the health care system: Results of the first phase of implementing the quality plan in Spain (1986-1992), Electronic Version]. *Revista de Sanidad e Higiene Pública,* 68(5-6), 535-548.

Rungtusanatham, M., *et al.* (2005). TQM across multiple countries: *Convergence Hypothesis* versus *National Specificity* arguments [Electronic Version]. *Journal of Operations Management,* 23(2005), 43-63.

Saltman, R.B., Figueras, J., & Sakellarides, C. (1998). *Critical Challenges for Health Care Reform in Europe*. Buckingham: Open University Press.

Samson, D., & Terziovski, M. (1999). The relationship between total quality management practices and operational performance [Electronic Version]. *Journal of Operations Management*, 17(1999), 393-409.

Sangüesa, M., Mateo, R., & Ilzarbe, L. (2007). How Hospitals Choose a Quality Management System: Relevant Criteria in Large Spanish Hospitals [Electronic Version]. *Total Quality Management,* 18(6), 613-630.

Saunders, M., Lewis, P., & Thornhill, A. (2007). *Research Methods for Business Students* (4th ed.). Harlow: Prentice Hall.

Sawicki, P.T. (2005). Qualität in der Gesundheitsversorgung in Deutschland – Ein randomisierter simultaner Sechs-Länder-Vergleich aus Patientensicht [Quality in the HC service provision in Germany – A randomised, simultaneous six-country-comparison from the patients' perspective, Electronic Version]. *Medizinische Klinik,* 100(11), 755-768.

Schreyögg, J. *et al.* (2005). Defining the “Health Benefit Basket” in nine European countries – Evidence from the European Union Health BASKET project [Electronic Version]. *European Journal of Health Economics,* 2005(Supplement 1, 6), 2-10.

Schwartz, F.W. *et al.* (2003). *Das Public Health Buch – Gesundheit und Gesundheitswesen* [The Public Health Book – Health and Health Care System]. München, Jena: Urban & Fischer Verlag.

Sebastianelli, R., & Tamimi, N. (2002). How product quality dimensions relate to defining quality [Electronic Version]. *International Journal of Quality & Reliability Management,* 19(4), 442-453.

Seenan, P., Long, M., & Langhorne, P. (2007). Stroke Units in Their Natural Habitat: Systematic Review of Observational Studies [Electronic Version]. *Stroke,* 2007(38), 1886-1892.

Senior, B., & Fleming, J. (2006). *Organisational Change* (3rd ed.). Harlow: Pearson Education.

Shannon, S. E., Mitchell, P. H., & Cain, K. C. (2002). Patients, Nurses, and Physicians Have Differing Views of Quality of Critical Care [Electronic Version]. *Journal of Nursing Scholarship*, 34(2), 173-179.

Soltani, E., Singh, A., Liao, Y.-Y., & Wang, W.-Y. (2010). The rhetoric and reality of ‘process control’ in organisational environments with a TQM orientation [Electronic Version]. *Total Quality Management,* 21(1), 67-77.

Sower, V.E., & Fair, F.K. (2005). There is More to Quality than Continuous Improvement: Listening to Plato [Electronic Version]. *Quality Management Journal*, 12(1), 8-20.

Sozialgesetzbuch, Erstes Buch [Social Code, First Book]: Allgemeiner Teil [General Part], December 11, 1975 (BGBI. I p.3015), last change by law December 6, 2006 (BGBI. I p.2748).

Sozialgesetzbuch, Fünftes Buch [Social Code, Fifth Book]: Gesetzliche Krankenversicherung [Social Health Insurance], December 20, 1988 (BGBI. I p.2477), last change by law September 7, 2007 (BGBI. I p.2246).

Specke, H.K. (2005). *Der Gesundheitsmarkt in Deutschland* [The health market in Germany] (3rd ed.). Bern: Verlag Hans Huber.

Spencer, E., & Walshe, K. (2005a). *Deliverable 1. WP 2. Strategies: literature and interview summary. Quality Improvement Strategies in Healthcare systems of the European Union* [Electronic Version]. Manchester: University of Manchester.

Spencer, E., & Walshe, K. (2005b). *Deliverable 6. Health Care Quality Strategies in Europe. A survey of quality improvement policies and strategies in health care systems of member states of the European Union* [Electronic Version]. Manchester: University of Manchester.

Spencer, L., Ritchie, J., Lewis, J., & Dillon, L. (2003). *Quality in Qualitative Evaluation: A framework for assessing research evidence.* London: Government Chief Social Researcher's Office, Strategy Unit, Cabinet Office.

Squires, A. (2003a). Quality in health. In L. Gaster, & A. Squires (Eds.), *Providing Quality in the Public Sector – A practical approach to improving public services* (pp. 138-154). Maidenhead: Open University Press.

Squires, A. (2003b). Making it work in health: a stakeholder model for quality management. In L. Gaster, & A. Squires (Eds.), *Providing Quality in the Public Sector – A practical approach to improving public services* (pp. 205-212). Maidenhead: Open University Press.

Steneck, N.H. (2004). *ORI Introduction to the Responsible Conduct of Research*. Washington DC: Department of Health and Human Services, USA.

Stoeckle-Roberts, S. *et al.* (2008). Closing Gaps Between Evidence-Based Stroke Care Guidelines and Practices with a Collaborative Quality Improvement Project [Electronic Version]. *Joint Commission Journal on Quality and Patient Safety,* 32(9), 517-527.

Suñol, R., *et al.* (2009). Impact of quality strategies on hospital outputs [Electronic Version]. *Quality and Safety in Health Care,* 18(Suppl I), i62-i68.

SVR (2009). *Koordination und Integration – Gesundheitsversorgung in einer Gesellschaft des längeren Lebens* [Coordination and Integration – Health services in a society of longer living, Electronic Version]. Bonn: SVR.

SVR (2007). *Kooperation und Verantwortung – Voraussetzungen einer zielorientierten Gesundheitsversorgung* [Cooperation and Responsibility – Conditions of an objectives-oriented healthcare provision, Electronic Version]. Bonn: SVR.

Szathmary, B. (1999). *Neue Versorgungskonzepte im deutschen Gesundheitswesen – Disease und Case Management* [New care structures in the German health system – Disease and Case Management]. Neuwied & Kriftel: Hermann Luchterhand Verlag.

Szecsenyi, J. (2004). Europäisches Praxisassessment (EPA) – Maßgeschneidertes Qualitätsmanagement für die Hausarztpraxis [European Surgery Assessment (EPA) – Taylor-made quality management for the GP surgery, Electronic Version]. *Der Allgemeinarzt,* 2004(7), 414-416.

Tarí, J.J., Molina, J.F., & Catejón, J.L. (2007). The relationship between quality management practices and their effects on quality outcomes [Electronic Version]. *European Journal of Operational Research*, 183(2007), 483-501.

Terziovski, M., Power, D., & Sohal, A.S. (2003). The longitudinal effects of the ISO 9000 certification process on business performance [Electronic Version]. *European Journal of Operational Research*, 146(2003), 580-595.

The Joint Commission (2009a). *Facts about Joint Commission Accreditation and Certification*. Retrieved October 13, 2009, from http:// www.jointcommission.org/AboutUs/Fact_Sheets/facts_jc_accr_cert.htm.

The Joint Commission (2009b). *Facts about The Joint Commission*. Retrieved November 13, 2009, from http://www.jointcommission.org/About Us/Fact_Sheets/joint_commission_facts.htm.

The Joint Commission (2008). *2008 Hospital Accreditation Standards*. Oakbrook Terrace, Illinois: Joint Commission Resources.

Thompson, A. (1995). Customizing the public for health care – What's in a label?. In I. Kirkpatrick, & M. Martinez Lucio (Eds.). *The politics of quality in the public sector* (pp. 65-83). London: Routledge.

Tilley, B.C. *et al.* (1997). Total Quality Improvement Method for Reduction of Delays Between Emergency Department Admission and Treatment of Acute Ischemic Stroke [Electronic Version]. *Archives of Neurology,* 54(12), 1466-1474.

Ulin, R.P., Robinson, E.T., & Tolley, E.E. (2005). *Qualitative Methods in Public Health – A Field Guide for Applied Research.* San Francisco: Jossey-Bass.

UoP (2006). *Performance Evaluation Session 7 – SERVQUAL.* Portsmouth: Unpublished Presentation.

US Department of Health and Human Services (2010a). *Medicaid Program – General Information – Overview.* Retrieved July 22, 2010, from http://www.cms.gov/MedicaidGenInfo/.

US Department of Health and Human Services (2010b). *Healthy People 2020: The Road Ahead.* Retrieved July 22, 2010, from http://www.healthy people.gov/hp2020/default.asp.

US Department of Health and Human Services (2010c). *Heart Disease and Stroke.* Retrieved July 22, 2010, from http://www.healthypeople.gov/ hp2020/Objectives/TopicArea.aspx?id=28&TopicArea=Heart+Disease+an d+Stroke.

US Government (2010). *Medicare Eligibility Tool*. Retrieved July 22, 2010, from http://www.medicare.gov/MedicareEligibility/Home.asp?dest=NAV| Home|GeneralEnrollment#TabTop.

Vallejo, P., & Suñol, R. (2009). MARQuIS: quality improvement strategies for European cross-border healthcare [Electronic Version]. *Quality and Safety in Health Care,* 18(Suppl I), i1-i2.

Vecchi, A., & Brennan, L. (2009). Quality management: a cross-cultural perspective [Electronic Version]. *Cross Cultural Management: An International Journal,* 16(2), 149-164.

Vukmir, R. B. (2006). Customer satisfaction [Electronic Version]. *International Journal of Health Care Quality Assurance,* 19(1), 8-31.

Wagner, C. *et al.* (2006a). The implementation of quality management systems in hospitals: a comparison between three countries [Electronic Version]. *BMC Health Services Research*, 6:50, retrieved November 1, 2008, from http://www.biomedcentral.com/1472-6963/6/50.

Wagner, C. *et al.* (2006b). Quality management systems and clinical outcomes in Dutch nursing homes [Electronic Version]. *Health Policy,* 75(2), 230-240.

Wagner, C., v. Merode, G.G., & v. Oort, M. (2003). Costs of Quality Management Systems in Long-Term Care Organizations: An Exploration [Electronic Version]. *Quality Management in Health Care,* 12(2), 106-114.

Waldman, J.D., & Schargel, F.P. (2006). Twins in Trouble (II): Systems Thinking in Healthcare and Education [Electronic Version]. *Total Quality Management,* 17(1), 117-130.

Waldman, J.D., Smith, H.L., & Hood, J.N. (2003). Corporate Culture: The Missing Piece of the Healthcare Puzzle [Electronic Version]. *HOSPITAL TOPICS: Research and Perspectives on Healthcare,* 81(1), 5-14.

Walshe, K. (2007). Understanding what works – and why – in quality improvement: the need for theory-driven evaluation [Electronic Version]. *International Journal for Quality in Health Care,* 19(2), 57-59.

Wanless, D. *et al.* (2004). *Securing Good Health for the Whole Population – Final Report* [Electronic Version]. Norwich: Her Majesty's Stationery Office.

Wayhan, V.B., Khumawala, B.M., & Balderson, E.L. (2010). An empirical test of Deming's Chain Reaction Model [Electronic Version]. *Total Quality Management*, 21(7), 761-777.

Wendt, C. (2003). *Krankenversicherung oder Gesundheitsversorgung? – Gesundheitssysteme im Vergleich* [Sickness insurance or health provision? – A comparison of healthcare systems]. Wiesbaden: Westdeutscher Verlag.

WHO (2008). *The world health report 2008 – primary health care now more than ever.* Geneva: World Health Organisation.

WHO (2005). *Health Promotion in Hospitals: Evidence and quality management* [Electronic Version]. Copenhagen: WHO.

WHO (2004). *Standards for Health Promotion in Hospitals* [Electronic Version]. Copenhagen: WHO.

WHO (2000). *The world health report 2000 –health systems: improving performance.* Geneva: World Health Organisation.

WHO (1981). *Global Strategy for Health for All by the Year 2000* [Electronic Version]. Geneva: WHO.

WHO (1946). *Constitution of the World Health Organization* [Electronic Version]. New York: WHO.

Windrum, P. (2008). Innovation and entrepreneurship in public services. In P. Windrum, & P. Koch (Eds.), *Innovation in Public Sector Services – Entrepreneurship, Creativity and Management* (pp. 3-20). Cheltenham: Edward Elgar.

World Stroke Organization (2009). *Official Homepage*. Retrieved August 13, 2009 from http://www.world-stroke.org/.

Yin, R.K. (2003). *Case Study Research – Design and Methods* (3rd ed.). London: Sage Publications.

York, K.M., & Miree, C.E. (2004). Causation or covariation: an empirical re-examination of the link between TQM and financial performance [Electronic Version]. *Journal of Operations Management,* 22(2004), 291-311.

Zabada, C., Rivers, P.A., & Munchus, G. (1998). Obstacles to the application of total quality management in health-care organisations [Electronic Version]. *Total Quality Management*, 9(1), 57-66.

Zahn, J.v., Gothe, H., & Häussler, B. (2005). *BMBF-Medizintechnikstudie 2005 – 11. Rahmenbedingungen im Gesundheitswesen: Zulassung und Regulierung, Demographische Entwicklung, Morbiditätstrends, Soziale*

Trends, Prognose der Angebotsregulierung und Krankheitsentwicklung [BMBF study of medical technology 2005 – 11. Contextual conditions in the healthcare system: registration and regulation, demographic changes, morbidity trends, social trends, prognosis for the regulation of supply and disease development]. Retrieved July 21, 2010, from http://www.gesundheitsforschung-bmbf.de/de/921.php.

Zaiß, A. (2003a). Einleitung und Grundlagen [Introduction and Basics]. In Zaiß, A. (Ed.). *DRG: Verschlüsseln leicht gemacht – Deutsche Kodierrichtlinien mit Tipps, Hinweisen und Kommentierungen* [DRG: How to code – German coding directives with tipps, tricks and comments] (pp. 1-8). Cologne: Deutscher Ärzte-Verlag.

Zaiß, A. (2003b). Allgemeine Kodierrichtlinien für Krankheiten [General coding directives for diseases]. In Zaiß, A. (Ed.). *DRG: Verschlüsseln leicht gemacht – Deutsche Kodierrichtlinien mit Tipps, Hinweisen und Kommentierungen* [DRG: How to code – German coding directives with tipps, tricks and comments] (pp. 9-43). Cologne: Deutscher Ärzte-Verlag.

Zenel, K., Kimmel, A., & Strippel, H. (2009). *Präventionsbericht 2009 - Leistungen der gesetzlichen Krankenversicherung: Primärprävention und betriebliche Gesundheitsförderung, Berichtsjahr 2008* [Prevention report 2009 – SHI services: primary prevention and workplace health promotion, reporting year 2008, Electronic Version]. Essen: MDS.

Appendix

1.) Basic Assumptions & Objectivist-Subjectivist Continuum

	Subjectivist Approaches to Social Science					**Objectivist Approaches to Social Science**
Core Ontological Assumptions (Reality)	Reality as a projection of human imagination **Nominalism**	Reality as a social construction	Reality as a realm of symbolic discourse	Reality as a contextual field of information	Reality as a concrete process	Reality as a concrete structure **Realism**
Basic Epistemological Stance (Knowledge)	To obtain phenomenological insight, revelation **Anti-positivism**	To understand how social reality is created	To understand patterns of symbolic discourse	To map contexts	To study systems, process, change	To construct a positivist science **Positivism**
Assumptions About Human Nature	Man as pure spirit, consciousness, being **Voluntarism**	Man as a social constructor; the symbol creator	Man as an actor; the symbol user	Man as an information processor	Man as an adaptor	Man as a responder **Determinism**

Source: Holden and Lynch (2004, p. 400)

2.) Research Implications: Objectivist & Subjectivist Approaches

	Positivist Perspective	Subjectivist Perspective	
Independence	The observer is independent of what is being observed.	The observer interacts with subject being observed.	**Interaction**
Value-freedom	The choice of what to study, and how to study it, can be determined by objective criteria rather than by human beliefs and interests.	Inherent biasness in the choice of what to study, and how to study it as researchers are driven by their own interests, beliefs, skills, and values.	**Value-laden**
Causality	The aim of social science should be to identify causal explanations and fundamental laws that explain regularities in human social behaviour.	The aim of social science is to try to understand what is happening.	**No Cause and Effect**
Hypothetico-deductive	Science proceeds through a process of hypothesising fundamental laws and then deducing what kinds of observations will demonstrate the truth or falsity of these hypotheses.	Develop ideas through induction from evidence; mutual simultaneous shaping of factors.	**No Hypothetico-deductive reasoning**
Operationalis-ation	Concepts need to be operationalised in a way which enables facts to be measured quantitatively; static design – categories isolated before study.	Qualitative methods – small samples investigated in depth or over time; emerging design – categories identified during research process.	**Operationalis-ation**
Reductionism	Problems as a whole are better understood if they are reduced into the simplest possible elements.	Problems as a whole are better understood if the totality of the situation is looked at.	**No Reductionism**
Generalisation	In order to be able to generalise about regularities in human and social behaviour it is necessary to select samples of sufficient size; aim of generalisations is to lead to prediction, explanation and understanding.	Everything is contextual; patterns identified – theories then developed for understanding.	**Generalisation**
Research Language	Formal, based on set definitions; impersonal voice; use of accepted quantitative words.	Informal, evolving decisions; personal voice; use of accepted qualitative words.	**Research Language**

Source: Holden and Lynch (2004, p. 403)

3.) Previous Research by the Author

The **aim** of the MSc dissertation (Halank, 2008) was achieved by investigating the following guiding objectives:

5. To identify the external challenges and internal difficulties of the German healthcare system that is mainly financed by a social health insurance (SHI) structure.
6. To analyse current political approaches to meeting these challenges and difficulties in terms of the concepts of excellence as defined in Chapter 4.
7. To briefly recommend how to translate an holistic SQM approach for improvement of the current political approaches into action and suggest further research.

The dissertation ends with these **conclusions and recommendations**:

The introduction defines three objectives for this piece of research to achieve its aim of analysing and recommending how a SQM approach at the national level could help to overcome the external challenges and internal difficulties confronting the German healthcare system. The academic background in Chapter 2 sets the general theoretical framework of quality and health. Chapter 3 then accomplishes the first objective by identifying the external challenges and internal difficulties of the German healthcare system.

This prepares the analysis in the previous chapter of the current political approaches to meeting these challenges and difficulties in terms of the concepts of excellence – the second objective. This analysis shows that the German healthcare system addresses all concepts of excellence, some in a more, others in a less advanced way – the most advanced being the partnership development.

Furthermore, links between general themes identified in the literature reviews in Chapters 2, 3 and the analysis are established. The issues

around implementing a true customer focus (for instance Øvretveit, 1992, p. 40) and overcoming cultural barriers to more cooperation and teamwork resulting from traditional medical prestige thinking (Cauchick Miguel, 2006, p. 628) represent the most relevant connection between this paper and the general research in quality and healthcare.

Oberender *et al.* (2006, pp. 104-106) criticise that the measures introduced by the reforms and analysed in Chapter 4 basically just fight the symptoms without addressing the root cause of the problems, i.e. the funding structure of the system. The author does not agree with this for several reasons: Firstly, the new integrated care structures should help to overcome traditional inefficiencies in the healthcare system. This should also have a positive impact on the financial burden of the SHI. Secondly, the most recent reform of 2007 introduces the "Gesundheitsfonds" which marks a first step towards changing the funding structure of the SHI.

After all, the analysed initiatives only represent the beginning of the journey towards TQM / SQM. This leads to the third and final objective of this piece of research: To briefly recommend how to translate an holistic SQM approach for improvement of the current political approaches into action and suggest further research.

It seems as though an overarching quality strategy in the German health sector that links the analysed initiatives and aspects and provides a holistic framework to communicate, promote and implement a quality culture is missing. This is supported by Davies *et al.* (2001, p. 91) for healthcare in general when they *"explore the need to create more coherent and comprehensive strategies aimed at quality improvement".* The question remains as to how these quality initiatives and aspects can be cascaded down and measured to truly penetrate the entire healthcare system with a TQM / SQM culture and create an holistic quality awareness throughout the system.

In the academic literature, different ways and models to implement TQM / SQM are suggested and discussed mostly at organisational level. These

include, for instance, the Goetsch-Davis 20-Step Total Quality Implementation Process (Goetsch & Davis, 2006, pp. 776-782) and Dale's TQM Framework (Dale, 2003, pp. 77-96). In the more specific context of quality management in healthcare, Section 2.3.1 describes how TQM was considered for and, in part, implemented in the Spanish healthcare system. Ruiz and Simón (2004, pp. 327-328) advocate a two-level integrated approach to achieve excellence in healthcare: Firstly, a quality management system (such as in ISO 9001:2000) and specific means for healthcare quality assurance should be implemented. Afterwards, health services should develop more holistic practices as found in the excellence models (such as the EFQM model). In a previous study, Ruiz and Simón (1994, p. 537) highlight the importance of adequate training and participation of everybody involved in the healthcare provision to achieve a positive attitude towards the ideas and principles of TQM / SQM.

Cauchick Miguel (2006) analyses how a Brazilian hospital has evolved through various cycles of strategic planning and continuous improvement towards excellence (see Section 2.3.2). Additionally, Dey and Hariharan (2006) propose a 10-step integrated healthcare quality management model that is depicted in Table 2 in Section 2.3.2. Further, Davies *et al.* (2001, pp. 92-93) identify the following strategies to promote quality improvement in healthcare that should be understood as *"coherent, interlocking, mutually reinforcing strategies – not* [as] *magic bullets working in isolation"*:

- Regulatory oversight
- Professional self-regulation
- Project-based quality improvement
- Continuous quality improvement / TQM
- Performance measurement and management
- Public release of performance data
- Evidence-based practice
- Individual and organisational learning
- Change management strategies
- Market-based strategies

Some of these strategies are already applied in the German healthcare system – for instance the public release of performance data by the annual BQS healthcare quality reports (see Section 4.2) and evidence-based practice as introduced by the healthcare reform in 2000 (see Section 4.7). Nonetheless, these initiatives seem to be dealt with in a fairly separate way without a coherent national strategy that interlocks and mutually reinforces them, as demanded by Davies *et al.* (see above), under a strategic umbrella aiming at the pursuit of excellence within given budgetary restrictions. Thus, Germany still needs to further develop a truly effective, holistic healthcare quality policy defined by Davies *et al.* (2001, p. 99) as *"that which sets an environment which encourages the emergence of self-governing organisations dedicated to clinical excellence, innovation and learning – within given cost constraints."*

To support and promote this – i.e. basically the TQM / SQM penetration at the national level that covers the entire healthcare system – the top leaders in the German healthcare system, such as the Federal Minster of Health and the top executives of the self-administration bodies, need to be firmly committed to quality and the pursuit of excellence (Goetsch & Davis, 2006, p. 778). Additionally, future research is required to eventually develop more sophisticated, holistic quality strategies and monitor their implementation. Since the analysis in this paper is mainly based on governmental or government-related sources (the limitations are discussed in more detail in Chapter 1) it represents a first theoretical overview of quality in the German healthcare system.

Before progressing to the development of more sophisticated quality strategies and potentially also of monetary / economic incentives to foster the creation of an adequate quality culture, future research should first analyse the issues identified by this piece of research in real-world scenarios. Section 4.1 highlights the need to define measures to holistically capture the outcome of all parts of the healthcare system and their interactions. Furthermore, throughout the analysis it becomes evident that the culture in the German healthcare system requires further research: Section 4.4 raises the question as to which impact the self-

administration leaders have on shared values and ethics. And Section 4.6 identifies the need to further assess cultural manifestations of a quality mindset in German health services and to find ways to permeate the entire system with a TQM / SQM culture. This leads to another issue as concluded in Section 4.7: Programmes have to be developed to train everybody involved in health services provision and management in the principles and techniques of TQM / SQM. Finally, Section 4.9 demands that CSR should be assessed at an organisational level.

The author intends to conduct part of this research by analysing and comparing quality initiatives in the English and the German healthcare system in terms of content and implementation. Firstly, an overview of these healthcare systems will be elaborated. Secondly, the *status quo* of quality aspects in English and German healthcare will be assessed and compared based on the triangulation of:

a. A literature review of academic and political publications.
b. Expert interviews with (quality) specialists in one or both systems such as medical practitioners with managerial insight, national and EU politicians, affiliates with the WHO.
c. Four to five case-study organisations per country ideally from different regions.

