Leadership in healthcare: from bedside to board

EHMA ANNUAL CONFERENCE 2014

24-26 JUNE 2014

University of Birmingham

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ABSTRACT BOOK

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Tuesday 24 June

10.00-15.00

Preconference Symposium “Global Mental Health and the situation in Europe - How can we work together to improve our service?”
The Mental Health Departments in Italy: the today role and future perspectives

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Context
Over the past thirty years, psychiatric care in Italy has experienced a profound change: in 1978 a Law promoted the abolition of psychiatric hospitals and the establishment of services units with a limited number of beds. During nineties, Mental Health Departments (MHD) were established within Local Health Units to improve out-of-patient mental health services. Albeit this location, MHDs have been always almost isolated from the LHUs’ governance. Thus, today MHDs presents a high heterogeneity in terms of services directly provided and managed and their networking relationships with private providers and other professionals.

Methods
The study design develops an explorative analysis aimed to: first, clarify what MHDs’ core functions are; and, second, to what extent the local and the regional health systems’ organisation have influenced over the MHD configurations. The study is structured in two phases. A desk research to gather information around the policy and organisational development of MHDs at the regional and local level was carried out, based on legislation and other grey literature. Secondly, a national survey was run including all MHD. The questionnaire submitted to MHD Directors centred on the organisational assets and the core function and services provided as well as some questions to detect the governance relationships with the LHUs they belong to and the Regional health system. Finally, questions over the local health economy were added to estimate the role of private and third sector providers with the mental health market.

Results
The desk research proves the puzzled scenario of MHDs in Italy, with high heterogeneity across MHDs even in the same region. Whilst the national ministry action on mental health in 2013 sought for listing at least a set of priority actions and services to be guaranteed as well as it put forward the need for developing a clinical governance within the local health systems, such objectives undermined the today situation. Some Regions autonomously strove for re-organising MHDs by mimicking other health sectors, but mental health presents two distinguishing features: a path-dependency to the de-institutionalisation movement of the seventies (community psychiatric tradition) that is flagged by part of the professional community, whereas it has limited its role in the health policy and management developments; and the strong embedded-ness within the local health economy. The latter causes the actual MHDs’ heterogeneity more than the policy and organisational variables of regional health systems.

Discussion
The value of the research relies on its first attempt to deal with the heterogeneous situation of MHDs at the national level. The survey conducted provides some useful tips to address yet the policy debate at the regional and LHUs levels around the strategies to include MHDs in health and social delivery system; yet it poses key issues for the psychiatric professional community to make it joining such debate. The mental health governance has come on the top of the political agenda in today society and there is a worldwide need of its deeper understanding from the policy and managerial perspectives. Mental health patients are increasing dramatically, because of the spread out of psychosocial and behavioural disturbs as well as the effects of multiple chronic conditions and drug consumption. Finally, there is a core ethical issue as mental health patients often belong to the most vulnerable segments.
Tuesday 24 June

10.00-12.00

Special Interest Group (SIG) on Best Practice in Management
Process optimization in the Emergency Department by the use of Point-of-Care-Testing (POCT): a best practice example from Germany

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Context
The number of patients admitted to A&E at German hospitals has increased by 16% in recent years, so optimizing work processes plays an important role when it comes to providing adequate patient care. Until now, however, sending samples to an external central lab for analysis has been an unavoidable component of the diagnostic process. Results can take a long time, even in acute cases, and can lead to delays in treatment. The concept of point-of-care testing (POCT) is based on efficient lab diagnostics in close proximity to the patient in A&E and is designed to prevent these delays.

Methods
The Center for Hospital Management conducted the so called NAPOC study. In this study the turnaround time (TAT) for clinically important laboratory parameters were compared in three different settings: (1) ED with POCT; (2) Centralized Laboratory in the hospital; (3) Laboratory not in the premises of the hospital (external laboratory). In the POCT-Setting a technology was used that measures cardiac, coagulation and infection markers in a single sample. Time-consuming sample preparation is unnecessary as mixing and analysis occur automatically, so specific lab parameters such as troponin levels or raised D-dimer are determined within minutes. The results decide the urgency of patient treatment.