Thirdly, expert interviews and literature regarding general national culture as well as specific national traditions in healthcare will help to suggest potential reasons for differences and similarities found in the research. Finally, possible recommendations for improvement of quality aspects in both systems will be derived from the comparisons in the intended research and input from the free-market orientation in the US-American healthcare system assessed through expert interviews and (documentary) analysis of BNQP Award winners in healthcare.

The academic community is already engaged in comparing healthcare systems throughout the world and also within Europe. These studies focus on two main fields of research:

- General health policy development (Riesberg, Weinbrenner, Busse, 2003; Wendt, 2003)
- Quality of the healthcare service provision mainly measured by parameters related to the patients or general cost / efficiency of the systems (Sawicki, 2005; Busse, 2006)

Recently, a European Union project has started to combine these fields in researching *"Methods for Assessing Response to Quality Improvement Strategies"* (MARQuIS; Spencer & Walshe, 2005a). This study provides an holistic literature review, whereas the practical research takes place at a fairly general level: A survey of quality improvement policies and strategies relies on 68 key experts from 24 member states (Spencer & Walshe, 2005b, p. 2) which equals to less than about three experts per member state.

The author aims to contribute to the same academic field of knowledge in more detail by focussing her research on only two member states – the UK and Germany – that represent the two main healthcare system structures existing in Europe (Busse, 2006, p. 10). Reasons for differences and similarities will be set in a cultural and tradition-related context. Finally, recommendations for improvement will be enriched by input from the US-American healthcare system, i.e. the third type of healthcare system. The intended piece of research will be based on an innovative combination of aspects dealing with quality in healthcare: It will consider political, economic and cultural perspectives in the overall framework of quality management in healthcare.

In terms of the future research requirements identified in this paper, mostly cultural aspects will be analysed at both national and organisational level while TQM / SQM or less specific quality training schemes and CSR issues will be researched only at organisational level. Additional research will still be required to define measures to holistically capture the outcome of all parts of the healthcare system and their interactions. Nonetheless, the intended research will represent a first step towards developing more

sophisticated, holistic quality strategies not only for German but also for European healthcare.

All in all, the present paper provides an overview of quality management in health services and analyses the German healthcare system in this regard. To conclude the research, it can be said that most of the quality aspects defined by the concepts of excellence are addressed by the German health policy. Nonetheless, one is left with the impression that a broader strategic understanding aiming at the pursuit of excellence within given budgetary restrictions and linking the analysed initiatives to provide an holistic framework for the communication, promotion and implementation of a quality culture still needs to be developed. Finally, this paper can be seen as a robust theoretical foundation for further research: It could help to increase the quality awareness of healthcare professionals and has the potential to enrich health policy debates by adopting an holistic quality, i.e. a Total and Strategic Quality Management, perspective.

4.) Deduction vs. Induction

Deductive Approach	*Inductive Approach*
• Scientific principles • Moving from theory to data • The need to explain causal relationships between variables • The collection of quantitative data • The application of controls to ensure validity of data • The operationalisation of concepts to ensure clarity of definition • A highly structured approach • Researcher independence of what is being researched – reliability • The necessity to select samples of sufficient size in order to generalise conclusions	• Gaining an understanding of the meanings humans attach to events • A close understanding of the research context • The collection of qualitative data • A more flexible structure to permit changes of research emphasis as the research progresses • A realisation that the researcher is part of the research process • Less concern with the need to generalise

Source: Saunders *et al.* (2007, p. 120)

5.) Constant Evolution of Wants and Needs

	Before 1980	**Late 1980's**	**1990's**	**Today**
To win	Product Quality	Customer Satisfaction	Time to market New value for customers	Balance all stakeholders' expectations and continually improve efficiency
To participate	Costs	Product Quality	Customer Satisfaction	Time to market New value for customers
Market entry requirements	Right Product	Costs Right Product	Product Quality Costs Right Product	Customer Satisfaction Product Quality Costs Right Product

Source: UoP (2006, Slide 14)

6.) SGB V § 92: Directives of the Federal Joint Committee

1. medical treatment (ärztliche Behandlung),
2. dental treatment including dental prosthesis and orthodontics (zahnärztliche Behandlung einschließlich der Versorgung mit Zahnersatz sowie kieferorthopädische Behandlung),
3. measures of early diagnosis of diseases (Maßnahmen zur Früherkennung von Krankheiten),
4. medical care during pregnancy and motherhood (ärztliche Betreuung bei Schwangerschaft und Mutterschaft),
5. introduction of new methods of diagnosis and treatment (Einführung neuer Untersuchungs- und Behandlungsmethoden),
6. prescription of medicine and other medical equipment, treatment in hospital, care at home and sociotherapy (Verordnung von Arznei-, Verband-, Heil- und Hilfsmitteln, Krankenhausbehandlung, häuslicher Krankenpflege und Soziotherapie),
7. evaluation of disablement (Beurteilung der Arbeitsunfähigkeit),
8. prescription of and information about medical rehabilitation (Verordnung von im Einzelfall gebotenen Leistungen zur medizinischen Rehabilitation und die Beratung über Leistungen zur medizinischen Rehabilitation, Leistungen zur Teilhabe am Arbeitsleben und ergänzende Leistungen zur Rehabilitation),
9. plan of supply / budget (Bedarfsplanung),
10. medical measures to cause pregnancy according to § 27a, 1 (medizinische Maßnahmen zur Herbeiführung einer Schwangerschaft nach § 27a Abs. 1),
11. measures according to §§24a and 24b (Maßnahmen nach den §§ 24a und 24b),
12. prescription of sickness transports (Verordnung von Krankentransporten),
13. quality assurance (Qualitätssicherung),
14. specialised out-patient palliative services (spezialisierte ambulante Palliativversorgung),
15. vaccinations (Schutzimpfungen).

7.) SGB V § 139a: Fields of Research

(3) The Institute for Quality and Efficiency in the Healthcare System carries out research about topics of fundamental importance to quality and efficiency of the services provided within the SHI especially in the following fields (Das Institut wird zu Fragen von grundsätzlicher Bedeutung für die Qualität und Wirtschaftlichkeit der im Rahmen der gesetzlichen Krankenversicherung erbrachten Leistungen insbesondere auf folgenden Gebieten tätig):

1. Research, documentation and evaluation of the current body of medical knowledge regarding diagnostic and therapeutic procedures for selected diseases (Recherche, Darstellung und Bewertung des aktuellen medizinischen Wissensstandes zu diagnostischen und therapeutischen Verfahren bei ausgewählten Krankheiten),

2. Academic studies about quality and efficiency of services provided within the SHI taking into account age, gender and situation in life (Erstellung von wissenschaftlichen Ausarbeitungen, Gutachten und Stellungnahmen zu Fragen der Qualität und Wirtschaftlichkeit der im Rahmen der gesetzlichen Krankenversicherung erbrachten Leistungen unter Berücksichtigung alters-, geschlechts- und lebenslagenspezifischer Besonderheiten),

3. Evaluation of evidence-based guidelines for the epidemiologically most important diseases (Bewertungen evidenzbasierter Leitlinien für die epidemiologisch wichtigsten Krankheiten),

4. Advice to disease management programmes (Abgabe von Empfehlungen zu Disease-Management-Programmen),

5. Evaluation of cost and effect of drugs (Bewertung des Nutzens und der Kosten von Arzneimitteln),

6. Publication of general, for all citizens understandable information about quality and efficiency in the healthcare provision as well as about the diagnosis and treatment of diseases with significant epidemiological importance (Bereitstellung von für alle Bürgerinnen und Bürger verständlichen allgemeinen Informationen zur Qualität und Effizienz in der Gesundheitsversorgung sowie zu Diagnostik und Therapie von Krankheiten mit erheblicher epidemiologischer Bedeutung)

8.) Relevant Situations for Different Research Strategies

Strategy	*Form of Question*	*Control of Behaviour*	*Contemporary Events*
Experiment	How, why?	Yes	Yes
Survey	Who, what, where, how many, how much?	No	Yes
Archival Analysis	Who, what, where, how many, how much?	No	Yes/No
History	How, why?	No	No
Case-study	How, why?	No	Yes

Source: Yin (2003, p. 5)

9.) Non-Probability Sampling Techniques

Sample type	*Likelihood of representative sample*	*Types of research*	*Relative Costs*	*Control over sample contents*
Quota	Reasonable to high depending on quota variables	Cost constraints, quick data need	Moderately high to reasonable	Relatively high
Purposive	Low, but dependent on choice: Extreme case Heterogeneous Homogeneous Critical case Typical case	Involving very small samples to focus on: Unusual/special Key themes In-depth Importance Illustrative	Reasonable	Reasonable
Snowball	Low but cases have desired characteristics	Difficult to identify cases	Reasonable	Quite low
Self-selection	Low	Exploratory research	Low	Low
Convenience	Very low	Very little variation in population	Low	Low

Source: Saunders *et al.* (2007, p. 228)

10.) Six Sources of Evidence: Strengths and Weaknesses

Source of Evidence	*Strengths*	*Weaknesses*
Documentation	• Stable – can be reviewed repeatedly • Unobtrusive – not created as a result of the case study • Exact – contains exact names, references, and details of an event • Broad coverage – long span of time, many events, and many settings	• Retrievability – can be low • Biased selectivity, if selection is incomplete • Reporting bias – reflects (unknown) bias of author • Access – may be deliberately blocked
Archival Records	• Same as documentation • Precise and quantitative	• Same as documentation • Accessibility due to privacy reasons
Interviews	• Targeted – focuses directly on case-study topic • Insightful – provides perceived causal inferences	• Bias due to poorly constructed questions • Response bias • Inaccuracies due to poor recall • Reflexivity – interviewee gives what interviewer wants to hear
Direct Observations	• Reality – covers events in real time	• Time-consuming • Selectivity – unless

	• Contextual – covers context of event	broad coverage • Reflexivity – event may proceed differently because it is being observed • Cost – hours needed by human observers
Participant-Observation	• Same as direct observation • Insight into interpersonal behaviour and motives	• Same as direct observation • Bias due to investigator's manipulation of events
Physical Artefacts	• Insightful into cultural features • Insightful into technical operations	• Selectivity • Availability

Source: Yin (2003, p. 86)

11.) Participant Checking of Interview Protocols

Seems fine
Thank you

Sender removed for confidentiality reasons

-----Original Message-----
From: Alina Halank [mailto:Alina.Halank@port.ac.uk]
Sent: 09 October 2009 15:01
To: *Recipient removed for confidentiality reasons*
Cc: Debbie Reed
Subject: Protocol

Dear *Recipient removed for confidentiality reasons*,

attached please find the protocol of our interview - if there's anything you are not happy with, please let me know.

Thank you so much for your invaluable support!

Alina

12.) Coding Guidance

1. Please familiarise yourself with the codes in the table below, they are phrased as questions or use more than one word to describe them. An example from another interview is included, to facilitate a common understanding of each code. The subsections within each code reflect the structure of the further analysis.

2. Then, read through the interviews and highlight the text in the colour corresponding to the code you think applies to the various text passages[105]. Occasionally, one part of the text corresponds to more than one code and not all codes can necessarily be applied to every interview.

3. We will compare how different researchers have coded the data during our next team meeting April 22. Please submit an electronic version of your coding until April 21, if possible.

[105] If you do this on your computer, you can use the format painter in Word to copy the colour formatting from the codes below and apply them to the text in the interview you want to highlight in this colour.

Title	Explanation & Examples	Coding Colour
1. QM/CG[106] Initiative / Project – Content and Timeline		
1a.	**General Overview:** When, why and how was the initiative implemented? Was there a certain initiator? Which model was used? For Germany: Does the Trägerschaft play a role? Was the help of management consultants sought? *"In 2001 CG really began to take off. We changed the name of the committee from Stroke Forum to Clinical Governance. The government asked for it as a key to improve risk management."*	light green
1b.	Do staff perceive CG/QM to be of **strategic importance** (they actually use the word strategic or link CG/QM to preparing the organisation to successfully stay in business in the future)? *"We have a 10 years strategy that provides the focus of our CG activities. Next to a general CG committee, a stroke strategy group meets regularly and very senior people discuss stroke-specific CG issues and areas for improvement."*	turquoise
1c.	What was **expected of the initiative** by management and to what degree have these **expectations been met**? Which **improvements or general effects** do all staff see as a result of implementing CG/QM? Which CG/QM **impact** do all staff identify for **staff, patients, efficiency / financial situation** and/or **other aspects**? Please indicate MA, P, $ or ~.	red

[106] CG stands for Clinical Governance, QM stands for Quality Management.

	MA (staff): *"CG provides staff with a framework to work within that gives them confidence they have the right skills, knowledge and competence to do their jobs."* **P (patients)**: *"CG helps to ensure that patients receive evidence-based care that does not do harm to them and is appropriate for them."* **$ (efficiency and finance)**: *"CG has helped to improve efficiency across the whole of the NHS because of fostering value-added treatments."* **~ (other):** *"Quality measures provide greater transparency – the Foundation Trust publishes quality accounts on a regular basis."*	
1d.	How does **ICT support the implementation** and **maintenance** of CG/QM? *"IT is very limited here. The national IT programme was a big hope that didn't quite happen. We still have a long way to go – it's important to have the data and information to support CG."*	bold turquoise
1e.	Which **Benchmarking activities, comparisons** or **other co-operation** (academic or with other service providers) are linked to CG/QM? *"We engage in different co-operations at a number of levels. At the national level, we participate in patient surveys and in the stroke sentinel audit among others. We do peer review for cancer services with selected hospitals and there is quite a lot going on at the SHA level*	green

2.Issues and Areas for Improvement		
2a.	Who do staff think is / are their **customer/s** and how adequate do they think the term "customer" is for their job and activities? *"My customer is the patient with stroke and TIA and emergencies of elderly people with general geriatric problems - the majority of them is over 60."*	dark pink
2b.	What is/are the staff's **definition / awareness / understanding of QM / CG** including the issue of "them" (the CG/QM department) versus "us" (staff from the ward) or QM/CG as an integral part of everybody's job? *"CG make sure that patient receive the best possible care. They are visible to us by attending meetings to support improvement projects and make sure guidelines are met."* (This is not only an example of a CG definition, but also of what I call "them vs. us" – for this interviewee CG is not something that they do everyday, but it is just another department that provides additional support services.)	orange
2c.	CG/QM impact on job, is **CG/QM** seen as **needed or** do staff think they have **done** parts of it **before** but it had a different or no name? *"Now it is all very academic, when I started my job the work was a lot more hands-on. An autocratic matron said how things were to be done and that was it – there was no monitoring/writing/ questioning. Now you have to think why you do something and provide evidence-based care."*	light green
2d.	How important is staff's **personal interest in CG/QM** to get involved / make it work? *"The will of team members to make improvement work is the key to implementing changes."*	yellow

2e.	Organisation of **QM/CG involvement** - how involved do staff feel, is there a them versus us mind set towards the QM/CG department, which group of staff gets more involved in QM/CG, how is **communication** about CG / QM initiatives and **training** approached (including learning about it at university versus on the ward)? *"Nursing staff is the most active and aware in CG and, therefore, also more involved. Consultants have a bigger say in it, but do they really want it?"* *"I have never received any formal training about CG."*	bold dark pink
2f.	**Inter-staff group conflicts, teamwork** – does it work / why / what is its value for CG/QM and does CG/QM support teamwork? *"We have a very good team cohesion here – CG can help to make it work, the speciality requires it and ultimately it also depends on the individual that have to work together."*	bold dark green
2g.	**Leadership issues** such as what is the role of top management support for CG/QM initiative and with regard to the background of QM/CG manager – how does it influence rapport with staff? *"As a CG manager, it helps to have a clinical background to ensure evidence-based practice and challenge practitioners – do we really do the best for our patients?"*	bright pink
2h.	How and why do staff **resist to change** (change being the implementation of CG/QM activities)? *"People that have been in the organisation for a long time resist change because they think that it works as it is and don't understand why they should change it."*	bold dark blue
2i.	**Implementation issues:** Which **time, resource or context constraints** affect how well CG/QM can be implemented and sustained?	light blue

	"Time and money are always problems. CG is an add-on to the daily work-load. We try to integrate CG sub-issues like patient safety with existing meetings like infection control and incorporate PDCA (plan-do-check-act) ideas to make it work."	
2j.	Is there a need for more **humanity / focus on relationships / special characteristics of care** involving elderly patients? *"Dealing with older patients requires different skills to communicate effectively with the patients and their relatives and to deal with age-related conditions like Alzheimer's and dementia. You have to have empathy, patience and tolerance – it's a whole different mind-set to appreciate the smallest glimpses of improvement in a patient. But then, it's different, if staff chose to work with the elderly or just happen to do so."*	light brown

3. 'Valued' Practice		
	What do staff and managers perceive to be **done really well** in their organisation? *"We have a comments book for patients and relatives which is really good for staff morale and helpful to get ideas for improvements – we get positive and negative feedback."*	purple

4. Suggested Improvements		
	What do staff and managers perceive to be in **need of improvement**? How do they suggest these issues should be improved? What do they think is needed to facilitate improvements? *"I would like to see more unification of the regulatory framework – a single framework for what it takes to be a good trust."*	light grey

Many thanks for your support!

13.) Informed Consent

University of Portsmouth

Information Sheet (UK)

Dear Participant,

As part of my PhD research at the University of Portsmouth (UK) I am comparing quality management initiatives in English and German hospitals and their impact especially on elderly patients. As key part of the study, health services experts, managers and providers are interviewed about their views regarding healthcare quality, its management and how it affects elderly patients. The final thesis is expected to be published in 2011, whereas parts of the findings are planned to be contributed to peer-reviewed academic journals before this.

I would like to speak to you about your experience with quality management in healthcare and about how you think it impacts the care of elderly patients. This interview should take around 15 minutes. According to ethical research practice at my university I would like to ask you to please give me your written consent to participate in my project (see Informed Consent form).

I will treat your responses confidentially and you will not incur any costs by participating in this study.

Your participation is voluntary. If at any time during this interview you wish to withdraw your participation or to refuse to reply to any of the questions, you are free to do so without prejudice.

In case of doubts or further questions, please do not hesitate to contact me (Alina.Halank@port.ac.uk) or my supervisor at the University of Portsmouth Dr Debbie Reed (Debbie.x.Reed@port.ac.uk) via email.

Thank you for your consideration!

Alina Halank

University of Portsmouth

Informed Consent (UK)

AUTHORISATION (Please tick the boxes to agree where appropriate.):

1) I have read and understood the information sheet about the PhD project of Alina Halank at the University of Portsmouth (UK). ☐

2) I have had the opportunity to have my questions related to this study answered and I know that should I have any comments or concerns resulting from my participation in this research, I may contact the researcher (Alina.Halank@port.ac.uk) or her supervisor at the University of Portsmouth Dr Debbie Reed (Debbie.x.Reed@port.ac.uk). ☐

3) I was informed that I could withdraw my consent at any time during the interview by advising the researcher and that by taking part in the interview I agree, of my own free will, to participate in this research. ☐

4) I agree to the researcher taking notes of the interview. ☐

5) I agree to the use of anonymised quotes in publications. ☐

6) Further, I agree to be contacted again by the researcher after the interviews if necessary. ☐

Participant's signature: _____ Date: _____

Researcher's signature: _____ Date: _____

Informed Consent (Florida)

Dear Participant,

As part of my PhD research at the University of Portsmouth (UK) I am comparing quality management initiatives in English and German hospitals and their impact especially on elderly patients. Both healthcare systems are highly state-controlled and welfare-oriented. In order to develop more meaningful suggestions for improvement, I would also like to include lessons learned from the more entrepreneurial perspective to be found in the US-American health service provision. The final thesis will be published in 2010, whereas parts of the findings are planned to be contributed to academic journals before this.

I would like to speak to you about your experience with quality management in healthcare and about how you think it impacts the care of elderly patients. This interview should take around 15 minutes. According to ethical research practice at my university I have to ask you to please give me your written consent to participate in my project (see below).
I will treat your responses confidentially and you will not incur any costs by participating in this study.

Your participation is voluntary. If at any time during this interview you wish to withdraw your participation or to refuse to reply to any of the questions, you are free to do so without prejudice.

In case of doubts or further questions, please do not hesitate to contact me via email (Alina.Halank@port.ac.uk).

AUTHORISATION:

I have read and understood the above information about the PhD project of Alina Halank at the University of Portsmouth (UK). I have had the opportunity to have my questions related to this study answered and I

know that should I have any comments or concerns resulting from my participation in this research, I may contact the researcher (Alina.Halank@port.ac.uk). I was informed that I could withdraw my consent at any time by advising the researcher and that by taking part in the interview I agree, of my own free will, to participate in this research. Further, I agree to be contacted again by the researcher after the interviews if necessary.

Participant's signature: _____ Date: _____

Researcher's signature: _____ Date: _____

Einverständniserklärung (Germany)

Lieber Teilnehmer,

im Rahmen meiner Promotion an der Universität von Portsmouth vergleiche ich die Qualitätsmanagementinitiativen von deutschen und englischen Kliniken und ihren Einfluss besonders auf ältere Patienten. Ein zentraler Teil der Studie besteht darin herauszufinden, wie die Mitarbeiter eines Krankenhauses Qualitätsmanagement-anforderungen in ihre alltäglichen Tätigkeiten einbauen und wie sich Veränderungen / Verbesserungen auf ältere Patienten auswirken.

Ich würde mich gerne mit Ihnen über Ihre persönlichen Erfahrungen mit Qualitätsmanagement unterhalten und wie es Ihrer Meinung nach die älteren Patienten in Ihrem Krankenhaus beeinflusst. Das Gespräch dauert etwa 5 bis 15 Minuten. Auf Grund von Ethik-Vorschriften an englischen Universitäten benötige ich Ihr schriftliches Einverständnis zur Teilnahme (siehe unten).

Ihre Angaben werden selbstverständlich vertraulich behandelt und für Sie fallen auch keine weiteren Kosten durch die Teilnahme an.

Die Teilnahme ist freiwillig. Bei Bedenken können Sie das Gespräch vorzeitig beenden oder Ihre Teilnahme ganz zurückziehen.

Falls Sie vor oder auch nach der Teilnahme weitere Fragen haben sollten, zögern Sie bitte nicht, mich per Email (Alina.Halank@port.ac.uk) zu kontaktieren.

EINVERSTÄNDNIS:

Ich habe die obenstehenden Informationen über das Promotionsprojekt von Alina Halank an der Universität von Portsmouth (England) gelesen und verstanden. Ich hatte die Gelegenheit, Fragen zur Teilnahme zu

stellen, und werde mich mit Bedenken oder Anmerkungen nach meiner Teilnahme an Frau Halank wenden. Ich bin darüber aufgeklärt worden, dass die Teilnahme freiwillig ist und ich mein Einverständnis jeder Zeit zurückziehen kann. Indem ich an dem Gespräch teilnehme, bin ich mit der Verwendung der Ergebnisse für die Studie einverstanden. Sollten nach dem Gespräch noch weitere Fragen aufkommen, kann mich Frau Halank wieder kontaktieren.

Unterschrift Teilnehmer: _____ Datum: _____

Unterschrift Doktorandin: _____ Datum: _____

14.) Ethical Review Checklist – Staff and Doctoral Students

This checklist should be completed by the researcher (PhD students to have DoS check) and sent to Sharman Rogers who will coordinate Ethics Committee scrutiny.

No primary data collection can be undertaken before the supervisor and/or Ethics Committee has given approval.

If, following review of this checklist, amendments to the proposals are agreed to be necessary, the researcher must provide Sharman with an amended version for scrutiny.

Project Title: Quality Management in European Health Care – An Analysis of its Content, Implementation and Impact on Elderly Care in English and German Hospitals

What are the objectives of the research project?

The aim of the research subject of this Ethical Review is to analyze and compare quality management initiatives in the English and the German health care (HC) system in terms of content and implementation with a specific emphasis on elderly care.

The HC systems are financed and organised in very different ways. In the late 1990s, however, the governments of both countries started to introduce a legal obligation for the application of formal quality management systems in hospitals yet without prescribing a defined way of how to do so. Quality management is employed as one of the means to increase cost-effectiveness and efficiency of the HC systems. Scarce HC resources are intended to be managed more carefully in response to the financial pressures resulting from demographic changes towards an aging, multi-morbid society and medical-technical improvements

Accordingly, the guiding objectives are as follows:

1. To elaborate an overview of these health care systems.
2. To assess and compare the status quo of quality management aspects in English and German HC based on:
   a. A literature review of academic and political publications.
   b. Expert interviews with (quality) specialists in the HC systems such as medical practitioners with managerial insight, national and EU politicians, affiliates with the WHO.
   c. Five case studies per country.

3. To suggest reasons for differences and similarities found in the research.
4. To develop recommendations for improvement of quality management aspects in both HC systems also taking into account input from the free-market orientation in the US-American HC system assessed through expert interviews.

Does the research involve *NHS patients, resources or staff*? **YES**

The local NHS REC discusses my application for ethical review on November 21.

If YES, it is likely that full ethical review must be obtained from the NHS process before the research can start.

Do you intend to collect *primary data* from human subjects or data that are identifiable with individuals? (This includes, for example, questionnaires and interviews.) **YES**

If you do not intend to collect such primary data then please go to question 14.

If you do intend to collect such primary data then please respond to ALL the questions 4 through 13. If you feel a question does not apply then please respond with n/a (for not applicable).

What is the *purpose* of the primary data in the research project?

The purpose of the primary data collection is closely linked to achieving the guiding objectives listed under question 1 of:

- Assessing and comparing the status quo of quality management aspects
- Suggesting reasons for differences and similarities
- Developing recommendations for improvement

All primary data collection aims at achieving a more detailed, real world understanding of quality management initiatives in both HC systems based on different functional, professional perspectives and insight resulting from practitioner, consultant, academic or political expertise.

What is/are the *survey population(s)*?

The survey populations are determined by professional occupation and / or expertise. Specifically, two main types of population will be involved:

- National and international health care experts
- 10 members of staff representing the staff groups involved for elderly care (e.g. doctors, nurses, therapists, housekeepers, caterers) from each of the case study organisations

The experts are based in the UK, in Germany and in Florida. The case study organisations are based in the UK and in Germany.

How big is the *sample* for each of the survey populations and how was this sample arrived at?

The sample size of the above defined types of survey population is:

- 20 experts
- A total of 100 members of staff from the hospitals.

The sample size was decided upon balancing feasibility and quantity to reflect a cross-section of different perspectives. The balance has also been influenced by financial constraints and time limitations determining the PhD.

How will respondents be *selected and recruited*?

Participants will be identified through the network of contacts that both the researcher and the director of studies / other supervisors have within the HC systems. This will result in a mix of convenience, purposive and snowball sampling. As elaborated above, participants will be selected depending on professional occupation and / or expertise regarding quality management in health services. The selection of the case study organisations will take into account various aspects to ensure inter- and intra-country comparability: All organisations shall be advanced / experienced in quality management practices. Furthermore, they shall be of similar size and situated in regions with comparable demographic structures, i.e. elderly care should be equally important.

What steps are proposed to ensure that the requirements of *informed consent* will be met for those taking part in the research?

The informed consent form to be signed by the interviewees is attached to this form. Details regarding the general nature of the research including planned publication are provided. The letter also informs the interviewees about the nature, content and consequences of participation and provides contact details in case of doubt or further questions.

How will *data* be *collected* from each of the sample groups?

All interviews will be conducted face-to-face where possible and roughly structured as follows:

<u>Questions for quality managers or equivalent:</u>

1. When has formal quality management been introduced and why?
2. What was expected to be achieved?
3. How has the formal quality management been implemented?
    a. Have consultants been involved?
    b. Has it been implemented to get certified against a standard (e.g. ISO)?
    c. Has it been implemented to apply for an excellence award (e.g. EFQM)?
    d. Is it of strategic importance?

4. Have the expectations been met regarding:
    a. Improvements for employees?
    b. Improvements for patients?
    c. Improvements of efficiency?
    d. Other improvements?
5. Which problems and barriers have you encountered?
6. How have you solved these?
7. Which role has information technology (IT) played?

Questions for medical and non-medical personnel:

1. Who do you perceive to be the customer of your service?
2. What does quality management mean for you?
3. Has the implementation of formal quality management changed your job?
4. Do you think the new procedures are needed?
5. How have you been involved in the implementation of quality management?
6. Which changes has the formal quality management brought for you:
    a. Impact on work-load and time management?
    b. Impact on elderly patients you deal with?
    c. General change for the better or for the worse?

The expert interviews will cover the same issues but in differing intensity depending on the area of expertise.

How will *data* be *stored* and what will happen to the data at the end of the research?

The notes of the interviews are handwritten and stored securely in the office of the researcher. The link to the interviewees can only be made by the researcher: The notes only include the date of the interview and the function of the interviewee, not the name of the interviewee or the organisation concerned. Other electronic resources will be kept on a password secured computer.

All data will be destroyed once they are not needed any longer for the research.

How will *confidentiality* be assured for respondents?

The informed consent form states that responses to the interviews will be treated confidentially: The researcher will ensure that no unauthorised access will be possible by the means explained under question 10. Anonymised excerpts of the data might be discussed with the supervisory team to reduce personal cultural or political bias. In the final report and other publications, no direct link will be made between the interviewees and their responses. The feedback to the case study organisations will only be at a general, not on an individual level, to avoid any impact of the participation.

What steps are proposed to safeguard the *anonymity* of the respondents?

The research will not report names or the location of the organisation. However, sound case study analysis requires a certain level of contextual detail so that readers might be able to guess which organisations have been researched. The answer to question 10 explains the data storage procedures used to help ensure anonymity.

Are there any *risks* (physical or other, including reputational) *to respondents* that may result from taking part in this research? **NO**

If YES, please specify and state what measures are proposed to deal with these risks.

Are there any *risks* (physical or other, including reputational) *to the researcher or to the University* that may result from conducting this research? **NO**

If YES, please specify and state what measures are proposed to manage these risks.[107]

Will any *data* be *obtained from a company or* other *organisation*. **NO** (please circle)
For example, information provided by an employer or its employees.

Only publicly available organisational data will be used for analysis.

If NO, then please go to question 18.

What steps are proposed to ensure that the requirements of *informed consent* will be met for that organisation? How will *confidentiality* be assured for the organisation?

Does the organisation have its own ethics procedure relating to the research you intend to carry out? YES / NO (please circle).

If YES, the University will require written evidence from the organisation that they have approved the research.

[107] Risk evaluation should take account of the broad liberty of expression provided by the principle of academic freedom. The university's conduct with respect to academic freedom is set out in section 9.2 of the Articles of Government and its commitment to academic freedom is in section 1.2 of the Strategic Plan 2004-2008.

Will the proposed research involve any of the following (please put a √ next to 'yes' or 'no'; consult your supervisor if you are unsure):

• Vulnerable groups (e.g. children) ?	YES		NO	√
• Particularly sensitive topics ?	YES		NO	√
• Access to respondents via 'gatekeepers' ?	YES		NO	√ *
• Use of deception ?	YES		NO	√
• Access to confidential personal data ?	YES		NO	√
• Psychological stress, anxiety etc ?	YES		NO	√
• Intrusive interventions ?	YES		NO	√

There are no 'gatekeepers' in the traditional sense but the research will use contact facilitators, advocates/spokespersons as necessitated, in particular, by the NHS procedures.

Are there any other ethical issues that may arise from the proposed research?

No.

Details of applicant

The member of staff undertaking the research should sign and date the application, and submit it directly to the Ethics Committee. However, where the researcher is a supervised PhD candidate, the signature of the Director of Studies is also required prior to this form being submitted.

	Name	Signature
Researcher	Alina Halank	
Director of Studies	Debbie Reed	
Date		19/11/2008

Approval by Ethics Committee

From: Sharman Rogers Wednesday - 3 December, 2008 1:13 PM
To: Debbie Reed
Subject: Fwd: Re: Ethics Review application E93 : Alina Halank [Debbie Reed]

Hi Debbie

Following on from our telecon a few moments ago, email from Judy [LCM] below - application approved, but with comments. Best wishes, Sharman

>>> Judy Rich 02/12/2008 16:24 >>>
Dear Sharman

I agree with David on this one. Now we have the response from the NHS I think this can be approved. I would just comment that we presume the informed consent form will be changed and also I wondered if the name and contact details of the supervisor should be added.

All the best
Judy

AMENDMENTS

If you need to make changes please ensure you have permission before the primary data collection. If there are major changes, fill in a new form if that will make it easier for everyone. If there are minor changes then fill in the amendments and get them signed before the primary data collection begins.

University of Portsmouth

Informed Consent

Dear Participant,

As part of my PhD research at the University of Portsmouth (UK) I am comparing quality management initiatives in English and German hospitals and their impact especially on elderly patients. As key part of the study, health services experts, managers and providers are interviewed about their views regarding healthcare quality, its management and how it affects elderly patients. The final thesis is expected to be published in 2011, whereas parts of the findings are planned to be contributed to peer-reviewed academic journals before this.

I would like to speak to you about your experience with quality management in healthcare and about how you think it impacts the care of elderly patients. This interview should take around 15 minutes. According to ethical research practice at my university I would like to ask you to please give me your written consent to participate in my project (see below).

I will treat your responses confidentially and you will not incur any costs by participating in this study.

Your participation is voluntary. If at any time during this interview you wish to withdraw your participation or to refuse to reply to any of the questions, you are free to do so without prejudice.

In case of doubts or further questions, please do not hesitate to contact me via email (Alina.Halank@port.ac.uk).

Thank you for your collaboration!

AUTHORISATION:

I have read and understood the above information about the PhD project of Alina Halank at the University of Portsmouth (UK). I have had the opportunity to have my questions related to this study answered and I know that should I have any comments or concerns resulting from my participation in this research, I may contact the researcher (Alina.Halank@port.ac.uk). I was informed that I could withdraw my consent at any time by advising the researcher and that by taking part in the interview I agree, of my own free will, to participate in this research. Further, I agree to be contacted again by the researcher after the interviews if necessary.

Participant's signature: _____ Date: _____

Researcher's signature: _____ Date: _____

15.) NHS Ethical Approval

NHS
National Research Ethics Service

DC/MFK

5 January 2009

ISLE OF WIGHT, PORTSMOUTH & SOUTH EAST HAMPSHIRE RESEARCH ETHICS COMMITTEE

1ST Floor, Regents Park Surgery
Park Street, Shirley
Southampton
Hampshire
SO16 4RJ

Tel: 023 8036 2863
Fax: 023 8036 4110

Email: scsha.SEHREC@nhs.net

Miss Alina Halank
PhD Student
University of Portsmouth
SBS, Portsmouth Business School
Richmond Building, Portland Street
Portsmouth
PO1 3DE

Dear Miss Halank

Full title of study: **Quality in European Health Care Systems: An Analysis of its Impact on Elderly Patients in England and Germany**

REC reference number: **08/H0501/111**

Thank you for your letter of 17 December 2008, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised,sub ject to the conditions specified below.

Ethical review of research sites

The Committee has designated this study as exempt from site-specific assessment (SSA). The favourable opinion for the study applies to all sites involved in the research. There is no requirement for other Local Research Ethics Committees to be informed or SSA to be carried out at each site.

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission at NHS sites ("R&D approval") should be obtained from the relevant care organisation(s) in accordance with NHS research governance arrangements. Guidance on applying for NHS permission is available in the Integrated Research Application System or at http://www.rdforum.nhs.uk.

This Research Ethics Committee is an advisory committee to South Central Strategic Health Authority

The National Research Ethics Service (NRES) represents the NRES Directorate within the National Patient Safety Agency and Research Ethics Committees in England

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	*Version*	*Date*
Letter from Sponsor		28 October 2008
Covering Letter		20 October 2008
Protocol	1	28 October 2008
Investigator CV		28 October 2008
Application	IRAS	28 October 2008
Response to Request for Further Information		17 December 2008
Participant Consent Form	2	01 December 2008
Participant Information Sheet	2	01 December 2008

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Now that you have completed the application process please visit the National Research Ethics Website > After Review

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

The attached document "After ethical review –guidance for researchers" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

We would also like to inform you that we consult regularly with stakeholders to improve our service. If you would like to join our Reference Group please email referencegroup@nres.npsa.nhs.uk.

08/H0501/111	Please quote this number on all correspondence

With the Committee's best wishes for the success of this project.

Yours sincerely

Mr David Carpenter
Chair

Email: scsha.SEHREC@nhs.net

Enclosures: "After ethical review – guidance for researchers", SL- AR2 for other studies

Copy to: Dr Debbie Reed, Strategy & Business Systems, University of Portsmouth, James Watson Hall, White Swan Road, Portsmouth, PO1 2BF

16.) Interview Tables: Organisational Context (Germany)

QM Initiative	***D-Pilot***
Timing	1998 / 1999
Reason	changes in the political landscape
Initiator	management (GF) & head of nursing
Implementation:	
~ *Model*	KTQ & EFQM, close link between external & internal quality management
~ *Certification*	KTQ
~ *Choice*	management
~ *Strategic Importance*	yes, but changing management priorities
~ *Mgmt Consultants*	to overcome resistance, very satisfied
~ *Ownership*	staff & customer focus as strengths of denominational orientation
Role of ICT	KIS provides crucial information for external quality assurance, problematic IT literacy of staff
Benchmarking / Comparisons	benchmarking & academic cooperations in a close network, membership of two organisations that foster prevention & patient safety

QM Initiative	***D-One***
Timing	2003 / 2004
Reason	management experience from previous job
Initiator	management (GF) & assistant & vice head of nursing & quality manager
Implementation:	
~ *Model*	mix of KTQ, EFQM & ISO
~ *Certification*	KTQ overall
~ *Choice*	management
~ *Strategic Importance*	yes
~ *Mgmt Consultants*	at the very beginning
~ *Ownership*	no impact of denominational orientation
Role of ICT	crucial for communication, data bases & KIS provide figures to overcome resistance, problematically low IT literacy among staff
Benchmarking / Comparisons	benchmarking & academic cooperations in a close network

QM Initiative	***D-Two***
Timing	1999 framework, 2004 certification
Reason	owner part of KTQ
Initiator	owner
Implementation:	
~ Model	KTQ &EFQM
~ Certification	KTQ
~ Choice	owner
~ Strategic Importance	officially yes - order to certify, quality manager says no
~ Mgmt Consultants	no internal know-how, very satisfied with support
~ Ownership	impact on content & orientation of QM
Role of ICT	KIS, intranet & email increase transparency, employees are better informed, high resistance at the beginning & elevated need for training
Benchmarking / Comparisons	benchmarking & academic cooperations in a close network

QM Initiative	***D-Three***
Timing	2002
Reason	legal context & decision of owner
Initiator	corporate owner
Implementation:	
~ Model	first EFQM, after 2004 just KTQ
~ Certification	KTQ
~ Choice	corporate group
~ Strategic Importance	yes
~ Mgmt Consultants	very helpful for the first four years for implementation process but not contentwise, organisation of training, coaching of the quality manager, still selected projects
~ Ownership	has to support QM
Role of ICT	KIS important to support QM implementation
Benchmarking / Comparisons	Benchmarking within the corporate group & with patient surveys, academic studies

QM Initiative	***D-Four***
Timing	published quality data since 1999
Reason	legal context & decision of owner
Initiator	corporate owner
Implementation:	
~ Model	own model for quality assurance / continuous improvement (taken up by switzerland!)
~ Certification	no ticking boxes, "not just the QM label", local certifications for comparisons with external hospitals but not over the entire hospital, nurse: certified for 1 year to demonstrate quality externally / advertisement, neurologists as strong supporters, now stroke centre berlin-brandenburg (before just berlin) and QM is a fix important part in it,documentation and care standards apply in general to the organisation as a whole
~ Choice	corporate group
~ Strategic Importance	yes to position the organisation for the future, aim: market leader
~ Mgmt Consultants	assistance of external partners bc not able or willing to do it in-house, fremdblick for innovation and improvement potential
~ Ownership	supports quality philosophie, doesn't care for "paper" (=certification) but for results, in the area there are just private hospitals left - they are more attractive for staff as more modern and good for further training on the job
Role of ICT	doesn't solve problems but helps to organise, do not overestimate its value even though it's indispensable, helps to make things easier and more transparent, but with many members of staff it's fruitless (different structures in different departments, difficult to get accept among older staff)
Benchmarking / Comparisons	previously international projects, now internal BM amongst the different members of the chain, academic cooperations with universities

17.) Interview Tables: Staff Understanding (Germany)

D-Pilot	**Improvement**	**Leadership**	**Involvement**
Staff Interviews	staying up-to-date with advances in therapy / medical care, benchmarking & comparisons for organisational improvement, guidelines and standards, structured process documentation, quality assurance	QM important framework informs coherent leadership, control	employee surveys, staff awareness, training
Vision & Mission & Quality Report	✓	✓	✓
	Teamwork / Partnerships	**Cultural Changes**	**Customer Priority**
Staff Interviews	internal and external cooperation and information sharing	only implicit	patient focus, patient surveys
Vision & Mission & Quality Report	✓	✓	✓

Comments	According to the quality manager, the main issue for the employees was to get an overview of the quality management activities and to understand why they were pursued in certain ways.	Staff supported this by imprecise use of terminology and lack of a crisp definition.

D-One	**Improvement**	**Leadership**	**Involvement**
Staff Interviews	Standards (patients, techniques), structured work, increased bureaucracy, description and clarification of processes, guidelines (e.g. hygiene), documentation of common sense procedures	umbrella concept	n/a
Vision & Mission & Quality Report	✓	✓	✓
	Teamwork / Partnerships	**Cultural Changes**	**Customer Priority**
Staff Interviews	coordination of different sectors	implicit	n/a
Vision & Mission & Quality Report	✓	✓	✓

Comments	According to QMB: missing critical reflection / structured holistic thinking among staff to understand organisation wide QM, improved awareness

D-Two	**Improvement**	**Leadership**	**Involvement**
Staff Interviews	continuous improvement (e.g. reduction of waiting times), quality of care, benchmarking and comparisons, transparency, quality management gives structure and an overview of work so that there is always enough staff on the ward, process thinking, foresight, efficiency, planning, standards, checklists, information / documentation, increased bureaucracy (negative connotation)	control, more positively: rewards / constructive criticism, overview of work so that always enough staff on ward, big all encompassing concept	n/a
Vision & Mission & Quality Report	✓	✓	✓
	Teamwork / Partnerships	**Cultural Changes**	**Customer Priority**
Staff Interviews	Explicitly mentioned as key for QM success, mutual respect	only implicit	only implicit, safety indirectly linked to patient focus
Vision & Mission & Quality Report	✓	✓	✓

Comments	The quality manager identifies staff understanding of quality management as a major obstacle and source of resistance. According to them, staff perceive quality management as control and fear rationalisation without seeing, in the quality manager's view, positive effects, such as increased transparency and efficiency.	The staff understanding of quality management includes control as highlighted by the quality manager. But they also appreciate efficiency aspects, such as reduction of waiting times.
Comments Continued	This contradicts the impression of the quality manager. One nurse with managerial responsibilities even calls quality management a big concept that encompasses everything.	From the context of the interview, it remains unsure, however, if this reflects a truly holistic understanding of quality management or if they just say everything because of not knowing how to define quality management more precisely.

D-Three	**Improvement**	**Leadership**	**Involvement**
Staff Interviews	process thinking, such as efficient use of resources, documentation, transparency, structure, good service provision implicitly requires this, state of the art technology, external assessment as positive control to achieve this, improved competitiveness	control, orientation for staff and many well-communicated rules (but slight criticism of and resistance towards QM - the participant says "many many rules that are very well publicised externally and some things are even realised"), satisfying everybody	n/a
Vision & Mission & Quality Report	✓	✓	✓
	Teamwork / Partnerships	**Cultural Changes**	**Customer Priority**
Staff Interviews	teamwork, cooperation and project teams	to achieve communication and penetration of QM throughout the organisation	"quality management aims to provide the biggest benefit to patients." (consultant)
Vision & Mission & Quality Report	✓	✓	✓

Comments	The quality manager does not identify any issues with regard to staff understanding and appreciation of quality management.

D-Four	**Improvement**	**Leadership**	**Involvement**
Staff Interviews	standards / guidelines, transparency, structure of the wards, processes / procedures, maintain and improve quality of care, CPD, benchmarking	ensure quality of care, control	training
Vision & Mission & Quality Report	✓	✓	✓
	Teamwork / Partnerships	**Cultural Changes**	**Customer Priority**
Staff Interviews	regular meetings to coordinate different activities, teamwork and coordination between all professional groups	no-blame culture and learn from mistakes, change management to be prepared for the future	rather fulfil another patient wish than fil in yet another form ("papierkram mach ich als letztes", nurse), patient / family satisfaction / meet their expectations
Vision & Mission & Quality Report	✓	✓	✓

Comments	difficult question (nurse)	In general: less precise use of terminology

18.) Interview Tables: Perceived Effects (Germany)

	Improvement
Management	
- D-Pilot	clear structures and consistency in spite of staff turnover, little impact on staff satisfaction because of contextual constraints, improved efficiency thanks to close cooperation with med controlling, transparency
- D-One	helps to introduce new staff, especially young consultants, increased accountability, expected cost savings but not measured, more structure / transparency
- D-Two	no overall improvements because of economic constraints, more transparent with cost unit accounting
- D-Three	projects are more sustainable within the quality management framework and communication structures have also improved, transparency, efficiency improved with DRG implementation and QM
- D-Four	QM does often not just simplify things but becomes a burden / people are questioned more - totally new processes that some perceive as bad in general, staff fulfil certain tasks with more awareness and more schematically, more efficient thanks to structured standardisation, increased transparency through publication of quality data and posters, better external image
Consultants	
- D-Pilot	n/a
- D-One	technical diagnoses in small areas, but QM necessary to control consistent, safe medical service provision
- D-Two	clinical guidelines have improved the medical service provision
- D-Three	quality management is needed and that it has improved at least certain aspects of the daily operations, mainly because staff become more aware of what they are actually doing, clear structures help to define roles (for the employee and the colleagues working with them), delineate areas of responsibility, accountability has increased with better documentation
- D-Four	torn - on the one hand it is a useful tool but it sometimes keeps you away from the core tasks
Nursing Care	
- D-Pilot	big need for formal QM - many new nursing standards that especially very experienced nurses do not necessarily incorporate into their daily routine, QM has improved adherence to these standards, QM and certification have improved staffing and staff coordination on the stroke ward, quality management system helps to spread the knowledge and enforce the application of improved standards of care, quality management including KTQ certification has improved for them: staffing level and staff coordination has improved considerably on the stroke ward with two new employees hired after the certification.
- D-One	indirectly because of increased consistency
- D-Two	apart from the younger nurses – agree that nothing has really changed and that they unconsciously worked like this before already. quality management makes sense and is helpful in their

	daily activities
- D-Three	some: quality management requires more time in the beginning, but in the long run the effort put in gets compensated by efficiency gains. head of nursing adds that quality management facilitates the training and induction of new employees, quality management is needed and that it has improved at least certain aspects of the daily operations, mainly because staff become more aware of what they are actually doing, clear structures help to define roles (for the employee and the colleagues working with them), delineate areas of responsibility, accountability has increased with better documentation
- D-Four	we need QM - it is really important, standards make it easier and more consistent, QM causes more work and we have to work extra hours - time that is gained through technology gets offset by more documentation - in the past you washed up now it's documentation but impossible without it, it is good for accountability but has to be kept in limits, QM here helps saving time by 'Formularvordrucke' and SAP
Therapists	
- D-Pilot	their work has not changed greatly because of new quality management requirements, they have always worked like this, yet their work is positively more structured and more formalised than before (supports QMBs views), increased transparency thanks to QM
- D-One	lack of time has made them forget crucial aspects of routine activities, brought to the fore by QM, common sense for experienced but needed for young practitioners
- D-Two	agree that nothing has really changed and that they unconsciously worked like this before already. quality management makes sense and is helpful in their daily activities
- D-Three	training has improved the service provision, quality management is needed and that it has improved at least certain aspects of the daily operations, mainly because staff become more aware of what they are actually doing, clear structures help to define roles (for the employee and the colleagues working with them), delineate areas of responsibility, accountability has increased with better documentation
- D-Four	changes in the working environment because of QM - different qualifications
Support Services	
- D-Pilot	n/a
- D-One	standards have been there before but now clearer and more transparent, helps to induct new staff
- D-Two	agree that nothing has really changed and that they unconsciously worked like this before already. quality management makes sense and is helpful in their daily activities
- D-Three	the buildings and the signposting of where to find what are more organised than before and visitors more easily find their way around. The researcher's observations during the visit support this – the arrangement and design of the buildings is remarkable: quality management becomes visible via posters in the hallways and in the cafeteria. quality management is needed and that it has improved at least certain aspects of the daily operations, mainly because staff become more aware of what they are actually doing, clear structures help to define roles (for the employee and the colleagues working with them), delineate areas of responsibility, accountability has increased with better documentation
- D-Four	n/a

	Leadership
Management	
- D-Pilot	more dynamic leadership
- D-One	n/a
- D-Two	n/a
- D-Three	n/a
- D-Four	n/a
Consultants	
- D-Pilot	n/a
- D-One	n/a
- D-Two	n/a
- D-Three	n/a
- D-Four	n/a
Nursing Care	
- D-Pilot	n/a
- D-One	n/a
- D-Two	n/a
- D-Three	n/a
- D-Four	n/a
Therapists	
- D-Pilot	n/a
- D-One	n/a
- D-Two	n/a
- D-Three	n/a
- D-Four	n/a
Support Services	
- D-Pilot	n/a
- D-One	n/a
- D-Two	n/a
- D-Three	n/a
- D-Four	n/a

	Involvement
Management	
- D-Pilot	n/a
- D-One	n/a
- D-Two	n/a
- D-Three	n/a

- D-Four	n/a
Consultants	
- D-Pilot	n/a
- D-One	n/a
- D-Two	n/a
- D-Three	n/a
- D-Four	n/a
Nursing Care	
- D-Pilot	n/a
- D-One	n/a
- D-Two	n/a
- D-Three	n/a
- D-Four	n/a
Therapists	
- D-Pilot	not directly affected but more aware of QM issues (supports QMB's views)
- D-One	n/a
- D-Two	n/a
- D-Three	n/a
- D-Four	n/a
Support Services	
- D-Pilot	n/a
- D-One	n/a
- D-Two	n/a
- D-Three	n/a
- D-Four	n/a

	Teamwork / Partnerships
Management	
- D-Pilot	QM has helped to balance interests of different staff groups, improved teamwork
- D-One	no clear impact of QM on staff morale but more teamwork
- D-Two	n/a
- D-Three	n/a
- D-Four	people realise that QM changes things - different more interdisciplinary communication structures develop, more mutual respect, flatter hierarchies, better atmosphere / staff feel better
Consultants	
- D-Pilot	n/a
- D-One	n/a
- D-Two	n/a
- D-Three	thanks to quality management communication between different staff groups has improved considerably. with this, cooperation

	between different staff groups has changed and staff are more aware of the need for cooperation to improve quality, even though this becomes difficult in emergency care. the elitist status of consultants as “demigods in white” (“Halbgötter in Weiß”) has come to an end.
- D-Four	in stroke the different professional groups have developed good cooperation independently of QM
Nursing Care	
- D-Pilot	QM and a special Stroke-Unit certification on their ward have helped to foster cooperation and join the different aspects of stroke care by clearly defining the responsibilities of every staff group
- D-One	n/a
- D-Two	QM projects have optimised coordination within care teams (one nurse)
- D-Three	immediate team is working well together, but this has been like this before – they attribute this to “individual good luck that the team members are a good match” (“individuell Glück gehabt, dass es passt”). The head of nursing highlights the need to reflect about the standing of nursing staff in the organisation. In their view, quality management has contributed to “making nursing more visible” (“Pflegearbeit sichtbar machen”), i.e. improve the respect for the nursing profession within the organisation.
- D-Four	introduction of mobility scale - the treatment becomes more consistent because every team member knows what the others have done (theory input from QM) - good for the patient, QM helps to foster interdisciplinary teamwork but there is still room for improvement, in general it is better in stroke than on a less acute ward because we really have to work together quite closely - the condition doesn't leave a choice and doctors are "nah am Geschehen dran" as there are many acute patients
Therapists	
- D-Pilot	QM and a special Stroke-Unit certification on their ward have helped to foster cooperation and join the different aspects of stroke care by clearly defining the responsibilities of every staff group
- D-One	QM supports the "human factor" and helps to improve relationship quality
- D-Two	n/a
- D-Three	n/a
- D-Four	n/a
Support Services	
- D-Pilot	n/a
- D-One	n/a
- D-Two	n/a
- D-Three	n/a
- D-Four	good communication and cohesion among team: what is the patient allowed to eat? Can he sit up? Does he have to stop eating x hours before surgery? - all this is very individual / reflects the ‘Leistungsanspruch’ of the ward / and is also a requirement of the patient structure

	Cultural Changes
Management	
- D-Pilot	n/a
- D-One	n/a
- D-Two	n/a
- D-Three	n/a
- D-Four	n/a
Consultants	
- D-Pilot	n/a
- D-One	n/a
- D-Two	n/a
- D-Three	n/a
- D-Four	n/a
Nursing Care	
- D-Pilot	n/a
- D-One	n/a
- D-Two	n/a
- D-Three	n/a
- D-Four	n/a
Therapists	
- D-Pilot	n/a
- D-One	n/a
- D-Two	n/a
- D-Three	n/a
- D-Four	n/a
Support Services	
- D-Pilot	n/a
- D-One	n/a
- D-Two	n/a
- D-Three	n/a
- D-Four	n/a

	Customer Priority
Management	
- D-Pilot	improved risk and complaint management, little impact on satisfaction because of contextual constraints
- D-One	improved risk management and safer service provision expected but not measured, standardised service provision
- D-Two	staff show an increased awareness of patient needs - improved soft quality, stable / more structured technical quality

- D-Three	patient surveys, less falls, improved emergency management, QM has also initiated the redesign of the wards and the open areas so that patient and visitors feel homier rather than being in a sterile and cold environment
- D-Four	patients do and can expect a working system no matter if the organisation is QM certified or not, service / patient outcomes have improved thanks to more organised structures, patients are more "mündig" now questioning more and their needs are taken more seriously, documentation is needed for consistency but less time with the patient whereas otherwise you forget about progress and ruin previous progress, more intense involvement of relatives, we take patient complaints / criticism more seriously, more competition in the market - we have to offer more also prevention, QM is a general trend (HC reforms) and also pushed by the hospital to fight for the patients - it takes time but you have to do it, more communication / dialogue with more empowered patients
Consultants	
- D-Pilot	n/a
- D-One	QM good for patients: mortality rates have gone down
- D-Two	general external conditions and a lack of trained consultants cause the quality of the medical service provision to deteriorate. Therefore, they think quality management becomes even more important to efficiently use scarce resources.
- D-Three	n/a
- D-Four	patient quality has gone up but this is more due to medical progress than to QM - indicators don't help to improve (e.g. mortality for stroke) as they can be manipulated (discharge patients so that they don't die in hospital - ethical conflict!)
Nursing Care	
- D-Pilot	QM documentation and other administrative tasks further aggravate the dilemma between the service they would like to provide to the patients and what they can actually achieve within given time and manpower constraints. Nonetheless, they appreciate the need for documentation. The increased staffing is seen to have improved the service provision for the patients.
- D-One	QM increases consistency not necessarily quality of care
- D-Two	head of nursing: staff are more aware of patient needs thanks to patient surveys and adapt behaviour accordingly, a nurse details that quality management projects have optimised the cooperation within the care teams – the patients benefit from this as staff are more responsive to their needs, quality management does not have a major time-consuming impact on their daily activities except during audits or certification
- D-Three	a nurse: patients are better informed about their treatments, their stay at the hospital and more involved by patient surveys. a younger nurse praises standardised, simplified documentation for giving more time with the patients, another more experienced nurse maintains that patient safety has improved thanks to more documentation and transparency at the cost of less time with the patients. a nurse: more competent nursing staff monitor the patients more efficiently and effectively. the head of nursing: quality management standardises treatment procedures while still leaving room for addressing the individual needs of the patients so that they get the care they need.
- D-Four	hygiene improves with it does quality, consistency goes up and risk goes down, service provision is more transparent but not necessarily better for the patient, QM requires a lot of time for documentation (you end up doing more than you write down) while also making sure we spend more time with patients (controversial between nurses) and documentation is important for

	hand-overs between shifts / staff groups and in case of legal problems, patient care becomes more transparent / consistent / traceable which is indispensable in law suits
Therapists	
- D-Pilot	shorter patient lengths of stay achieved also thanks to QM that complicate the provision of effective post-stroke therapies
- D-One	n/a
- D-Two	n/a
- D-Three	quality management is too “extensive” (“umfangreich”) for the employees and this time is missing to work with the patients taking into account the general scarcity of resources. less time for treating patients because of increased quality management obligations, training and continuous professional development have improved with the implementation of quality management and this has positive effects on the patients.
- D-Four	the impact of QM on the patient is 50/50 - PC documentation for accountancy is useless as too generic, should be replaced, curve data near the bed tells you exactly what has happened but takes a lot of time - in the past the whole team came around during the ‘Visite’ and it was all communicated verbally / today you have to write it down
Support Services	
- D-Pilot	n/a
- D-One	more documentation is good but “Der Patient ist oft nur eine Nummer, um den Standard zu halten.” – the patient often becomes a number to adhere to the standard (QMB aware of this criticism)
- D-Two	n/a
- D-Three	quality management requires more time in the beginning, but in the long run the effort put in gets compensated by efficiency gains. patients are better informed about their treatments, their stay at the hospital and more involved by patient surveys.
- D-Four	we are a small ward and it's easy to address individual patient needs, in general: hygiene standards make sense (increased consistency) but all the others don't because the creator has no idea, patients after surgery heavily complained and now there is more choice of soups

19.) Interview Tables: Perceived Issues (Germany)

	Improvement
Management	
- D-Pilot	n/a
- D-One	n/a
- D-Two	n/a
- D-Three	n/a
- D-Four	n/a
Consultants	
- D-Pilot	n/a
- D-One	n/a
- D-Two	n/a
- D-Three	n/a
- D-Four	n/a
Nursing Care	
- D-Pilot	n/a
- D-One	n/a
- D-Two	n/a
- D-Three	n/a
- D-Four	n/a
Therapists	
- D-Pilot	n/a
- D-One	n/a
- D-Two	n/a
- D-Three	n/a
- D-Four	n/a
Support Services	
- D-Pilot	n/a
- D-One	n/a
- D-Two	n/a
- D-Three	n/a
- D-Four	n/a

	Leadership
Management	
- D-Pilot	n/a
- D-One	nursing background, difficult to gain Dr.s respect, in general

	frequent management changes compromise working climate
- D-Two	top management do not show commitment to quality management. it does not surprise that staff are not involved. at higher managerial levels, the quality manager maintains, quality management is consciously sabotaged: manager misuse quality management for “horse-trading” (“Kuhhandel”) to increase their influence and power – “if you give me this, I will do quality management” (“wenn du mir das gibst, mach ich Qualitätsmanagement”). accordingly, the quality manager explains, quality management projects cannot achieve sustainability.
- D-Three	personal interest and character are key – it depends on the departments and the head physicians (Chefärzte)
- D-Four	n/a
Consultants	
- D-Pilot	n/a
- D-One	n/a
- D-Two	n/a
- D-Three	n/a
- D-Four	n/a
Nursing Care	
- D-Pilot	they criticise that the head physicians do not positively appreciate the work of the other employees; rather they just complain and discipline mistakes – they focus on their medical speciality without any interest in holistic quality management and there is little interaction with the staff on the ward: “you don’t see them, you don’t meet them” (“man sieht keinen, man trifft keinen”)
- D-One	n/a
- D-Two	n/a
- D-Three	the personality of the head physician and the head of department significantly influence teamwork and cooperation on the ward
- D-Four	n/a
Therapists	
- D-Pilot	n/a
- D-One	n/a
- D-Two	n/a
- D-Three	n/a
- D-Four	n/a
Support Services	
- D-Pilot	n/a
- D-One	n/a
- D-Two	n/a
- D-Three	n/a
- D-Four	n/a

	Involvement
Management	
- D-Pilot	n/a
- D-One	challenge to develop a common language, them vs us overcome
- D-Two	only two to three percent of all employees get actively involved with quality management independently of the professional group they belong to, personal interest makes or breaks involvement
- D-Three	most involved employees come from the nursing profession – the other non-nursing employees get involved because of an elevated personal interest, according to the quality manager. three main reasons for the nursing dominance in quality management: first, the head of nursing is actively involved in quality management and leads nursing staff by example. secondly, nursing staff enjoy the most noticeable improvements in their daily activities. thirdly, they represent the biggest staff group and are always on the ward.
- D-Four	very different degree of involvement - some very active quality circles - depends on if you really want it
Consultants	
- D-Pilot	n/a
- D-One	personal interest, mirrors own approaches / attitudes
- D-Two	n/a
- D-Three	feel well involved but are not active members of any committee
- D-Four	no direct involvement / indirectly: but my work is represented by a figure and I aim at comparisons, training / education is selected individually - few obligatory sessions e.g. on hygiene
Nursing Care	
- D-Pilot	voluntary participation in quality circles
- D-One	nurses as "Vorreiter" - QM long history in nursing care, personal interest, mirrors own approaches / attitudes
- D-Two	head of nursing agrees that no professional group is more dominantly involved, although the field of nursing is a traditional “trendsetter” (“Vorreiter”) when it comes to quality management. they see the overall involvement of staff more optimistically when saying that around ten to fifteen percent of all staff are actively involved. younger nurses: their training already included quality management – they never knew otherwise.
- D-Three	one nurse cautions that the final decision to get involved or not lies with the employee
- D-Four	involvement through project groups staffed from different wards - but lucky if on it - others are not asked, not everybody is allowed to join, but it takes time to assimilate the content and realise newly learned practices and patterns in the daily routine - you have to go to the training after the shift and you're tired / don't listen and talk to others - training takes too long, documentation changes constantly
Therapists	
- D-Pilot	self-impose a job specific concept of QM
- D-One	n/a
- D-Two	n/a
- D-Three	involvement depends on individual attitude, although involvement as such is not perceived to be an issue and training has improved the service provision
- D-Four	you get trained on the handling of numbers that you then can't

	escape - but we are dealing with humans: if they have another question later on I don't send another invoice
Support Services	
- D-Pilot	n/a
- D-One	n/a
- D-Two	they were not even asked about anything related to quality management and rather "were presented with fait acompli" ("wurden vor vollendete Tatsachen gestellt"), even though they would have liked to be more involved. this has been changing over the past twelve to eighteen months and involvement is now more proactively lead (one member of support staff).
- D-Three	depends on individual attitude
- D-Four	there is some feedback from patients to standard creator but no other involvement but then nothing gets controlled anyway, it also depends on my judgement: if the patient has to eat in bed then small carrott pieces only make a mess - I then just do as I think is best, i have had one hygiene training and one for dealing with patients / communication, i regularly meet my boss and the kitchen folks

	Teamwork / Partnerships
Management	
- D-Pilot	experiences it as difficult to raise an awareness among the head physicians for quality management and general business issues in addition to their medical expertise
- D-One	consultants pay lip-service to QM leadership only – they are used to give orders and not to accept non-medical / business-oriented concepts like QM
- D-Two	n/a
- D-Three	no issues around teamwork and partnership development appears to be working well
- D-Four	in the past there used to be the issue of the big "doctor in white", works very well here thanks to staff - "es menschelt sehr"
Consultants	
- D-Pilot	n/a
- D-One	n/a
- D-Two	n/a
- D-Three	n/a
- D-Four	n/a
Nursing Care	
- D-Pilot	consultants often lack interest in the view of the nursing staff (caution: no consultant there to defend themselves)
- D-One	communication between different staff groups is a problem
- D-Two	n/a
- D-Three	head of nursing - on the wards nursing staff and consultants become allies against the administrative staff.
- D-Four	teamwork with physios works quite well and with consultants also whereas with them it depends more on the individuals
Therapists	
- D-Pilot	consultants need to understand and appreciate more all activities involved in healthcare services provision (caution: no consultant

	there to defend themselves)
- D-One	n/a
- D-Two	n/a
- D-Three	n/a
- D-Four	a lot of teamwork with nurses, with docs communication is mainly via curve data and orders on there - usually no direct contact unless for stroke patients
Support Services	
- D-Pilot	n/a
- D-One	especially the QM certification process neglects interpersonal relationships and the "miteinander"
- D-Two	solely one member of support staff: lacking acceptance from other staff that see them as the most unimportant department. this has changed since they are also more involved in quality management activities. teamwork does not seem to represent a problem.
- D-Three	n/a
- D-Four	cooperation with nurses, therapists sit patient up so that they can eat

	Cultural Changes
Management	
- D-Pilot	n/a
- D-One	missing internal communicative structures biggest obstacle, resistance: has worked like this for many years - why change, “information ist macht” (“information is power”) - QM increases transparency that endangers this
- D-Two	staff understanding of QM as major obstacle and source of resistance, staff perceive QM as control and fear rationalisation without seeing positive effects such as increased transparency and efficiency, not coherent with what staff say! quality management increases the workload and this also causes resistance next to a general resistance towards new initiatives. employees in hierarchically higher positions fear to lose power when the organisation becomes more transparent because of quality management. even though no department is sufficiently staffed, employees fear to be made redundant if the efficiency of the departments is analysed because of the implementation of quality management.
- D-Three	at the beginning some head physicians showed resistance depending on age and personality because they feared that increased bureaucracy would keep them and the staff on the wards away from the patients.
- D-Four	at the beginning staff often react like - oh my God here comes another but then interest picks up the longer it goes on, educational deficits, routine that staff don't want to overcome - why not continue like up to now?
Consultants	
- D-Pilot	n/a
- D-One	n/a
- D-Two	caution that the “quality label” gets put on all new initiatives dealing with organisational structure. this misuse of the name as counterproductive – it creates resistance and initiative fatigue
- D-Three	resistance to change was an issue at the beginning

- D-Four	n/a
Nursing Care	
- D-Pilot	acceptance of technical changes no issue anymore
- D-One	n/a
- D-Two	n/a
- D-Three	a nurse criticises that ticking a box for so-called accountability does not necessarily mean that this task has actually been fulfilled. also complain about too much “typically German bureaucracy” (“typisch deutsche Bürokratie”)
- D-Four	it depends - if it makes sense and more effort ok (e.g. cannulas would be usable for longer but it is better to change them more regularly to avoid infections, but it doesn’t make sense to have yet another form for documentation purposes although it is all the same), the nature of the service changes - more towards hospitality but you have to balance it - be honest without a fake airhostess smile and cultivate respectful behaviour
Therapists	
- D-Pilot	just one therapists cautions that standards should not automatically be adopted, but that everybody should critically question their value (technical changes)
- D-One	n/a
- D-Two	n/a
- D-Three	“frozen structures” (“eingefrorene Strukturen”) prevent the project teams to efficiently change anything
- D-Four	more bureaucracy
Support Services	
- D-Pilot	n/a
- D-One	n/a
- D-Two	n/a
- D-Three	n/a
- D-Four	n/a

	Customer Priority
Management	
- D-Pilot	time and personnel constraints to truly realise this, customer = patient
- D-One	“the patient feels like a patient not like a customer, the brain is left at the reception desk” - customer concept is not common in hospital setting (confirmed slightly by some staff hesitating to answer this question), traditional patient dependency, problematic situation of both the overall economy and the healthcare system affect the working climate negatively - work consolidation reduces time for tasks instead of optimising processes and eliminating waste, not enough time and scarce resources impede full QM implementation and adequate services provision to patients, patient as only or main customer
- D-Two	patient as a customer
- D-Three	patients, referring doctors, relatives and staff as customer
- D-Four	customer: patient and relatives as main but also consultants / referrers / SHI / care homes / rehabilitation clinics - all that are in

	interaction with us
Consultants	
- D-Pilot	n/a
- D-One	patient as only or main customer
- D-Two	there are no customers apart from maybe the health insurance company
- D-Three	quality management does not represent important time constraints, but there is a general lack of consultants – if one consultant leaves the organisation, no other consultant is hired in replacement. young consultants leave to work abroad or in the pharmaceutical industry because of better working conditions and higher salaries. patients as customers.
- D-Four	customer: patient / but not happy with the concept because medicine not understood as service - it's not the same if you go and get your hair cut or if you have severe health issues
Nursing Care	
- D-Pilot	time and personnel constraints to truly realise this, customer = patient, relatives are also a customer
- D-One	not enough time and scarce resources impede full QM implementation and adequate services provision to patients, patient as only or main customer, other employees as internal customer
- D-Two	one nurse does not like the concept of a customer - the patient needs help and is not really a customer, patient as a customer, head of nursing differentiates between patients as primary customers and other partners, such as rehabilitation clinics, nursing homes and mobile nursing services, as extended customers
- D-Three	patients as customers, patients are better informed, especially elderly patients with certain conditions are not able to absorb or understand this information.
- D-Four	customer: patient, who chooses, where to go, including relatives (but don't like the concept, it's all coming from the US and if that's so good...?)
Therapists	
- D-Pilot	time and personnel constraints to truly realise this, customer = patient
- D-One	not enough time and scarce resources impede full QM implementation and adequate services provision to patients, patient as only or main customer
- D-Two	too much work and not enough personnel, patient as a customer
- D-Three	next to patients they also include relatives, other internal staff and also external staff that cooperate from other hospitals or rehabilitation clinics in their customer concept
- D-Four	customer: patient
Support Services	
- D-Pilot	time and personnel constraints to truly realise this, customer is a "horrible word
- D-One	not enough time and scarce resources impede full QM implementation and adequate services provision to patients, patient as only or main customer, other employees as internal customer
- D-Two	too much work and not enough personnel, one member of support staff extends the customer concept to include relatives and the hospital as a whole, patient as a customer
- D-Three	patients and the other employees as their two customer groups, whereas they do not think that customer is the adequate term as neither patients nor staff directly buy their services. patients are

	more informed, especially elderly patients with certain conditions are not able to absorb or understand this information.
- D-Four	customer: patient

20.) Interview Tables: 'Valued' Practice, Lessons-Learned (Germany)

	Improvement
Management	
- D-Pilot	one model for quality management should be consistently applied and implemented across the entire organisation to achieve holistic improvements. don't follow fashions and trends to certify isolated subsystems according to different standards without checking compatibility and overlap with the main system in use, i. e. KTQ. it is better to stick to the basic model and work on continuous improvement, as this also reduces resistance from employees because of initiative fatigue.
- D-One	don't waste time on too much documentation, results transparency has to be achieved by measuring and analysing implementation progress for further development. internal and external comparisons highlight good practices and areas for improvements.
- D-Two	n/a
- D-Three	n/a
- D-Four	n/a
Consultants	
- D-Pilot	n/a
- D-One	n/a
- D-Two	n/a
- D-Three	n/a
- D-Four	n/a
Nursing Care	
- D-Pilot	n/a
- D-One	n/a
- D-Two	n/a
- D-Three	excessive unnecessary documentation takes too much time – it is important to focus on the essentials (one nurse)
- D-Four	n/a
Therapists	
- D-Pilot	n/a
- D-One	n/a
- D-Two	n/a
- D-Three	n/a
- D-Four	n/a
Support Services	
- D-Pilot	n/a
- D-One	n/a
- D-Two	n/a
- D-Three	n/a

- D-Four	some of the standards really make no sense (the food looks disgusting anyway and this doesn't change just because you put some decorative parsley on it), but most are really good and well integrated into daily activities - sometimes difficult to organise it all and put it into practice

	Leadership
Management	
- D-Pilot	without the complete support and commitment of the general management the employees would have felt more uncertainty and, therefore, would have shown more resistance towards the implementation of quality management. with a change in the general management the strategic priorities are also changing. this is a problem. quality policy needs to be stable. leadership from the top is not enough – it has to cascade down through the organisation. each department appoints their own quality management representative ("Beauftragter") – in the medical service provision both a member of the nursing staff and a consultant take over this role additionally to their regular obligations on the ward. this helps to make quality management relevant for the practitioners.
- D-One	implementation efforts need to be well focussed and organised with a concrete action plan including smart objectives, dividing core activities from waste and starting with burningly acute themes, such as liability issues, plan and expect enough time for the implementation process, as a precondition for the successful implementation of quality management the top management has to fully support the initiative. this leadership has to cascade down through all levels supported by both non-clinical and clinical managers and leaders – the latter being the more difficult to achieve. the quality manager also has to contribute certain skills for a successful implementation of quality management: empathy for the employees in their daily routines ("alltägliches Hamsterrad") is crucial to understand that for them it is usually difficult to step back and reflect about what they are doing as required by quality management. in order to achieve this empathy and to understand inter-staff conflicts, the quality manager has to have relevant experience in the field including project and change management skills. as the quality manager comes from a nursing background, they initially experienced acceptance problems because of this. further academic studies and a higher degree are claimed to improve acceptance especially with the consultants. these experiences help the quality manager to find a common language to edit quality management and implementation information in a way that is understandable for all the affected staff groups, the quality manager and top management have to act as role models by applying the quality management instruments and philosophies to be implemented also in their own jobs in order to remain credible in front of their staff. they should search for charismatic advocates and emotional leaders that support the implementation and not necessarily bear official leadership / management positions.
- D-Two	their leadership, their personal presence and approachability in the entire hospital is key. they are well known throughout the organisation thanks to their previous post as a consultant. the whole implementation process takes too long, there are too many 'to-do's' and it takes too long until these are tackled.
- D-Three	the commitment and support of the general management (Geschäftsführung) as well as their own acceptance among staff

	thanks to their nursing background at the hospital are most important. nursing background has a positive impact on their new role because they know the hospital very well thanks to their previous job, importance of an accurate self-assessment report that staff can relate to and identify themselves with
- D-Four	privatisation in 2000 made a difference - not just certification but also focus on results - previously "Papiertiger"
Consultants	
- D-Pilot	n/a
- D-One	n/a
- D-Two	n/a
- D-Three	in favour of obligation for quality management – without this top-down approach the initiative would lose momentum
- D-Four	n/a
Nursing Care	
- D-Pilot	the nursing director is perceived to strongly support quality management and the quality manager is also from a nursing background
- D-One	need to actually do things and not just talk (“Nägel mit Köpfen machen”)
- D-Two	n/a
- D-Three	the quality manager is “one of us” (“eine/r von uns”)
- D-Four	n/a
Therapists	
- D-Pilot	n/a
- D-One	implementation schedule was very strict and tight – the quality manager is seen to have supported staff to achieve the balance between routine activities and the new quality management requirements
- D-Two	n/a
- D-Three	n/a
- D-Four	n/a
Support Services	
- D-Pilot	n/a
- D-One	n/a
- D-Two	n/a
- D-Three	the presence of the quality manager in the organisation – they are visible on the wards and well known
- D-Four	n/a

	Involvement
Management	
- D-Pilot	the quality management activities need to be results-oriented so that especially the head physicians can be convinced – this combines the planning of content and people focus. the same is true for the quality manager’s suggestion to follow a PDCA logic and link quality management with concrete actions in order to make quality management more tangible and with this reduce resistance. suggests concentrating implementation efforts at the

	beginning on those employees that are interested. employees are motivated by successful self-assessment and certification – the idea of positive feedback is crucial here and needs to be planned for. quality management terminology as a major barrier to successful implementation – the right language has to be found to reach all employees. employees react most open towards the implementation of quality management if it is accompanied by honest and detailed communication about what happens, when, why, how and where. personal development and training of every employee has to be strategically linked to the organisational development
- D-One	the quality management implementation should start with a ward or department that is interested and can act as a role model. fighting resistance and improving involvement is more directly addressed by transparency achieved via communication and training. “knowledge is power” (“Wissen ist Macht”). “information is power” is identified as one of the sources for resistance. training needs to let the employees try the new instruments and involve them so that they see the advantages of more information transparency and of quality management knowledge. this “learning by doing” approach needs to be supported by an open intra-organisational communication infrastructure that not only informs the employees about the changes but also proactively seeks both positive and negative feedback. certification is seen by the quality manager as a key motivator. the certification process and internal audits make quality management more binding and tangible for staff. even though, content-wise, neither certification nor audits make a difference in the view of the quality manager, they provide a significant “psychological incentive” (“mentaler Ansporn”) and can act like “a carrot on a stick” (“Zuckerstückchen”). (maintain momentum!)
- D-Two	resistance is prevented and involvement is achieved most effectively by showing employees which concrete, tangible advantages they will enjoy in their daily activities by supporting quality management. adequate leadership also increases transparency for staff by communication and training and this reduces resistance and fears, as the quality manager experienced. at the beginning of the quality management implementation, the quality manager informed staff with a big information event and several local “kick-off events” (English expression used by QMB)
- D-Three	the implementation was planned and transparently communicated to counter resistance and foster involvement of staff. the organisation applied a top-down approach: first, the most senior management got involved with the EFQM self-assessment. secondly, the results filtered down to the quality management representatives throughout the organisation. finally, the organisation-wide implementation according to KTQ was achieved by involving interested staff in specialised project teams. this makes quality management more tangible and reduces resistance. organisational structures for involvement. further, the quality manager places high importance on transparency of the implementation and maintenance via open and regular communication: a “kick-off event” prepared and informed staff about quality management and the expected changes. in order to successfully implement quality management tools such as checklists or documentation forms, the quality manager developed a common language using simple and short sentences – this required effort even though KTQ is geared to hospital-specific application. momentum for quality management is further maintained by regular quality management updates to all staff. once per quarter a quality management newsletter is circulated amongst all staff, each department appoints a quality

	management contact person, employees can get involved in specialised project groups and once per month the quality manager informs all committees about the latest quality management development
- D-Four	"die leute mitnehmen" (“take the people with you”), certification gives a corporate identity to have achieved something together and increases motivation, communication about quality results on posters throughout the hospital, staff live for the certification before is after, staff can complain about QM changes on scientific grounds - most standards are circulated among all staff, training on care and medical diagnosis yes – training on QM is more to stay fit and not to forget it
Consultants	
- D-Pilot	n/a
- D-One	good initial QM training, management gives plenty of opportunities to be involved, sought it for initial implementation in spite of top-down approach
- D-Two	n/a
- D-Three	adequate organisational structures and good opportunities for involvement in quality management
- D-Four	n/a
Nursing Care	
- D-Pilot	they perceive it as very positive that quality management was not “imposed on them” (“übergestülpt”). the employees are very “happy” and “pleased” with the implementation of the quality management system and the related training. but rather cooperatively developed in working groups. all agree that the organisation facilitates involvement
- D-One	management gives plenty of opportunities to be involved, sought it for initial implementation in spite of top-down approach
- D-Two	n/a
- D-Three	n/a
- D-Four	obligatory training for the implementation of DRG documentation - timely and very positive, first hm but in retrospective really good and needed - most training is elective / happens regularly and makes sense, you can talk to the responsible people about the new forms during the test phase, we have a heavy focus on continuous education and training which is great and for new things there is a quick focus on it and it works but you can also ask again if something remains unclear
Therapists	
- D-Pilot	they perceive it as very positive that quality management was not “imposed on them” (“übergestülpt”). the employees are very “happy” and “pleased” with the implementation of the quality management system and the related training. but rather cooperatively developed in working groups. all agree that the organisation facilitates involvement
- D-One	management gives plenty of opportunities to be involved, sought it for initial implementation in spite of top-down approach
- D-Two	n/a
- D-Three	n/a
- D-Four	n/a
Support Services	
- D-Pilot	they perceive it as very positive that quality management was not “imposed on them” (“übergestülpt”). the employees are very “happy” and “pleased” with the implementation of the quality management system and the related training. but rather

	cooperatively developed in working groups. all agree that the organisation facilitates involvement
- D-One	management gives plenty of opportunities to be involved, sought it for initial implementation in spite of top-down approach
- D-Two	n/a
- D-Three	adequate organisational structures and good opportunities for involvement in quality management
- D-Four	n/a

	Teamwork / Partnerships
Management	
- D-Pilot	in order to build this awareness for future generations of head physicians, the quality manager motivates senior physicians (“Oberärzte”) to become a quality management representative on their ward – they are younger, more open towards new ideas and usually achieve high levels of acceptance among other staff groups. this impact compensates the fact that they often move on quickly to push their career. medical and business leaders are joined in project teams early on so that the resistance from consultants can be mitigated
- D-One	"Herr Gott in Weiss" (“the Lord in white”) needs to support QM
- D-Two	partnerships with local elderly care homes & mobile nursing service providers
- D-Three	in order to efficiently and effectively implement quality management and maintain momentum quality management was introduced simultaneously at al hospitals belonging to the corporate group. nowadays the hospitals work more closely together, learn from each other and exploit synergies, for instance in continuous professional development. the goal is to “not reinvent the wheel every time” (“nicht das Rad jedes Mal neu erfinden”). this corporate cooperation also helps to maintain momentum for the quality management initiative. many cooperations with speech therapists / physio therapists / music therapists / rehabilitation clinics
- D-Four	in the past the patients stayed in hospital as long as needed until well again - nowadays quicker so closer cooperation with ambulant sector – ‘überleitungspflege’ (transitory care) to be prepared to be home
Consultants	
- D-Pilot	n/a
- D-One	n/a
- D-Two	n/a
- D-Three	n/a
- D-Four	n/a
Nursing Care	
- D-Pilot	n/a
- D-One	n/a
- D-Two	n/a
- D-Three	n/a
- D-Four	consultants / therapists / nurses meet once a day to discuss patients

Therapists	
- D-Pilot	n/a
- D-One	n/a
- D-Two	n/a
- D-Three	n/a
- D-Four	n/a
Support Services	
- D-Pilot	n/a
- D-One	n/a
- D-Two	n/a
- D-Three	n/a
- D-Four	n/a

	Cultural Changes
Management	
- D-Pilot	quality management representatives as ambassadors that support the implementation process. this is one way of improving the horizontal connections between different parts of the hospital. quality management implementation can only be achieved if overall clear organisational structures encourage these horizontal connections to enable organisational learning
- D-One	resisting parties should be isolated and encircled by working with quality management supporters so that they have no choice but to cease their resistance. build databases and calculate figures from the measurements and comparisons to further convince critics
- D-Two	there is little solidarity with the entire hospital, no “corporate identity” (“Wir-Gefühl”) among staff. the organisation as a whole seems to be too big and too intangible compared to the work on the wards and within departments. underline local implication of QM
- D-Three	resistance was easily overcome, as all the components had already been in place and quality management just gave more structure to the organisation
- D-Four	intensely work with resisting staff to explain QM and make goals clearer, set incentives, establish a no-blame culture - where work gets done, mistakes happen from which you can and have to learn
Consultants	
- D-Pilot	n/a
- D-One	n/a
- D-Two	n/a
- D-Three	it is easier to implement and apply quality management procedures on a non-emergency ward
- D-Four	n/a
Nursing Care	
- D-Pilot	n/a
- D-One	n/a
- D-Two	n/a

- D-Three	n/a
- D-Four	n/a
Therapists	
- D-Pilot	n/a
- D-One	n/a
- D-Two	n/a
- D-Three	n/a
- D-Four	n/a
Support Services	
- D-Pilot	n/a
- D-One	n/a
- D-Two	n/a
- D-Three	n/a
- D-Four	n/a

	Customer Priority
Management	
- D-Pilot	n/a
- D-One	carry out staff, referrer and patient surveys on a regular basis to maintain an overview of the overall situation from different perspectives
- D-Two	n/a
- D-Three	n/a
- D-Four	n/a
Consultants	
- D-Pilot	n/a
- D-One	n/a
- D-Two	n/a
- D-Three	n/a
- D-Four	n/a
Nursing Care	
- D-Pilot	n/a
- D-One	n/a
- D-Two	n/a
- D-Three	n/a
- D-Four	n/a
Therapists	
- D-Pilot	n/a
- D-One	n/a
- D-Two	n/a
- D-Three	n/a

- D-Four	n/a
Support Services	
- D-Pilot	n/a
- D-One	n/a
- D-Two	n/a
- D-Three	n/a
- D-Four	n/a

21.) Interview Tables: Suggested Improvements (Germany)

	Improvement
Management	
- D-Pilot	When directly asked about which improvements they would like to see in terms of quality management, all staff unanimously state that they are completely “happy” (“zufrieden”) with how things are.
- D-One	n/a
- D-Two	n/a
- D-Three	n/a
- D-Four	improvements are always possible
Consultants	
- D-Pilot	n/a
- D-One	n/a
- D-Two	n/a
- D-Three	there is always room for improvement and it is important “not to rest on one’s laurels” (“nicht auf seinen Lorbeeren ausruhen”)
- D-Four	n/a
Nursing Care	
- D-Pilot	When directly asked about which improvements they would like to see in terms of quality management, all staff unanimously state that they are completely “happy” (“zufrieden”) with how things are.
- D-One	n/a
- D-Two	would also appreciate less documentation
- D-Three	need for structuring rosters (‘Dienstplan’) on the wards, a lot of improvement to be realised in nursing documentation
- D-Four	overall improvements are always possible - if something new does not work you should change it - but generally ok here, QM structures should be simplified, it would be good to have formal structures / forms for patient reports (they are illegible anyway if written in a rush), QM is bureaucratic effort for the SHI - do we really need it? couldn't it be simpler? and less ‘Papierkram’ (paper stuff) - "it's the last thing I do" and rather fulfil another patient wish to be confident that patient is well cared for, patient forms are too complex - they don't understand most of it and don't have time to fill it all in
Therapists	
- D-Pilot	When directly asked about which improvements they would like to see in terms of quality management, all staff unanimously state that they are completely “happy” (“zufrieden”) with how things are.
- D-One	n/a
- D-Two	n/a
- D-Three	n/a
- D-Four	documentation on pc for accountancy should be removed, there is a lot that could be changed
Support Services	
- D-Pilot	When directly asked about which improvements they would like to see in terms of quality management, all staff unanimously state that they are completely “happy” (“zufrieden”) with how things are.

- D-One	n/a
- D-Two	would also appreciate less documentation
- D-Three	agree with consultants
- D-Four	n/a

	Leadership
Management	
- D-Pilot	consistent and stable quality management and general leadership should be further pursued, awareness of the importance of positive leadership for successful quality management should be communicated and trained from management to ward level
- D-One	n/a
- D-Two	leadership and quality management commitment from top management as a prerequisite for successful quality management implementation. but here: lacking leadership, commitment and sustainability of the project
- D-Three	n/a
- D-Four	n/a
Consultants	
- D-Pilot	n/a
- D-One	n/a
- D-Two	n/a
- D-Three	n/a
- D-Four	n/a
Nursing Care	
- D-Pilot	ask for more positive feedback from especially medical management who just focus on mistakes and negative feedback
- D-One	n/a
- D-Two	more rewards for hard work that is taken for granted
- D-Three	need for executive development (‘Führungskräfteentwicklung’)
- D-Four	n/a
Therapists	
- D-Pilot	ask for more positive feedback from especially medical management who just focus on mistakes and negative feedback
- D-One	n/a
- D-Two	n/a
- D-Three	n/a
- D-Four	n/a
Support Services	
- D-Pilot	ask for more positive feedback from especially medical management who just focus on mistakes and negative feedback
- D-One	n/a
- D-Two	more rewards for hard work that is taken for granted
- D-Three	n/a

- D-Four	n/a

	Involvement
Management	
- D-Pilot	n/a
- D-One	n/a
- D-Two	importance of involving the quality manager and the affected employees in the decision-making process. for instance, management planned new staff facilities that in the end remained unused as they were too far away from their working environment, involving the quality manager and staff could have avoided this
- D-Three	n/a
- D-Four	more training and education for staff would be good, communications and information structures need to improve (e.g. change in ward structure - contradicting information have been passed to staff)
Consultants	
- D-Pilot	n/a
- D-One	n/a
- D-Two	n/a
- D-Three	n/a
- D-Four	n/a
Nursing Care	
- D-Pilot	n/a
- D-One	n/a
- D-Two	for quality management projects front staff should be more involved to ensure their practicality and practice orientation, nursing training puts a stronger emphasis on quality management issues that should also be adopted for consultants' training
- D-Three	head of nursing: there remains a lot of improvement to be realised in continuous professional development of nurses, another nurse agrees with this and adds that the hospital should help financing training courses
- D-Four	it would be nice to be more involved but overall ok, we only had one training on documentation but every month there is a new form - they should be bundled (just 2 instead of 7) as still needed for accounting and transparency, we should get time off for training - like 10 minutes during breakfast break, QM needs to correspond more to the ground staff - staff surveys to see what should be improved would be good to balance theory and reality, more communication - this can always be improved, more dialogue with staff so that they feel involved and this is good for motivation
Therapists	
- D-Pilot	n/a
- D-One	n/a
- D-Two	n/a
- D-Three	n/a
- D-Four	n/a

Support Services	
- D-Pilot	n/a
- D-One	n/a
- D-Two	for quality management projects front staff should be more involved to ensure their practicality and practice orientation. one member of support staff complains about how quality management is dealt with: communication and feedback are seen to lack behind
- D-Three	need for training in respectful and friendly communication with patients and other staff
- D-Four	n/a

	Teamwork / Partnerships
Management	
- D-Pilot	teamwork seems to have improved. even though the quality manager wants to give the impression that teamwork is not an issue any longer, the content of the interview with them proves otherwise: soft issues around management of resistance and harmonising conflicts between staff group make up most of the interview. this additionally supports the need for future continued and continuous improvements in this area
- D-One	n/a
- D-Two	n/a
- D-Three	n/a
- D-Four	n/a
Consultants	
- D-Pilot	n/a
- D-One	n/a
- D-Two	n/a
- D-Three	n/a
- D-Four	n/a
Nursing Care	
- D-Pilot	leaves room for improvement – consultants receive specifically harsh critique from the other staff groups (but not interviewed!), starting to improve mutual respect and understanding thanks to the Stroke-Unit certification
- D-One	n/a
- D-Two	n/a
- D-Three	the head of nursing claims that the organisational wide awareness of the importance of and respect for the nursing profession needs to further develop and that quality management offers a good platform for this. another nurse: improvements in coordinating appointments in multi-disciplinary care are needed
- D-Four	interdisciplinary work could still improve more
Therapists	
- D-Pilot	leaves room for improvement – consultants receive specifically harsh critique from the other staff groups (but not interviewed!), starting to improve mutual respect and understanding thanks to the Stroke-Unit certification

- D-One	n/a
- D-Two	suggest more cooperation with nursing staff in order to harmonise standards of care and therapy
- D-Three	n/a
- D-Four	working on 2 or 3 wards and have to walk back and forth several times because of workflow on the wards - could be coordinated better
Support Services	
- D-Pilot	leaves room for improvement – consultants receive specifically harsh critique from the other staff groups (but not interviewed!), starting to improve mutual respect and understanding thanks to the Stroke-Unit certification
- D-One	n/a
- D-Two	even though the quality manager positively underlines cooperation with local elderly care homes and mobile nursing services, the member of support staff claims that communication and cooperation with after-care organisations, i.e. the nursing homes, needs to improve
- D-Three	n/a
- D-Four	the food for the patients comes from an external supplier far away in foil / stored for two days - not good but two-year long contract

	Cultural Changes
Management	
- D-Pilot	n/a
- D-One	n/a
- D-Two	n/a
- D-Three	n/a
- D-Four	n/a
Consultants	
- D-Pilot	n/a
- D-One	n/a
- D-Two	n/a
- D-Three	“certification does not necessarily mean anything” (“Zertifizierung muss nichts heißen”)
- D-Four	n/a
Nursing Care	
- D-Pilot	n/a
- D-One	n/a
- D-Two	n/a
- D-Three	management changes continuously. but the implementation of results and changes agreed upon in project teams remains difficult internally – this needs to change. otherwise, involvement in such activities becomes useless
- D-Four	it is all so capitalised - in DDR times it all worked too - it's horrible when hospitals issue stock options, they reinvent the wheel here every six months testing this here and that there and then they anyway change their mind and yet something else comes in from the top - of course you have to change but it has to be better

	planned so that less people have to do it
Therapists	
- D-Pilot	n/a
- D-One	n/a
- D-Two	n/a
- D-Three	“there is too much talk, but nothing happens” (“es wird zu viel geredet, aber es passiert nichts”). there are no incentives to actually implement improvements developed in project teams and sometimes it is not even possible because those working on these projects do not have the rights to decide about their implementation. last criticism deals with certification – it is just a written prove every other year which does not make a difference as long as nothing is questioned practically
- D-Four	n/a
Support Services	
- D-Pilot	n/a
- D-One	n/a
- D-Two	n/a
- D-Three	n/a
- D-Four	n/a

	Customer Priority
Management	
- D-Pilot	scarce resources need to be used more effectively and efficiently
- D-One	all respondents unanimously agree on scarce resources with regard to time and manpower as a major obstacle to fully implement quality management. the quality manager highlights the need to cut out waste and focus on essential activities, this should at least in part help to solve the resource problem
- D-Two	n/a
- D-Three	n/a
- D-Four	n/a
Consultants	
- D-Pilot	n/a
- D-One	all respondents unanimously agree on scarce resources with regard to time and manpower as a major obstacle to fully implement quality management
- D-Two	n/a
- D-Three	n/a
- D-Four	change indicators: not mortality in hospital but 6 months after
Nursing Care	
- D-Pilot	scarce resources need to be used more effectively and efficiently
- D-One	all respondents unanimously agree on scarce resources with regard to time and manpower as a major obstacle to fully implement quality management
- D-Two	increased staffing

- D-Three	n/a
- D-Four	we need more staff - It would be good to have an extra person on the ward to take care of all the "Schreibkram" (writing) - it would be routine for him/her - "with all this writing I might as well have become a banker" - it keeps you from concentrating on the most important aspect - your patient - doctors need to write many letters too, officially there is one nurse per two patients but in reality this is totally different because you can't pay for it, all in all we need more time / money / staff, it would be good to react to simple patient requests / needs (such as food)
Therapists	
- D-Pilot	scarce resources need to be used more effectively and efficiently
- D-One	all respondents unanimously agree on scarce resources with regard to time and manpower as a major obstacle to fully implement quality management
- D-Two	n/a
- D-Three	would like to see more time analyses of the workload and enough personnel resources assigned accordingly. high staff turnover represents the main obstacle towards delivering consistent quality treatments by the therapists. most staff are hired for 75 percent jobs – the wages are not high enough so that staff go elsewhere if they find a better paying job
- D-Four	we need more staff and more time with the patients
Support Services	
- D-Pilot	scarce resources need to be used more effectively and efficiently
- D-One	all respondents unanimously agree on scarce resources with regard to time and manpower as a major obstacle to fully implement quality management
- D-Two	increased staffing, would like to see more respect for the needs of and patience with elderly patients – the customer focus in this regard requires further development
- D-Three	n/a
- D-Four	patients would love to have more fresh food but the kitchen is too small and there is no storage space

22.) Interview Tables: Organisational Context (England)

CG Initiative	***Case E-One***
Timing	1994 / 2001
Reason	launch of stroke services / government regulation
Initiator	government
Implementation:	
~ Model	own model / 7 pillars / standards for better health
~ Certification	national stroke strategy as a guiding quality framework
~ Choice	government
~ Strategic Importance	yes
~ Mgmt Consultants	no need
~ Ownership	n/a
Role of ICT	communication improved by email, building database for patient statistics, problematic implementation of electronic document management: not enough money, far from holistic system & poor project scoping
Benchmarking / Comparisons	national stroke sentinel, UK stroke forum & research network

CG Initiative	***Case E-Two***
Timing	1999
Reason	Bristol scandal, government reaction
Initiator	government, internally lead by medical director
Implementation:	
~ Model	initially 7 pillars (still used for training as people understand this better), now standards for better health (for working)
~ Certification	EFQM, ISO etc not applicable, heard of Charter Mark in network
~ Choice	government
~ Strategic Importance	yes
~ Mgmt Consultants	no
~ Ownership	n/a
Role of ICT	small / over stretched IT department, complaints and incident reporting, clinical audit / patient information leaflets / guidelines on database online, no specific software packages, good intranet, no need for more IT - "you can have as much IT as you want, if awareness is not there" - many don't like IT
Benchmarking / Comparisons	BM: Dr Foster intelligence (problems: not real time data, data quality is questionable), national stuff that is obligatory: national patient surveys (care quality commission - midstaffs report) / audits (stroke) / standard for better care / NCEpod / Royal College, nothing internally, external infos are used to get an action plan out of

CG Initiative	***Case E-Three***
Timing	around 2000
Reason	government regulations
Initiator	government
Implementation:	
~ Model	7 pillars, now towards integrated governance model
~ Certification	no
~ Choice	government
~ Strategic Importance	yes absolutely, growing quality agenda, patient safety manager: yes, good buy-in from senior people, recognition that it is an important aspect of what we do, assurance - gotta do it, culture of improvements, CG in business planning documentation and patient safety stratefy
~ Mgmt Consultants	no
~ Ownership	therapist about private vs NHS (previous experience in private hospital): private - more robust and ownership for CG, more systematic but lead from HQ so distant, NHS more local ownership, private more bureaucratic, more rigorous scrutiny and standards (on paper and for paperwork) - they can be closed while it's NHS policy that trusts aren't closed, but the outcome is not necessarily better - staff care either way
Role of IT	very limited here, national programme was a big hope that didn't happen, no good integration, no data confidence, a long way to go still, new information officer -> new strategy, important to have the data and information and to have a single interface (integration - single log-in) so that everybody could access what they need, already in place: systems for training, GM elderly medicine: intranet to share info / policies / procedures, email to cascade information to everyone / sharing links, databases around finances / waiting lists
Benchmarking / Comparisons	number of levels: national a lot - patient surveys, stroke sentinel, dr. foster, national joint registry (orthopaedics), 12 big national audits, peer review for cancer service, patient safety comparison with US, a lot at SHA level, GM elderly medicine: Pickers Institute for patient satisfaction and staff surveys

CG Initiative	***Case E-Four***
Timing	late 1990s
Reason	government regulations, consultant: Bristol as kick-start
Initiator	government
Implementation:	
~ Model	7 pillars initially, now standards for better health to report and quality framework by care quality commission
~ Certification	no
~ Choice	government
~ Strategic Importance	one of the top issues in the trust, should be number one but difficult in the current financial climate, patient safety and quality of patient service are number one, SHA focuses on quality
~ Mgmt Consultants	no
~ Ownership	n/a, therapists: not sure about differences between regular and teaching hospitals
Role of IT	forums, databases, network, reporting, patients have more easily access to information online e.g. guidelines and policies, "that's life these days"
Benchmarking / Comparisons	national stroke audit, Dr's part of regional stroke network, academic cooperation, multi-organisational research to reduce lengths of stay and achieve less disabling strokes - now manage more quickly through clinics rather than in-patient care

23.) Interview Tables: Staff Understanding (England)

E-One	**Improvement**	**Leadership**	**Involvement**
Staff Interviews	benchmarking, implicitly: clinical excellence and quality, process approach, standards, structure, policies, guidelines and procedures, a tool to provide effective and efficient services	control of meeting standards, financial control, accountability, and risk management, framework to provide effective / efficient services	"everybody's business" (nurse), meetings, paperwork (negative connotation)
Vision & Mission & Quality Account	✓	✓	✓
	Teamwork / Partnerships	**Cultural Changes**	**Customer Priority**
Staff Interviews	explicitly included	CG umbrella for whole person care that fosters the concept of confidentiality	client satisfaction and focus
Vision & Mission & Quality Account	✓	✓	✓

Comments	The clinical governance manager in stroke care cautions that staff might not always understand the big picture of clinical governance. But they should still be aware of their role in it. More pointedly, the general manager for elderly care identifies different understandings of governance among staff as a problem and promotes the "need to take the big perspective".	one nurse is sure to be working to it everyday while not knowing the concepts in depth. nurse team-leader - "people don't know about clinical governance but work with it, anyway". the clinical stroke coordinator: "I don't understand it, don't understand the reasoning or background, but I know that I have to do it". don't perceive this to be upsetting – understood the seven pillars model in the past and are sure that clinical governance is just "re-jargoned" while the ideas are probably still there. senior staff tend to have a better understanding as they have a broader overview of the organisation. support staff: do not exactly understand the whole concept

E-Two	**Improvement**	**Leadership**	**Involvement**
Staff Interviews	documentation, regulation, integrated care pathways, standards, clinical audit, standards, transparency, processes, consistency, quality control, cost-effective care, government targets / initiatives, CPD, ensure quality, constantly improve quality & patient experience, audit	(quality) control, accountability, risk mgmt, "pain in the backside", "thought police", monitor quality of services, umbrella term, support decision making without replacing it	accountability, safety (liability for practitioners)
Vision & Mission & Quality Account	✓	✓	✓
	Teamwork / Partnerships	**Cultural Changes**	**Customer Priority**
Staff Interviews	integrated care pathways, multi-disciplinary teams	evidence-based care, research	effective: right patient / time / care, constantly improve patient experience, patient safety
Vision & Mission & Quality Account	✓	✓	✓

Comments	The clinical governance manager remembers that s/he was not aware of clinical governance when it was initially introduced on the ward s/he worked then. S/he cautions that even now many nurses do not understand the ideas and are not aware of the concept.	The chaplain supports this, admitting that his/her comments might reflect a lack of knowledge regarding clinical governance. Nurses: most don't understand what CG really is

E-Three	**Improvement**	**Leadership**	**Involvement**
Staff Interviews	clear (measurements) framework, audit, clinical effectiveness, value for money, set of guidelines / requirements / standards / policies / protocols, fair distribution of resources, infection control, benchmarking, monitor quality, consistency, government objectives, CPD, maintain/ improve / optimise quality of care, right way at right time, clinical effectiveness, best practice	various pillars / broad concept/ clear framework, staff support, accountability, managing people's expectations, define responsibilities, risk based approach, complaints mgmt, fair distribution of resources, health & safety, infection control, monitor quality	staff education, accountability, makes you think about wider issues than your own job (CG manager, therapist), empowerment, training
Vision & Mission & Quality Account	✓	✓	✓
	Teamwork / Partnerships	**Cultural Changes**	**Customer Priority**
Staff Interviews	explicitly mentioned to support patient safety, audit, sharing when learned from mistakes	research / evidence-based information, openness to learn from mistakes & share this, investigate what / why we do	patient safety, patient satisfaction / positive patient experience, involvement of patients and families, patient at the heart (learn from and respond to complaints), meet patient & community needs
Vision & Mission & Quality Account	✓	✓	✓

Comments	"CG supplies the conscience of the organisation" -> challenge practice (CG manager) Clinical staff used to buy in better into 7 pillars.	Therapist: people didn't understand CG at the beginning, "managers did it", Consultants: now more mainstream understanding, at university CG very nebulous phrase with no specific meaning - referring to hand-washing / don't waste money / talking to relatives / hazy idea of what it meant - "behaving well and rationalise" but still doesn't know any different

E-Four	**Improvement**	**Leadership**	**Involvement**
Staff Interviews	review and planning, quality control, audit, standards to maintain quality, government guidelines, consistency, correct clinical care in best possible way to meet patients needs, "CG is all about improvement" (Dr), best practice, CPD	(quality) control, ensure effective patient outcomes, pillars, risk assessment, umbrella term / framework, clearer expectations / requirements, health and safety, vast areas - it's everywhere (Dr)	maintain staff competencies / more education, communication, reflect on own work
Vision & Mission & Quality Account	✓	✓	✓
	Teamwork / Partnerships	**Cultural Changes**	**Customer Priority**
Staff Interviews	"CG makes you work together" (staff nurse)	most up-to-date research, culture to learn from things / incident reporting, CG part of multiple changes in HC, evidence-based practice	patient / carer feedback, meet patient needs, effective / best patient outcomes
Vision & Mission & Quality Account	✓	✓	✓

Comments	students are taught about CG, in theory doesn't mean much but in practice they'll understand (CG manager)

24.) Interview Tables: Perceived Effects (England)

	Improvement
Management	
- E-One	evidence-based care
- E-Two	CG should improve efficiency and did help to do so but not in isolation, same for transparency / openness
- E-Three	evidence-based, greater transparency thanks to quality measures, quality accounts are published by foundation trust, CG is needed, staff are at heart to improve efficiency, believe: genuine improvements and quality cost less, reduce readmission / pharmaceutical errors costs less, reduce admin burden and safer, reduce MRSA, but also costs: why have different regulatory bodies? this offsets savings thanks to quality improvements, GM elderly medicine: efficiency improvements generically yes for the NHS as a whole, NICE tips for added value treatments and medications - comes from CG, patient safety manager: CG not always boosts efficiency but should do if done properly as less negative outcomes occur, but problematic redundancies (like unnecessary additional paperwork that is required for external assurance, formal reports where internally an email would do), by preventing negative outcome there's nothing to measure - you can only do historical benchmarking but there's no way to cost it
- E-Four	CG is embedded part of practice - even before it was there - just more formalised today through white and green papers by the government, must improve efficiency to some extent, "if done badly costs more", e.g. if thrombosis happens the treatment costs more, ongoing education, good infection control
Consultants	
- E-One	n/a
- E-Two	one couldn't do without CG - aware of obligations towards customers and also the support / wide expertise that's available from other members (hospitals) / larger groups of colleagues, increased awareness of safety issues and risk assessment, we now reflect more on what we do rather than just doing, ensure to measure what we aspire to achieve, a lot more attention to risk management, before - we understood quality and risk but now CG gives a framework to crosscheck ourselves against standards by DoH that are more likely to be internalised and integrated into practice, documentation has increased the workload - do CPD and document it, CG has changed the face of medicine in the UK - it's missing abroad (seen during charitable work usually in Africa)
- E-Three	CG is needed, more time than at beginning of career for effectiveness and patient safety, horror stories from the past and it seems to have made a difference, cutting costs in NHS in general - reduce investigations to save money and achieve maximum effective use of resources
- E-Four	CG is needed - "as clinicians we are bad at looking at the generic things - just high-tech medicine", people are more aware of looking at what they are doing is the right thing - seeing the small important things - e.g. infection control: hand-washing - more overview / generic non-specialised work, CG supports improvement, audit (e.g. sentinel stroke) has improved a lot of things, "CG is all about improvement and it does happen", audit as a powerful tool for improvement,

Nursing Care	
- E-One	“loads of paperwork” and more managers nowadays than in the past, whereas not sure if this is good or bad, it would be difficult to take clinical governance away – “What would you replace it with?” – and everybody needs something to adhere to, boxes to tick, framework that makes work more ordered and organised, more efficient and responsibilities are signposted more clearly especially in terms of risk management, evidence-based care
- E-Two	CG is needed - quality has improved, couldn’t do without it, documentation is better, more accountability, evidence-based, consistency and transparency with new protocols, a lot of trusts only pay lip-service to CG, on the surface it seems like CG has an impact on the workload but if it's busy the paperwork doesn't get done / it's the first thing that's let down but we still have to be accountable - whereas another nurse says she doesn't even realise any difference, is it really CG that has improved care or management pressures or public? not sure - most of CG comes from within, difficult: a lot of good practice out there but also bad - hopefully overall getting better
- E-Three	CG has improved staff empowerment, in the past an autocratic matron said so and it was done: no monitoring / writing / questioning, now better as staff and patient are protected from harm / litigation - think why you do something and provide evidence-based care, CG is needed to a certain degree - "you need someone to guide you to adhere to trust policies etc" and it helps to reduce litigation, CG helps to meet targets / "do what we say we are doing" and monitors this, CG also filters government publications so that staff get most important updates, CG has changed job - heightened awareness - working practices are improved - new control elements / more measures - it's needed but might be less strict in the future, it's good to have feedback through audit - "daily stuff helps you to make things better", but CG also puts strain on time management: audit of mattresses a big loss of time / frustrating - quite new mattresses have to be condemned if a little tear that is no question of infection control / then not enough mattresses on wards for the patients - odd prioritising by manager that doesn't understand the work on the ward / not well thought through - focus needs to be on the patients!, modern matron: CG is needed as we are expected to have more evidence - more data crunching but not sure if the data is used to change things - CG impacts on workload but not a bad thing as it helps to focus on what is important
- E-Four	emphasis on evidence-based practice is new with CG, more staff education, audit is also new and more standards, CG is needed to always look at improvements and know what you are measured against - everything always changes, but documentation does take time, not sure if it's CG but workload has changed and fear of litigation is higher nowadays - health and safety is very much in fashion making work harder but also reducing risks - more meetings / writing / H&S requirements (e.g. hoist to lift patients out of bed saves patients backs but takes more time) - care is more transparent
Therapists	
- E-One	responsibilities are signposted more clearly especially in terms of risk management, increased documentation and structure are seen as beneficial for accountability and system thinking, organisation is more focussed and goal oriented, while the expectations towards staff are clarified. however, most of the projects and guidelines are common sense and reflect practices they had adopted anyway
- E-Two	CG is needed especially in the NHS - public is never going to be happy, CG helps to show learning from mistakes, CG protects

	from litigation, "it's great for me as I learn all the time" - constantly prove what you do and improve is the whole sense of CG, CPD - training up-to-date / evidence based / effective treatment
- E-Three	CG is needed, an "overall necessary evil" - important to have a measurement framework - know which standard you are aiming at, provides consistency within and between organisations nationally (e.g. infection control), CG should improve workload for staff but hasn't (depends on who comes through door)
- E-Four	audit is new and evidence-based practice, reading articles - effective reflection on your own work, CG is needed as it provides a structure that helps to make things work - it's everywhere so you can't really compare how it would be without it
Support Services	
- E-One	positive opinion regarding increased documentation – it helps to learn from mistakes by root-cause analysis, offers an opportunity for training and can be used to “protect your back”
- E-Two	leaflet and IT website are a good start to make tangible improvements, more paperwork that is demanded e.g. weekly attendance sheet for chaplains, not sure if because of CG or something else, surely CG is needed as a backup in case of complaints / non-consistent practice / communications errors with patients - if next shift doesn't know what previous one has done the patient might die
- E-Three	n/a
- E-Four	CG is needed even though it hasn't changed a lot (no impact on job) but there is more awareness about what good service consists of and how to improve it

	Leadership
Management	
- E-One	n/a
- E-Two	n/a
- E-Three	n/a
- E-Four	n/a
Consultants	
- E-One	n/a
- E-Two	n/a
- E-Three	n/a
- E-Four	n/a
Nursing Care	
- E-One	n/a
- E-Two	n/a
- E-Three	n/a
- E-Four	n/a
Therapists	
- E-One	n/a
- E-Two	n/a
- E-Three	n/a

- E-Four	n/a
Support Services	
- E-One	n/a
- E-Two	n/a
- E-Three	n/a
- E-Four	n/a

	Involvement
Management	
- E-One	n/a
- E-Two	n/a
- E-Three	CG gives staff a framework to work within to have the right skills / knowledge / competences to do their jobs, internet also gives them confidence and allows to share best practice through the NHS institute, hope that it gives job satisfaction - if you understand what and why you do it, you do it better and more gets done
- E-Four	n/a
Consultants	
- E-One	n/a
- E-Two	n/a
- E-Three	n/a
- E-Four	n/a
Nursing Care	
- E-One	n/a
- E-Two	n/a
- E-Three	n/a
- E-Four	n/a
Therapists	
- E-One	n/a
- E-Two	n/a
- E-Three	n/a
- E-Four	n/a
Support Services	
- E-One	n/a
- E-Two	n/a
- E-Three	n/a
- E-Four	n/a

	Teamwork / Partnerships
Management	
- E-One	geriatricians tend to be more team-friendly and respectful for the other professions involved in stroke care because the treatment of elderly patients requires this. further, another manager states that consultants and managers have developed a good relationship and that consultants are aware of operational pressures. CG supports “checks and balances”
- E-Two	n/a
- E-Three	partnership with clinicians to address patient safety / facilitate audit / support admin / do the number crunching so that clinicians can focus on their clinical work, multidisciplinary teams work well if good Dr leadership (depends on personality and how the service develops) - it's still new and needs time to embed and people to realise the need for it and communication about it to develop mutual respect, teamwork varies in areas - because of condition works well on stroke / cardiovascular / cancer but not in GM as nursing teams with different consultants that come in
- E-Four	in geriatrics it's impossible without multidisciplinary teams - integral to the speciality but has progressed into other specialities, too - different aspects / roles depend on different clients and how it is appropriate to the field, good results from audit like information sharing among staff
Consultants	
- E-One	agree with the view of the clinical stroke coordinator (nurses), see the team as a network to share knowledge independently from formal structures like clinical governance
- E-Two	concept of multidisciplinary teams is now embraced in more fields - more accountable
- E-Three	teamwork here is excellent but not sure if that's because of CG or local personalities
- E-Four	generally good teamwork because of stroke, a lot of mutual respect / good at conflict solving - stroke: patient requirements for teamwork - you know this before and don't chose it if you don't enjoy it
Nursing Care	
- E-One	“speciality might be a reason for being more down to earth”. agree with the idea of multidisciplinary teams. team approaches have changed over the last ten years with clinical governance particularly fostering the increase of communication within these teams. clinical stroke coordinator – in spite of being the link of the medical, nursing and therapy members of the team – puts a different emphasis on the role of clinical governance for teamwork. in their view, clinical governance does not per se foster teamwork. rather, it gives a lever for related discussions: specific issues come up during clinical governance meetings for which an action plan is developed involving multidisciplinary teams.
- E-Two	very good multi disciplinary team with others - typical for stroke, have to work together, developed over last 5 to 8 years, before not as good but did exist, lots of activities (also social) with therapists
- E-Three	CG helps team to be more efficient (it designs and communicates pathways and expectations towards care) but no effect on staff morale, CG can support teamwork but it's more how the team gets together - the speciality helps but also the will of team members to make it work, good team cohesion here - all want it to work which is a success for team and patients, team: this ward is good as OTs & physios & docs are always there - a lot to do with the

	speciality that requires teamwork, modern matron: here some good teamwork but line management structures don't support integrated working
- E-Four	good teamwork thanks to stroke (or maybe not ward specific but rather because people get along well or it comes from a higher level), CG supports teamwork, consultant nurse: teamwork is the very nature of stroke - in elderly care tend to work better more respectfully together - numb limb not just OT but all in joint goal-setting with the patient at the core of it
Therapists	
- E-One	clear link between clinical governance and increased teamwork – "more sharing between different professional groups that is really beneficial". a multidisciplinary, joined-up approach and team dynamics differentiate the quality of care provided by stroke-units from care for stroke patients on a regular ward. however, it remains questionable if this motivation and passion to make a difference for the client is connected with clinical governance – the therapists say: "call it clinical governance, quality management or whatever you want, this motivation is the key."
- E-Two	CG helps to build team relationships (no them and us but working towards the same goal) - depends on people, stroke more conducive than acute ward - here longer-term - mutual learning
- E-Three	CG should support teamwork - but professions have unique mindset / culture and CG doesn't fit in with all (link to issues), multidisciplinary working is better in stroke as patients are in a bit longer - condition supports teamwork - "lends itself more to it" by complexity of patient group - less medical more about nursing / therapy and rehab - even spread of tasks - but it has to be the people working in stroke too
- E-Four	teamwork between physios and OTs is good and also communication with nurses about progress - all have the same goal: do best job for patients
Support Services	
- E-One	"speciality might be a reason for being more down to earth". build the bridge between teamwork and the need for cultural changes. multidisciplinary work tends to cause less problems in elderly care than on other wards
- E-Two	CG reaffirms the importance of support staff
- E-Three	n/a
- E-Four	hard-working, busy but good and very inclusive team on the stroke ward, right people but also 'bondship' of people who have been along for a long time - yet always welcoming to newcomers, stroke is high on the government agenda - money gets put into it - this high profile makes a more proactive team

	Cultural Changes
Management	
- E-One	n/a
- E-Two	n/a
- E-Three	n/a
- E-Four	n/a
Consultants	
- E-One	n/a

- E-Two	record / report accidents (falls, wrong drugs) to organisation and patient - more openness and assessment of clinicians, more accountability of consultants for mistakes through risk mgmt
- E-Three	n/a
- E-Four	n/a
Nursing Care	
- E-One	n/a
- E-Two	n/a
- E-Three	n/a
- E-Four	n/a
Therapists	
- E-One	n/a
- E-Two	n/a
- E-Three	n/a
- E-Four	n/a
Support Services	
- E-One	n/a
- E-Two	n/a
- E-Three	n/a
- E-Four	n/a

	Customer Priority
Management	
- E-One	CG ensures more patients are treated per month, holistic approach to also consider minor issues such as exemptions from parking fees
- E-Two	overall improvement: better accommodation / quality care / informed plus more rights, more educated staff practicing more safely, patient feedback gets used and is dealt with proactively
- E-Three	hope: huge benefit, assurance that services are operated to a minimum standard across England, big drive to make systems safer, achieve greater learning, put patient perspective back in service delivery, received care doesn't do harm and is appropriate for patients, there is a proactive view of patient quality now, a lot of the improvements the patients won't know about as they don't see them (like bedsores)
- E-Four	CG improves patient safety by trained staff / sharing of good practice / feedback / complaints management
Consultants	
- E-One	“some things have changed and others not”. doubt that the overall quality of the services received by the patients has improved. whenever patient care is supposed to be improved other unforeseen consequences happen that make things worse. an example for this, the reduction of working hours for junior doctors – this way they are supposedly fitter for working but spend less time with the patients, thus learn less from them and consistency becomes an issue because of more staff handovers
- E-Two	my job is to see patients so I set priorities and miss a committee meeting rather than not seeing the patient, but overall we have to collect a lot more data so can see fewer patients but those that

	are seen are seen in great detail, it's very hard to prove but I would like to think that care is better thanks to CG, involve patient in clinical audit - now partners, seek views from a better informed public, ensured safe environment for patient, thanks to clinical audit: safer / more consistent / better quality care, in past different practice everywhere but no evidence for that
- E-Three	service provision was less patient centred in the past but this changes now with new education, CG is good to put different perspectives together and improves patient quality / efficiency and satisfaction with care - less infections / less public fear / high profile media campaign - higher public confidence, overall CG a good thing - no negative impact so far but also no comparison
- E-Four	CG makes you focus on the less exciting basic things that make a huge difference for the patient (like hand-washing), downside: it sometimes feels like too much time in CG meetings that would be better spent with patients, better infection control - make sure to not harm patient while in hospital - awareness, better incident reporting, CG helps "to ensure we do most we can for the patient", CG results in positive patient outcomes, patient surveys show they are well informed but are they really happy? no or less adverse outcomes but patient usually aren't aware
Nursing Care	
- E-One	generally positive view that clinical governance ensures customer-focused care and that staff is up-to-date about the current developments and improvements in their field. this has improved more consistent patient care that respects patient wishes also with regard to gender and age. one nurse, however, adds a slightly critical comment: increased paperwork takes staff away from “being hands-on with patients” and the focus has switched to “getting everything right on paper rather than spending more time with the patients”. the clinical stroke coordinator supports the improved patient focus by stating that “clinical governance is about the patient”. at the same time, s/he also acknowledges that the patients do not necessarily see these improvements: while changes in the hospital environment are immediately obvious even to the lay public, patients cannot easily judge changes – i.e. improvements – in therapy procedures that have been identified by clinical governance
- E-Two	all we want to do is care for patients - CG improves patient care (better journey) as it's more consistent but patients don't actually see CG as such, always talk about user involvement - best quality service delivered to the patient is what I want to see, patients expect and should be able to do so an evened out standard level of care, measure of CG: patient complaints went down = patient satisfaction - most people don't understand its importance that's why they drop it first when busy
- E-Three	CG ensures that patient needs are met - not one fits all but personal needs, people look up more on the internet (up-to-date practice) - patients are better informed and make more informed choices of hospitals, not sure if care is actually better but communication is better between hospitals and patients and families and carers, CG facilitates how education is taken up and guides to indirectly affect care (better / improved), CG plays the role of advocate for patients and good patient care as in appropriate people giving appropriate care (improved now!) in terms of patient needs AND official guidelines - weighing what you should be doing with individual patient needs, CG protects staff and patients through documentation (litigation vs. harm), thanks to CG patients have a say - complaints are listened to, sometimes patient should be more directly in the focus as highest priority of the service (as with mattress example under improvement) but to make things better for the patient overall is a good thing

- E-Four	hopefully higher quality services for patients / latest type of care / not patchy (consistent across docs and nurses), CG sets guidelines for best care which is great for the patients - there are probably + and - as always but overall CG improves the hospital stay for the patients, "CG is better for the patient 90% of the time" - higher standards and safer for patients and no-blame culture in theory (sometimes still covering up mistakes but no proof for it) is also good for the patients as mistakes are being dealt with, clinical governance makes you think how to get best for patients
Therapists	
- E-One	time-wise clinical governance requires some more effort because of the associated meetings. neutral opinion that some aspects have improved while others have worsened
- E-Two	CG makes sure that all get the same standard of care (safeguarding standards and constant monitoring of this) - protects from litigation and ensures patient gets best treatment, new idea of patient experience to take input from patients to improve
- E-Three	you'd hope that CG improves technical quality of care - cleaner / safer / proper qualifications, but for the patient experience it's hard to say if patients feel more satisfied, you get mixed responses - but CG should change this - at least seem quicker - there is more of a move to include patient experience in service development
- E-Four	CG takes you away from clinical work and you need to get the balance right between improving the service while still caring for the patients, overall: more knowledge - less risk which is good (more awareness, solve problems and have theory background to do so) and the patient benefits from safer and better care
Support Services	
- E-One	clinical governance promotes patient rights. this is probably linked to the Data Protection Act and a general phenomenon of the “society we are living in nowadays”. improvements in the experience of being in hospital, the journey is better – not necessarily the outcome. this involves better communication between staff and patients so that the latter understand more and can be included in decision-making for their own healing process in an empowered way. this inclusion makes the patients feel cared for and valued with respect for human dignity and privacy – especially for elderly patients. this inclusion also refers to relatives to ensure that patients do not feel like a burden.
- E-Two	multifaith-leaflets benefit the patients but they aren't displayed properly - patients are not aware, it's just a box on the wards
- E-Three	n/a
- E-Four	CG can improve the hospital experience for the patient

25.) Interview Tables: Perceived Issues (England)

	Improvement
Management	
- E-One	n/a
- E-Two	n/a
- E-Three	n/a
- E-Four	n/a
Consultants	
- E-One	n/a
- E-Two	n/a
- E-Three	n/a
- E-Four	n/a
Nursing Care	
- E-One	n/a
- E-Two	n/a
- E-Three	n/a
- E-Four	n/a
Therapists	
- E-One	n/a
- E-Two	n/a
- E-Three	n/a
- E-Four	n/a
Support Services	
- E-One	n/a
- E-Two	n/a
- E-Three	n/a
- E-Four	n/a

	Leadership
Management	
- E-One	n/a
- E-Two	CG starts to get more attention from the top again
- E-Three	n/a
- E-Four	n/a
Consultants	
- E-One	have the impression that the organisation is just trying to “cover its backside and diffuse responsibility to others” with documentation – for them the good reason would be to protect patients while they

	are convinced that the real reason is to protect the government, the organisation and the managers. the idea behind clinical governance is worthwhile pursuing to improve patient safety, but it should not "be used as a weapon to intimidate staff by asking unachievable things and transferring blame downwards to the coal face"
- E-Two	n/a
- E-Three	n/a
- E-Four	changes are management / DoH imposed
Nursing Care	
- E-One	nursing team-leader: the information flow about clinical governance depends on how the team leaders deal with it – they chose whether to take their staff to the meetings or at least inform them about the outcomes. there are no hierarchical motivations or incentives to participate and involve the team. the clinical stroke coordinator also highlights the role of personal interest and individual character for the success of clinical governance – they explain the success of stroke clinical governance meetings with the good leadership from the chair.
- E-Two	there are so many people above you and what do they do? It doesn't get explained, probably all government driven
- E-Three	some very senior people don't take governance as serious as they should (says modern matron)
- E-Four	CG is a good thing in principle but depends on who leads it
Therapists	
- E-One	impact of clinical governance depends on the willingness of the ward leadership to cooperate and to shape a team environment receptive to new ideas
- E-Two	n/a
- E-Three	n/a
- E-Four	n/a
Support Services	
- E-One	"clinical governance depends on personalities"
- E-Two	n/a
- E-Three	n/a
- E-Four	n/a

	Involvement
Management	
- E-One	general problem in cascading down clinical governance throughout the organisation, which is comparably well solved in stroke services.
- E-Two	training: e-learning package (last year 155 did it for CG, overall only 5 out of 3000 staff failed), part of induction, used to do workshops, there used to be CG meetings in every clinical directorate that have now disappeared, now directorate board speaks about CG among other issues - higher level of staff - still missing the lower levels, regular CG reports, all levels are involved in: clinical guidelines / pat info leaflets / audit, it tends to be key individuals - depends on their interest & understanding somehow also linked to their role, clinical effectiveness and patient safety committee meet once per month with

	representatives from all areas - mid-working level, a lot of staff would say that CG is really bureaucratic because they don't have the right awareness
- E-Three	challenge for them as added onto their day-to-day job, staff have to try to integrate CG, not sure the current model is that good - clinical staff used to buy in better into 7 pillars
- E-Four	risk management heads of subgroups go to CG meetings "well you know they are meetings…", but people seem to think it's worth it and important shown by good attendance, it's there for everyone: engrained in their work - including ongoing education / right infection control / medical management / audit / incident reporting
Consultants	
- E-One	are involved and integrated in clinical governance but also say: “we do learn – but not from the organisation, from ourselves”
- E-Two	involved as part of the medical directorate boards but "I'm not a policy maker", it's left to those who are really enthusiastic about CG, clinical audit becomes part of our work
- E-Three	training: formal awareness for safety learning opportunities, "we all have to be involved" - not on official meetings but doing hand-washing and all that, stroke - national sentinel audit / NICE / royal college of physicians - apply and deliver CG, new but doesn't clash with my philosophy of care - it's appropriate and worth it, CG is fairly engrained now as has been around for a while, as docs very little exposure to CG, nurses a lot more (e.g. infection control)
- E-Four	CG meeting every 2 months and involved in subgroups (risk - incident reporting), no training in general but specific training e.g. external tube to feed stroke patients (it's risky, look at it, discuss it, trial and train) - just emails with information attachment / on agenda in other meetings too, CG anyway engrained in job, reporting / traffic light system of standards for better health are frustrating and not helpful, CG is well integrated into daily work but competes with other commitments - there is too much work and you need to prioritise: e.g. adverse events handling is normal and also is speaking to patients and reducing infection risk - but managers might have different priorities, CG is medically (doctor) lead - also including nurses, everybody in CG but difficult to get nurses to come to meetings (understaffing and shift work)
Nursing Care	
- E-One	it would be good to have more training about what clinical governance actually is. do not feel involved and criticise missing communication by managers – even though most people have heard of it, only know more about it if go out to find out for themselves. nursing team-leader - one formal training session was delivered at the very beginning years ago, but new staff do not receive any additional training. clinical stroke coordinator contradicts her/himself: on the one hand, feel not involved in the big picture and do not understand it. also state that especially the stroke related clinical governance meetings are really productive and well attended by most employees. however, have the impression that more junior staff in general do not see the relevance of clinical governance
- E-Two	not really involved, get emails about new practices / printed emails on communication board (not all on mailing list!), no formal training but also not interested - don't know an awful lot about CG, initially not aware but the further into the career the more thinking about how it affects you, stroke nurse specialist: very well involved as responsible for clinical audit (stroke sentinel) - many conversations with CG, but most of CG is about myself / my own practice not about a department, most don't understand what CG really is - it depends on personality, not all will bother to

	proactively seek information about it, people always think it is something that someone does and don't see their responsibility for CPD, nursing policy forum checks documentation in cooperation with CG (nurses from all areas), specialist nurses might get more training, as a normal nurse lucky if involved in some research, historically nurses least academic - academic studies help to learn to think to take on board concepts like CG but: QM / standardised practice have started in nursing - nurses good at following guidelines / protocols (better than doctors) - but whole concept of being accountable is less common among nurses, doctors are worst for using standards of care, stroke nurse specialist: here we have a CG department but problem if you have an extra department - people on the shop floor invariably perceive it as something that someone else does not as everybody's responsibility!
- E-Three	nurse: CG - they are visible / attend meetings to support projects and make sure guidelines are met, CG is more engrained now - people have an awareness - the more aware the better integrated - CG needs to be engrained to work, no direct involvement in a formal way but there is a general newsletter and a notice board - sister goes and reports back to the others, no formal training in CG, "do it without realising you do it" - CG is well integrated into everything, it's individual how people take up education for improved practice, private interest is key - parent governor at school of kids so exposed to the concepts and in principal education and health are the same, relatively new concepts, no involvement here, in general nursing most active / aware of CG and thus more involved while consultants have a big say but do they want it? - CG more in nursing training, it's good to have more university but not sure if balance is right today - need for academic bits but hands-on stuff is missing - many use nursing as a stepping stone not actually wanting to do it - exclusiveness: bursaries / need for financial support from parents - nursing becomes a middle class profession while other people might be fabulous nurses, no big fan of university training because nurses are less or not interested in the basics (vital signs training is optional! not effective! but also regional differences between universities) but it's also good as they think differently and use evidence-based practice etc., didn't think that university bits were all that relevant - majority learned on the wards so spend more time there! at university more in-depth training about CG (not interesting, dry subject) that had to write an essay about, modern matron: involved every day being responsible for safe staffing and ensuring that staff have adequate skills (if not, training) / checks incident reporting and infection control and cleaning and date of cannula insertion / no overall training but specific on root cause analysis / court statements / leadership / fraud and confidentiality, division: HC assistant probably doesn't know about CG, nurses are more used to accept CG guidance, doctors have quite some personalities and CG is alien to them but start to accept it while not necessarily agreeing, modern matron: nurses are good at reporting / sharing learning / performance management - not sure other disciplines are as effective as they have different professional codes of conduct
- E-Four	examples of them vs us! consultant nurse: if generic like infection control let them sort it and tell me what to do, CG is perfectly engrained and "a habit now" - CG is part of your job and you have to do it (don't think what is the best for the patient? automatically doing it), CG effectiveness group - has too many meetings - not enough time for that - question of priorities if not enough staff on ward then can't go to CG meeting - senior sister goes to meetings and then discusses the stuff the other nurses need to know with them - information (leaflets / posters) in staff room, no CG general

	training but training on new specific things, e.g. national patient safety: check patient details against details on blood transfusion - follow the same standard - a few are trained and they then cascade it down, CG is a good thing in principle but depends on the people that get involved - some don't really think of it and just want to do the best , CG training at university - on ward more task oriented, involvement depends on personal interest - consultant nurse: competing priorities - if stroke specific yes (believes in and feels responsible for) but if generic like infection control let them sort it and tell me what to do, physios and OTs have more time for CG while nurses don't
Therapists	
- E-One	n/a
- E-Two	pretty involved: stroke improvement groups to keep up with government, pilot study to improve service, sentinel audit review, journal group among OTs, the organisation runs it - whether you participate or not is your choice, it's good to understand how an organisation works, own motivation - a lot you can do as an individual, went to visit another best practice hospital to bring back good practice into own organisation - private contact with hospital, identified through journal group, it's easy to not see CG, just day-to-day running is what you see, but I want to understand why - personal curiosity and conviction it is important to see the bigger picture, internal training - as far as I know no, short intro in corporate induction but didn't stick in memory so not too amazing, people don't tell you - this is CG, do it, a lot of people participate without knowing it is CG, people have to be involved in stroke development groups, CG does not change work for staff as automatically integrated into everything, very rare for docs and nurses to join journal group - probably because they don't have time and maybe also because they are taught differently, at the organisational level: you hear of CG then nothing etc so it is not so engrained / no consistent communication / feeding down of information - some better at it others worse
- E-Three	no training, just briefly mentioned during induction, ownership is bigger among nurses (also bigger body of people), challenging to get docs on board but important, therapists tend to get forgotten - e.g. dealing with commodes - nurses obviously involved but therapists get forgotten, here: therapists pushed for integration and involvement of therapy services, professions have unique mindset / culture and CG doesn’t fit in with all
- E-Four	all need to be aware of what's going on in CG and do what they have to do, one therapist is clinical lead for risk assessment (infection control - develop and improve), involved through CPD and audit, training: as students your supervisor informs you and then formal training at the hospital (compulsory when start and then every two years for everyone in the trust) but then it's up to you what you do (audit etc.) - also depends on how senior you are - more senior means more non-clinical stuff, i.e. CG, how you deal with extra-work to be involved with CG depends on personality (some stress and take work home, others don't), shift patterns make it difficult to participate in training, not sure how well informed about CG other members of staff are that have been here for longer, OTs seem really good at CPD and CI - training at university now really focuses on all that
Support Services	
- E-One	did not have any special training
- E-Two	not much involved as not enough time (would be detrimental) and to be perfectly honest not interested - but also own fault: CG not known in parish, not natural in that world, not used to quality control, more people focussed, all leaflets gone through CG this

	year - very hard to get approval, very angry with committee: turned leaflets down but 2 patient representatives were fine with them only the 2 staff reps wanted to take religion out of the leaflets to achieve the end aim of multi-faith, this felt to be arbitrary, why just 4 members in committee? small group has a lot to say about chaplaincy leaflet - do they even have a religion? too bad power change and after complaints to line manager it all got accepted!, good thing: now multi-faith material in there, over 10 years various courses but no memory of proper CG training, but problem for chaplains: how define what they do and how link it into CG?, thanks for having been asked, it is good to be heard - "what you do today is what I do in my job and it's really reaffirming", spiritual care is important also for non-religious people - it's mostly listening, but how to measure?, main function: listening and give people a chance to talk about the experience of being in hospital, not just functional but about hopes, dreams, worries, home life, families etc - difficult to keep records, just not natural to do so when you meet somebody on the ward (vocation vs job?), them vs. us: "what CG is doing, who THEY are, what THEY do" - "I don't really have to deal with them, just helped with one of their studies"
- E-Three	n/a
- E-Four	no involvement, CG training only informally, training is not just for docs and managers but for all

	Teamwork / Partnerships
Management	
- E-One	no nurse representative forms part of the World Stroke Organization
- E-Two	n/a
- E-Three	the relationship between docs and others tends to be conflictual but changing for the better with younger generation (working 45 hours instead of 100 hours before) - more acknowledgement of other professional groups that also have degrees (but still has to be balanced with hands-on training!)
- E-Four	n/a
Consultants	
- E-One	n/a
- E-Two	n/a
- E-Three	docs move on / nurses stay in one place for longer
- E-Four	no strong negative doctor characters any longer
Nursing Care	
- E-One	n/a
- E-Two	n/a
- E-Three	now nurses think that a lot of the former core tasks (see poorer nursing care under customer priority) are just to be done by untrained staff similar to dr vs nurses conflict but nurses vs HCSW
- E-Four	n/a
Therapists	
- E-One	n/a
- E-Two	n/a

- E-Three	n/a
- E-Four	n/a
Support Services	
- E-One	feel as though clinical governance was more out on the wards and question whether they were involved the same way even though they form a team with the ward staff. doctors feel like they were being God
- E-Two	consultants tend to see themselves as "Gods in white", chaplaincy usually seen as marginal in HC - great ignorance among other staff of what chaplains do in spite of leaflets/ staff induction training - not sure what else to do, depending on how people see health - if holistic then accepted, if just medical then no acceptance of chaplaincy - seen as a luxury that can be removed
- E-Three	n/a
- E-Four	n/a

	Cultural Changes
Management	
- E-One	agree with nurses saying: because of the rate of change in the NHS, clinical governance is often seen as “just another initiative”, frustrated by the organisational changes introduced by the government that make staff they have developed a constructive working relationship with just disappear. feel like their improvement projects went “one step forward and two steps back”
- E-Two	initiative fatigue: tick-box exercise a problem, resistance to change: "why should we change if it was always done like this?", productive ward - new quality improvement programme but: constant change vs sustainability, too many changes in the NHS so that one cannot say what has caused which effect
- E-Three	elderly care (rather than medicine) is nicest for human aspect - age group (but difficult to define as some are old at 50 others young at 70) with different needs, promote independence as much as possible, consultants and their professional ethos / perception of their own profession that they know better makes it difficult to move to a learning organisation with a no-blame culture, people that have been in the organisation for a long time resist change because it works as it is so why should we change?, a lot of initiative fatigue, CG is not recognised as a benefit but rather seen as a burden (occasionally even by the chief executives), culture of improvements has been developed but staff turnover makes it difficult to achieve permanent sustainable changes
- E-Four	n/a
Consultants	
- E-One	n/a
- E-Two	it keeps changing so much that we never get the best out of the system before it changes again
- E-Three	older person is nicer than others (aging and health also as topics out there)
- E-Four	older people most polite - but difficult: prefers older people and patients like it but among colleagues usually use elderly / geriatrics even though sounds like something wrong with them, CG as part of multiple changes in HC
Nursing Care	
- E-One	because of the rate of change in the NHS, clinical governance is

	often seen as “just another initiative”.
- E-Two	never liked geriatric - infers lack of cognitive skills, almost like children with specialist needs, CG is here to stay - has been around for 10 years
- E-Three	geriatrics sounds negative, elderly care or older persons' care is nicest but usually people don't like it because they don't perceive themselves as old / better in the US senior citizens, older person requires different skills: communicate effectively with patient and relatives / deal with Alzheimer's and dementia / calm agitated people / also empathy and patience and tolerance (important to appreciate these skills but unless you are experienced you don't see them) - different mind-set to appreciate small glimpses of patient improvement that is different if staff chose to work with elderly or just happen to
- E-Four	you can have CG ok on paper without any changes on the ward so that it turns into a ticking boxes exercise, elderly care better even though implies they are frail - not geriatric as negative connotation - personally prefers care of older person, when patient is dying you have other priorities than "ticking boxes for the government", no-blame culture in theory (sometimes still covering up mistakes but no proof for it)
Therapists	
- E-One	n/a
- E-Two	people don't like change especially in traditional organisations even if it's just a minor one to improve things
- E-Three	here called elderly - better than geriatrics (before, connotation of old and medicalised) - older people is best and more sensitive than the others
- E-Four	n/a
Support Services	
- E-One	speed of change with regard to government initiatives – “today it is clinical governance, tomorrow something else, maybe in the end it is all the same?”
- E-Two	n/a
- E-Three	n/a
- E-Four	privacy and dignity are very important when dealing with patients and patient data

	Customer Priority
Management	
- E-One	the clinical governance manager for stroke care explains the financial tensions and pressures: the primary care trusts want as many services as possible for the money being paid. need to find a more stable financial management system to avoid cycles of financial swings – at the moment a new deficit has developed and the organisation is in a “rush to achieve balance” again. apart from financial mismanagement, sees a problem in elevated public expectations of what health services have to deliver which causes more expenses than necessary. another manager agrees with this by saying that “finance is a frustration”. demands to set the right priorities in order not to pursue efficiency at all cost if “it is bad for the patient”. customer definition: patients, their families and the commissioners at the primary care trusts who pay for the services. however, does not like the connotations that come with the concept of a customer, as it is “too cold”. the notion of patient –

	especially in elderly care – includes comforting and the idea of being under the care of somebody. considering a patient as a patient and not as a customer or client changes the relationship – they are seen as a “person”. additionally to this differentiation, the clinical governance manager for stroke services also underlines that people who have had a stroke should be called stroke survivor, not stroke victim, in order to pay respect for the effort they have done themselves to recover. also demands to not address the spouse as the carer since this devaluates the relationship. another manager sees the need to expand the customer idea to include internal and external customers with the patient “at the heart”. thinks this understanding filters down into the wards, while intending to develop from a customer to a partner approach to carers, agencies (e.g. nursing homes, charities, mental health organisations) and social services - contrary to the manager's view that this holistic understanding filters down throughout the organisation, most staff only include the patient – predominantly over 65 years old – in their customer definition
- E-Two	customer: everybody who walks through the front door or phones in but on the wards it depends - understanding is very different, now integrated governance more than just CG / more and more squeeze on CG / financial governance priority because of government pressures even though CG should improve $$, too much workload for everybody to make CG work like it should, more ICT literacy (NICE, internet) causes problems: too high expectations - not just rights also responsibilities (drugs, alcohol, teenage pregnancies)
- E-Three	customer: "we all are" - internal (facilitate rather than actually doing) and external customers - ultimately the patient or service user - including the potential users in the local community (strong geographical focus), time and money are always a problem there's usually not enough time (CG as add-on to daily work) - it's difficult to get the split of resources right between central and wards, nowadays high patient expectations and information via internet
- E-Four	customer: patients and supporters / commissioners, the biggest barrier to CG is to have time to do it properly but if it's important time will be made for it, resources are finite - it's always an issue to have the right staff at the right time (not enough of either)
Consultants	
- E-One	carers and families also as customers
- E-Two	customer: patient and people that look after them (usually relatives) or more generally population of the area (residential and visiting), CG has made a positive difference but we are underfunded / -staffed so it is a bit remote unless there is enough money
- E-Three	customer is mainly the patient but also the PCT
- E-Four	customer: patients with stroke and TRAs and emergencies for elderly people / geriatric problems (majority 60+), era of recession and national debt - less is less not less is more so we need to do good basic care (i.e. nursing), cost conflicts with CG needs: length of stay is being more and more reduced - it will get worse with more staff cuts - common problem everywhere
Nursing Care	
- E-One	agree with therapists: there are not enough time and resources to train everybody and not everybody has the time and motivation to self-train. the clinical stroke coordinator more holistically includes not only the patient as the main customer in their understanding but also develop secondary customers from there, such as radiographers, GPs and other external service providers

- E-Two	customer: patients (main focus) and relatives (family and friends) obviously also staff you work with (role model for younger nurses), in nursing training nowadays not enough focus on patients - when directly from university on the ward you can tell who doesn't have experience - they have to learn how to make a bed
- E-Three	customer: patient / older person at the centre - modern matron adds relatives and everybody who comes into building including people from other departments such as doctors / physios / pharmacists, time and money are always a problem there's usually not enough time (CG as add-on to daily work) - it's difficult to get the split of resources right between central and wards, modern matron: there are other pressures that make CG be overlooked, e.g. when patient targets aren't met - patient safety not always a priority - counterproductive targets: 4 hours waiting time in emergency but when about to be breached patient will be transferred to wrong ward / same for ICU - in the whole CG is good but lots of competing factors such as capacity - norovirus patient should be separated but there is not enough space
- E-Four	customer: patient / relatives / friends / multidisciplinary team members, problem: patients are sicker / faster turnover but less nurses on the wards, the main problem with CG is that we have finite resources - there is more emphasis on gathering information but not enough money and people to implement changes, want to improve without cost because there is no time and money - dilemma: identify risk but can't do anything about it, would find on the job training for nursing more helpful than at university - do less essays it doesn't help the nursing rather examine the tasks - another nurse admits that you learn more on ward but it's good to have the theory behind - in the end you learn so much more when you start working because you are then specialised - consultant nurse: need to find better balance between ward training (too much responsibility too early) and university training - now not exploited on the wards / less dangerous but are they really qualified when they graduate? staff on the ward don't have time to help them (less resources) - university training is very academic and not enough hands-on / not enough responsibility, good ideas come up during CG meetings but not much time to implement changes - e.g. new drug chart audit, you know you should do it but not enough staff, in past drug documentation improved a lot
Therapists	
- E-One	agree with customer understanding of consultants while adding rehabilitation units and wards they go into, but they see the main problem in external pressures mainly of financial nature to “push patients through” as fast as possible. this is not caused by clinical governance, but it impacts on it because even though the willingness to be involved in clinical governance exists, there is not enough time to actually do so.
- E-Two	customer: generally everybody - enable people to function as independently as possible - here specifically work with clients (patients) and families and also the team
- E-Three	many customers: patients, also PCT, commissioners, PC providers, GP, agencies that refer patients in (nursing homes)
- E-Four	customer: patient / family / friends / ourselves (educational sense - learning from patients), biggest issue with CG: not enough time as CG is an extra thing / add-on to your work (nurses seem to find it difficult too) - set patient first and then attend CG meetings
Support Services	
- E-One	see patients, relatives and staff in general as their customers, agree with therapists: there are not enough time and resources to train everybody and not everybody has the time and motivation to self-train

- E-Two	customer interesting word, not readily comes to mind, chaplaincy as a consumer product? not thought of it before, primarily patients, relatives, staff important too (resource to them for personal crises and to help provide information for patients), strangers that walk through the hospital doors, no time for more CG: "I'm here for the patient and it would take me away from my main tasks.", the only full-time chaplain, problematic integration of chaplaincy into NHS organisations - business pressures not religious priorities
- E-Three	n/a
- E-Four	customer: patient and staff, biggest problem is lack of staff and money

26.) Interview Tables: 'Valued' Practice, Lessons-Learned (England)

	Improvement
Management	
- E-One	n/a
- E-Two	n/a
- E-Three	n/a
- E-Four	n/a
Consultants	
- E-One	n/a
- E-Two	n/a
- E-Three	stroke sentinel audit is a great tool that reviews quality over time
- E-Four	access to knowledge / journals so much easier now to keep up-to-date
Nursing Care	
- E-One	n/a
- E-Two	n/a
- E-Three	good about CG here: there is lots of information about very low infection rates and falls (says modern matron)
- E-Four	dot against right answer for documentation - really clear and saves time - impressed, at old hospital had to document when patient washed themselves (pointless) - now better as you only note key things like changing catheter (but maybe you miss something?)
Therapists	
- E-One	think that responding to local needs is key to improve the agenda for improvement and quality
- E-Two	n/a
- E-Three	n/a
- E-Four	n/a
Support Services	
- E-One	specialised committees and groups – such as clinical services support or patient experience – that feed ideas for improvement into the overall clinical governance structure so that improvements happen in different areas additional to the core medical services
- E-Two	n/a
- E-Three	n/a
- E-Four	n/a

	Leadership
Management	
- E-One	being known everywhere as the key to success of her/his role. handling clinical governance proactively, the clinical governance manager for stroke services ensures that tangible actions from

	meetings are taken. leads by example to gain trust. additionally, need for being passionate about clinical governance and improvement – “you never stop; nothing’s a problem, just a challenge”. “need for a champion to push things forward” – the clinical governance at the hospital is supported at board level. another manager: supports the importance of committed figureheads – such as the clinical governance manager for stroke services – to spread clinical governance in well-defined areas of the organisation
- E-Two	you need CG people to get out and work with front-line staff on a daily basis, important to have rapport / recognition / respect with staff - to know what you are speaking about as a CG person it helps to have a clinical background, whereas also good without because different way of looking at things, nursing background
- E-Three	plan to set up a project office for productivity to streamline which government input is inside already and identify biggest risk areas e.g. outpatients - re-model / engage patients / build patient safety into it, leadership buy-in makes CG work, it helps to have a clinical background to ensure evidence-based practice and challenge practitioners - do we do best for patients?, staff from ground are ok with leader without clinical background, Drs accept it if the leader is well educated, historically here many managers without clinical background - problem with people doing the same job that have a clinical background
- E-Four	look at risks within your means to prioritise efforts
Consultants	
- E-One	n/a
- E-Two	n/a
- E-Three	n/a
- E-Four	need a strong, strict leader
Nursing Care	
- E-One	n/a
- E-Two	n/a
- E-Three	n/a
- E-Four	n/a
Therapists	
- E-One	pick up the point made by the clinical governance manager for stroke services that successful clinical governance requires a corresponding infrastructure and hierarchy with supporting leaders at the top of the organisation
- E-Two	n/a
- E-Three	most CG people are on the wards too which is good
- E-Four	n/a
Support Services	
- E-One	n/a
- E-Two	n/a
- E-Three	n/a
- E-Four	n/a

	Involvement
Management	
- E-One	involves everybody inter-professionally. another manager agrees with her/him on the importance of involving everybody and adds to this the need to ensure that everybody understands what clinical governance means for her/his job. uses adequate language to communicate with all staff groups
- E-Two	engage them with enthusiasm and word of mouth that cascades down, show staff the benefits CG has for them and give the right information, education raises awareness, Drs are also good for CG here - most subcommittees are chaired by consultants
- E-Three	communication, dialogue, make sure people own / write the strategies they are responsible for, organisation supports staff when they want to pursue special training and it becomes part of CPD and appraisals, explain why what gets measured / done for CG (vision) and what it means, invest in training programmes to support a CG-friendly culture, CG provides mechanisms to challenge consultants
- E-Four	n/a
Consultants	
- E-One	n/a
- E-Two	meetings can be short / frequent or longer / infrequent but it's important that they are focused
- E-Three	n/a
- E-Four	n/a
Nursing Care	
- E-One	n/a
- E-Two	it is better to be involved than getting things thrown at you - you can think it through
- E-Three	comments book for patients and relatives is really good and helpful - getting positive and negative feedback is good for staff morale, induction week at hospital (very helpful snapshot) included a 30 minutes slot on CG (power-point and handouts) - you know it's important (can relate it to your care) and you have to do it
- E-Four	n/a
Therapists	
- E-One	in general, “the will is there” to develop improvements and to seriously think forward to anticipate consequences
- E-Two	it helps to have been trained with this mind-set at university
- E-Three	n/a
- E-Four	different pockets of people work on small subparts and every two months all get together to join up the work - department balances it well, good at providing internal training and fostering pro-active self-education, one therapist attends trust board meetings and communicates the results to the team
Support Services	
- E-One	mention the need for understanding amongst staff about clinical governance and good drivers to motivate everybody, foster the spirit of improvement and clinical governance. with regard to the clinical governance reports, like the fact that these reports also highlight what goes well – a good source of motivation for staff.
- E-Two	n/a
- E-Three	n/a

- E-Four	n/a

	Teamwork / Partnerships
Management	
- E-One	n/a
- E-Two	n/a
- E-Three	it's all about partnerships and communication - all have their part to play, nobody is more important than the others, as managers try to balance all admin so that clinicians can focus on their job, training on human factors in processes for staff to overcome hierarchy and develop teamwork (multidisciplinary) - really good to get all sorts of impetus, get the staff balance right (do more with less - there is not enough money)
- E-Four	n/a
Consultants	
- E-One	n/a
- E-Two	concept of multidisciplinary teams is now embraced in more fields - more accountable
- E-Three	team: talk a lot, cannot agree all the time but try to move forward as a team, share values of patient safety, new meeting on mondays and wednesdays for 20 minutes to have a catch-up between the disciplines - helps to get patients through more quickly - all are aware of problems in almost real-time - not sure who introduced this
- E-Four	n/a
Nursing Care	
- E-One	support the need for a common language – sometimes doctors and nurses do not understand each other immediately, but they do not see this as an issue as long as they are “not talked down to”
- E-Two	german nurse: it gives nurses more credibility and a better standing among the team when you have a degree
- E-Three	n/a
- E-Four	n/a
Therapists	
- E-One	n/a
- E-Two	n/a
- E-Three	n/a
- E-Four	it's good as therapists to just work during the day - better than work times for e.g. nurses
Support Services	
- E-One	n/a
- E-Two	n/a
- E-Three	n/a
- E-Four	n/a

	Cultural Changes
Management	
- E-One	do not take resistance personally, but this requires *"having broad shoulders"*. to achieve the more difficult task, proceed incrementally instead of trying to solve everything in one go.
- E-Two	key: find the right enthusiastic people that drive things
- E-Three	CG drives the organisation forward - should and does underpin what we do / a framework to make things better within a no-blame culture that learns from mistakes, to make change happen make sure consultants think its their idea ("like husband"), need to change culture and shift accountability: e.g. risk assessment - have a central support team but let people on the ward do it themselves, identify key people to facilitate the change, pull regulatory card - we need to do this or we get into external troubles, involvement in change - demonstrate how it makes their lives easier, e.g. nurses against PC but easier to print-out wrist-bands / stickers instead of hand-writing them - they have taken up the change now - e.g. stroke big national priority - PCT comes up with a new measure - not yet captured - plan with Drs to see how to implement
- E-Four	n/a
Consultants	
- E-One	n/a
- E-Two	n/a
- E-Three	CG changes the structures but here is a will to change
- E-Four	it's friendly here - everybody is helpful - good culture - it helps that everything is in one unit, culture to learn from things
Nursing Care	
- E-One	share the view of support staff regarding no-blame culture
- E-Two	n/a
- E-Three	n/a
- E-Four	it's good to have a no-blame culture, show staff what and how things have changed thanks to CG
Therapists	
- E-One	n/a
- E-Two	good place to develop, showing that people are already doing CG helps to take fear away
- E-Three	n/a
- E-Four	n/a
Support Services	
- E-One	working in a no-blame culture that enables learning from mistakes offering opportunities for training
- E-Two	n/a
- E-Three	n/a
- E-Four	n/a

	Customer Priority
Management	
- E-One	n/a
- E-Two	n/a
- E-Three	try to integrate different aspects - e.g. patient safety into infection control using PDCA and have people like me (patient safety manager) to facilitate and help to make it happen, quality has to be at the fore even in times of financial difficulty but hard to make the business case for quality - you need formal structures to keep it on the agenda
- E-Four	n/a
Consultants	
- E-One	n/a
- E-Two	FAST stroke initiative to increase public awareness about stroke and its symptoms
- E-Three	n/a
- E-Four	n/a
Nursing Care	
- E-One	n/a
- E-Two	n/a
- E-Three	n/a
- E-Four	n/a
Therapists	
- E-One	n/a
- E-Two	n/a
- E-Three	n/a
- E-Four	n/a
Support Services	
- E-One	n/a
- E-Two	n/a
- E-Three	n/a
- E-Four	n/a

27.) Interview Tables: Suggested Improvements (England)

	Improvement
Management	
- E-One	need for information and data governance, but in a slightly different sense. see a need for the collection of process and outcome data to enable Benchmarking. gaining comparable data is really difficult and Benchmarking should be done by commissioners rather than by provider as they are more neutral.
- E-Two	record keeping has to improve, have qualitative not just quantitative reports
- E-Three	need to consolidate paperwork and requirements for HC quality - people sometimes seem to think that adding more paperwork helps
- E-Four	n/a
Consultants	
- E-One	n/a
- E-Two	n/a
- E-Three	it would be good to have a similar tool like the stroke sentinel audit in every field to do more Benchmarking - shared standards and views are helpful
- E-Four	less paperwork - feasible as a lot of duplication and not focused enough, "IT is debilitatingly slow and complex" - get it up-to-speed to be useful for staff
Nursing Care	
- E-One	n/a
- E-Two	n/a
- E-Three	n/a
- E-Four	management and measuring are problematic - as long as you hit targets it's all fine, but very nebulous not true measurements (meaningless), e.g. saving patient lives audit - cannula: did person putting it in wash hand before?, you don't know for sure all the time but just have to say yes - with hand hygiene it's important to raise awareness and highlight the need but the score is meaningless, you just have to make sure the figures look good, a more meaningful score is that there is not many MRSA cases
Therapists	
- E-One	n/a
- E-Two	it's generally never completely well running - there are always many stroke improvement projects
- E-Three	n/a
- E-Four	n/a
Support Services	
- E-One	the number of policies and procedures needs to be reduced as it is questionable whether they actually get read. information governance should guide staff to where information can be found when needed. the complicated, non user-friendly style of how clinical governance related documents are written needs to change
- E-Two	do more qualitative work / research about what chaplains do - look at chaplaincy standards and how they have changed since

	appointment, "measure what I do with a qualitative tool would help me improve what I do.", uses a lot of volunteers in chaplaincy (40+, probably more than in other departments) would have to be distinguished in measurement
- E-Three	n/a
- E-Four	n/a

	Leadership
Management	
- E-One	n/a
- E-Two	we need to get back on the quality agenda, this has to come from high-up, board needs to be aware of quality issues and put importance to it
- E-Three	need to tick too many boxes - too many agencies that want information / have requirements - so complicated to balance it all - cut out duplication to match national and PCT requirements with local needs - would like to see more unification of the regulatory framework to one single framework for what it takes to be a good trust - clarity for how to do performance management - set and ascertain standards - saves money, engagement by leadership to show that quality is number one, leadership-walk-rounds need to also include non-clinical areas, we are good at identifying problems but we don't do action plans (partly because of bad leadership, partly turnover of staff)
- E-Four	n/a
Consultants	
- E-One	the DoH issues too much information to be considered in clinical governance and there is not enough time to deal with this. most initiatives are well meaning but not thought through: for instance, the reduction of A&E waiting times to four hours is theoretically a good idea. but this often results in patients being admitted into hospital and staying over night in order not to break the four hours rule even though they just require out-patient emergency treatment or they get admitted to the wrong ward. most policies, like this example, remain unachievable – also because the less known ones cannot be easily accessed when needed as they are too long to be carried along on the ward. clinical governance is too politicised – the media are highly involved and the DoH responds with a “knee-jerk reaction” to an ill informed public opinion.
- E-Two	government should not just say what but until when and how, make it relevant to people
- E-Three	n/a
- E-Four	time management and prioritisation to ensure important things get done - there is just too much to do, there are too many initiatives and not sure if they help at all
Nursing Care	
- E-One	clash between the idealised clinical governance world and the reality on the wards. it is good to have a standard agenda for clinical governance meetings, but the structure does not reflect the needs, concerns and the work of the nursing teams. apart from this, everybody seems to interpret them differently.
- E-Two	not enough people (clinicians and managers) understand the whole CG concept, it may have worked better had it been better packaged in the first place - very jargonistic, difficult to understand - make it tangible

- E-Three	staff need to know what needs to improve but also need to be praised for what they do good! not where we stop it but what do we do about the control? how much central control do we need from the government? too many controls to really individualise CG locally (now: not enough local focus), gives a negative picture to the public to have too many regulatory bodies that all collect the same data in different ways with different analyses - be slicker in getting information together - people can access internet etc - harmonise and localise CG, managers don't necessarily understand the way a ward works
- E-Four	CG lead as main job not just add-on for somebody as this makes it difficult to focus
Therapists	
- E-One	n/a
- E-Two	"managers should come down and actually get their hands dirty on the ward"
- E-Three	n/a
- E-Four	need to align trust and departmental objectives, there is so much to it that a lot of people don't know what CG is - needs to be changed
Support Services	
- E-One	n/a
- E-Two	nobody has ever asked to see the control charts - why do them?
- E-Three	n/a
- E-Four	n/a

	Involvement
Management	
- E-One	n/a
- E-Two	at beginning: customer service training - might be brought back, should be reinvigorated, question of courtesy / manners, CG has to be covered in students training especially for nurses as the biggest part of the workforce and make the link to practice
- E-Three	staff say too busy for documentation but crucial to have it - your word against the patients' - show them with real cases that it is important - streamline it but also include all the important aspects, we need to help support staff make the link between their work and CG - need for more education, use the right language - quality is understood, patient safety not necessarily, don't call it CG - call it quality and improvement, it's more tangible for people, lack of skills around quality improvement - people can't design a form on PC - not good at technical stuff (medicak records are better in Africa than here - e.g. e-prescribing) - training is key also to challenge current practice
- E-Four	n/a
Consultants	
- E-One	clash between the idealised clinical governance world and the reality on the wards. “clinical governance people live in a separate world” and “real life goes on but clinical governance looks in a different direction” – its aim is to provide completely risk-free care which is impossible to achieve
- E-Two	regular training of staff at all levels - better training on audit (how to) / data collection, one to one tutorials

- E-Three	only hazy understanding / idea / concept of CG - it would be good to know more about it
- E-Four	n/a
Nursing Care	
- E-One	clinical stroke coordinator: need for clinical governance to be more open to everybody, for instance by broader circulation of better summarised minutes of meetings that would ideally invite and motivate more staff to attend and get involved. there are no incentives to involve lower level staff in this way – this needs to change. it would be good to have more training about what clinical governance actually is. clash between the idealised clinical governance world and the reality on the wards. it is good to have a standard agenda for clinical governance meetings, but the structure does not reflect the needs, concerns and the work of the nursing teams. everybody seems to interpret them differently.
- E-Two	it would be better if all were on the mailing list for communications so that understanding, awareness and involvement are supported, would like to know more about it to be able to judge it, not everybody knows what CG is doing even though it's important - more training and communication, CG is a big word - there is just a few posters around about it, internalise CG as everybody's responsibility by training and communication and more individual commitment to audit would come if people understood CG by being given tangible examples to realise how they are doing it already - key: training development and education, but another nurse points out that this will be almost impossible anyway because of lack of time, maybe better through e-learning modules, CG is needed as a mind-set, not to be put in a box - it is better to call it CG support department as CG department infers that they do CG while it's about everyone
- E-Three	it seems sometimes that CG is like a king that oversees it all without interfering too much (comment by researcher: reflects them vs us!), staff need to be taught how to deal with complaints and learn from them this way enhancing knowledge and skills to provide better care, more input into CG from the wards would be good
- E-Four	you don't always have to be on the meetings - there is internet and all sorts of other ways that would be possible, many members of staff aren't involved or don't realise they are - increase awareness and real involvement, maybe people need to be made more aware of CG - more regular communications would help as especially older staff are not so used to research etc, CG needs more awareness and people understanding what it is - it's a huge buzzword and people assume you know what it is - the term is used so much - people think they know but probably don't - supported by consultant nurse comment: one of these words that started to get used but no training
Therapists	
- E-One	it is difficult to recruit the right people for the available jobs and to keep them. the organisation does not invest in people.
- E-Two	too many buzz words - if information was better people could choose to use it, documents / guidelines are theorised and many things are not realistic / appropriate - test it on the wards before implementing
- E-Three	CG is about individuals delivering good services not about bureaucracy and meetings - CG shouldn't take people off wards (exception: incident follow-up) - day-to-day activities should be embedded and just special audits etc should take more time, try to engage people delivering the services to improve them rather than just doing CG at executive level - needs to evolve, also involve non-clinical staff - just as important! make it "sexy" / interesting /

	meaningful by making people see the effects resulting from quality initiatives and communicate this (e.g. "I had this idea and it got implemented")
- E-Four	there is so much to it that a lot of people don't know what CG is
Support Services	
- E-One	“clinical governance information does not get spread everywhere”. formal information governance should bridge the gap between theory and practice to aid meaningful development of clinical governance from both a managerial and a clinical point of view.
- E-Two	would be good to have relevant CG training for what I'm doing - it's difficult to see relevance of quantitative training when working qualitatively
- E-Three	n/a
- E-Four	n/a

	Teamwork / Partnerships
Management	
- E-One	n/a
- E-Two	n/a
- E-Three	get senior medical people on board - it's a slow game with them as they think about it at individual not strategic level, support staff don't understand their importance in CG
- E-Four	n/a
Consultants	
- E-One	n/a
- E-Two	n/a
- E-Three	junior doctors need to fight with consultants to get MRSA test done - it should be more straight forward - if known that definitely needed, go for it
- E-Four	it would be more effective to have stroke nurse and CG administration in one person to support the speciality and help to develop CG, communication needs to improve (too many shift changeovers)
Nursing Care	
- E-One	n/a
- E-Two	n/a
- E-Three	CG could help to improve line management structures to support teamwork for integrated working - seamless service will improve patient experience / reduced length of stay / less risk of hospital acquired infections
- E-Four	HC assistants don't get any CG training but should be informed about it too as they also have patient contact
Therapists	
- E-One	n/a
- E-Two	n/a
- E-Three	CG should provide a forum to get staff's problems solved, need to improve pathways through the whole NHS including social services, PCTs and trusts - initiatives have started for this
- E-Four	it would be good to have non-clinical support to teams to put data together etc

Support Services	
- E-One	feel like a “spectator who sees more of the game” than the players, i.e. the clinical personnel on the wards. non-clinical background allows not to be afraid of looking foolish by asking questions. because of working with all the different departments, have a better overview of what is going on in the organisation than most clinical or administrative staff. this is quite valuable, but can seem to be dangerous for other members of staff. the management of the organisation should more consciously use this overview and detailed knowledge about the functioning of the organisation. crucial to further develop teamwork practices to move away from the idea of “doctors are being God”
- E-Two	n/a
- E-Three	n/a
- E-Four	n/a

	Cultural Changes
Management	
- E-One	n/a
- E-Two	don't put more change on NHS - it takes time to properly implement initiatives, report when things go wrong - accountability needs to be brought to the fore
- E-Three	awful lot of changes happening in the NHS - need time to embed them, needs to be de-politicised, organisational learning needs to improve - forums are needed - people don't see the link to other areas where there is one
- E-Four	n/a
Consultants	
- E-One	n/a
- E-Two	n/a
- E-Three	n/a
- E-Four	n/a
Nursing Care	
- E-One	n/a
- E-Two	n/a
- E-Three	trust perspective: not that much specific input for CG - don't fire-fight
- E-Four	n/a
Therapists	
- E-One	in a general manner change is difficult to achieve in a “huge size machinery”, such as the NHS. too many changes have been imposed recently. for instance, the name of the service has changed three times in three years. as soon as it gets more stable, work gets better with the right people in the right places to build rapport with.
- E-Two	n/a
- E-Three	n/a
- E-Four	n/a
Support Services	

- E-One	the pace of change should be reduced so that the relevant cultural changes can happen on the wards and not just on paper. cultural change should introduce more management training for consultants and avoid specialisation and separation in favour of cooperation and synergic use of skills. however, the organisation has to try to influence behaviour and be aware that “things change slowly”.
- E-Two	n/a
- E-Three	n/a
- E-Four	n/a

	Customer Priority
Management	
- E-One	initiatives should also include aspects of stroke prevention to raise awareness among the public so that stroke patients are recognised as such and receive adequate treatment as soon as possible to prevent brain damage.
- E-Two	n/a
- E-Three	nationally we have a target driven culture that has improved infection control (MRSA is lower now) but patient falls is a huge issue and nothing is done about it strategically - how to persuade people to report mistakes and also near-misses?, people think that more quality requires more staff but they just need to work more efficiently, especially in elderly care a lot of staff don't care that much about the patients as they will die anyway and don't challenge practice that much - issues of dementia / dealing with confusion, national targets are good for the patients but they are not linked to CG - also infection control and CG really close topics but separate, complicated drug therapies and treatments - need to be academically trained to understand cochrane reports etc - but balance not right - need for more practical not just academic training - e.g. you need to read body language to suggest pain killers (can't learn in class room) - nice electric gadgets but if power fails you need to be able to take blood pressure and pulse etc. - you are missing out on the feeling (how does pulse, skin etc feel like), we are very good at asking about TV / food / parking etc but still room for improvement on how was the doctor / treatment / did you understand it
- E-Four	continued access to nursing staff levels would help - staff gets transferred temporarily to mitigate risk throughout the whole trust
Consultants	
- E-One	appropriate costing of policies and initiatives in terms of manpower and resources including anticipating adverse events and related costs. the realisation of policies and initiatives should depend on this. compare this to the introduction of new drugs that have to be cost-effective, are clinical governance policies and initiatives as rigorously tested?
- E-Two	money in order to improve staffing levels so that time to focus on patient, FAST stroke initiative - research the awareness achieved
- E-Three	n/a
- E-Four	need to tie it back to patient care again - what you do and what effect it has - in the daily routines you lose sight of that, independent geriatricians used to come in to do Benchmarking before to look at the patient journey - should start again, CG keeps you off the ward too much - need more nurses / money and training then we wouldn't need any CG as we would do a better

	job
Nursing Care	
- E-One	n/a
- E-Two	n/a
- E-Three	modern matron: would like to see when things get pressured, capacity gets tight - governance doesn't get jeopardised: do proactive discharge, more capacity, better capacity planning at night - sometimes on the surface it looks good but underneath things are not ideal - e.g. hit 4 hours waiting target but embarrassed to see how patients have to wait, nursing staff: now care and CG is very academic - it used to be very hands-on when trained
- E-Four	need for more time and resources to be able to implement changes / more nurses on the wards: very sick complex patients and not enough nurses to deal with them (you have to cut corners and set priorities that you are not happy about at the end of the day) - situation will probably get worse over the next years, when you come from university it's all still fresh in mind but on the ward there are other distractions from focussing on CG
Therapists	
- E-One	n/a
- E-Two	n/a
- E-Three	CG hasn't solved the capacity problem - never enough beds
- E-Four	more resources would be good
Support Services	
- E-One	n/a
- E-Two	it would be good to have a welcome leaflet for patients with chaplaincy in it and put a leaflet in each locker, problem: not enough time
- E-Three	n/a
- E-Four	n/a