Results
For the ED, the consequences of implementing POCT are a reduction of LOS of AMI patients of 40-60 minutes and optimization of the use of the examination/treatment beds. POCT reduces the risk of transferring patients to the ICU where the daily costs per bed lie between 1.000 and 1.200 Euros. In addition, patients receive individually targeted treatment earlier; an important step for better outcome.
The NAPOC study also shows that POCT technology improves the ED physician's control of the diagnosis processes and makes it easier to schedule the next medical steps. The variance of TAT for Troponin T is reduced to 13-34 minutes with POCT compared to 40-60 minutes with a centralized laboratory.
Another parameters like natriuretic peptides (clarification if a dyspnoea is of pulmonary or cardiac origin), TSH (decision criterion for the use of imaging procedures), Creatinine and D-dimer were also compared and evaluated in favor of POCT.

Discussion
Quality and efficiency of emergency care depends directly on a timely laboratory result. The proportion of the laboratory medicine in the diagnostic process is as high as 70%. For shortening the laboratory TAT, time-and therapy-critical parameters can be advantageously determined with POCT devices. The primary aim of the POCT concept is to optimize the diagnostic process and, as a result, to assure adequate patient treatment. Fast analysis using POCT-technologies also helps process optimization and therefore saves costs. Efficient primary diagnostics help reduce the use of available, and sometimes limited, resources. Examination results produced quickly on site can, for instance, help avoid protracted CT or MRT procedures, and immediate diagnostics also prevent patients from being allocated to the wrong ward, or prolonged stays in a crowded A&E. POCT-technologies also enable parallel determination of multiple parameters in short sequence, significantly increasing the number of results over a defined period.
Process optimization in the Emergency Department by the use of Point-of-Care-Testing (POCT): a best practice example from Malta

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Context
The main aim of this study is to assess the potential benefits of two patient-side point-of-care tests (POCT) at A&E Department of a Maltese tertiary-level hospital. In POCT, diagnostic testing is conducted at or near the site of the patient, thereby enabling earlier diagnosis and faster medical decision-making in the management of acute patients. The first POCT considered in this study is medical ultrasonography, focusing on two life-saving conditions, namely abdominal free-fluid post-blunt trauma and abdominal aortic aneurysm. The second POCT is blood testing for arterial blood gases and electrolytes for early diagnosis of respiratory failure and life-threatening electrolyte imbalance.

Methods
Using multiple case study approach and methodological triangulation, Data on the use of POCT ultrasonography, arterial blood gases and electrolytes in the above-mentioned clinical conditions were collected from A&E registers and patients’ records for the year 2013. Additionally, semi-structured interviews were conducted with emergency doctors, physicians, and surgeons involved in the management of a randomly selected sample of patients.

Results
This study shows clear examples highlighting the effectiveness of POCT in life-threatening conditions. The results from A&E records show ample evidence of the benefits arising from immediate diagnoses of life-threatening conditions. Indeed by shortening the time towards achieving definite and potentially life-saving diagnoses, the morbidity and mortality of the patients in the study were substantially avoided. Additionally, the data from registers and patients’ records of faster decision-making and patient management were substantiated by the qualitative data from elite semi-structured interviews with caring physicians and surgeons, as well as with emergency doctors, who were the POCT users in this study. The Maltese A&E department, in line with practices adopted in emergency departments in developed countries, recognises that POCT systems can improve the efficiency in the use of resources, improve patients’ safety, as well as decrease the throughput times for patients attending the department.

Discussion
A major problem currently being faced by this hospital is the small size of the A&E Department, in which the demand-supply gap is progressively widening due to the ageing population, and the increasingly more complicated poly-morbidity patients. POCT will help in categorising patients into those requiring urgent care as opposed to others whose findings are negative, and therefore can be immediately ruled out from the admissions pathway. Additionally, POCT ultrasound avoids the transfer of patients from acute care settings to radiology, thereby preventing complications associated with transfer of critically ill patients. For example, ultrasound directs the patient straight to theatre if free fluid is found in the abdominal cavity of a blunt trauma patient. Serial assessment of blood gases helps to alter and fine-tune the management of respiratory failure, thereby improving clinical outcomes. The same applies to life-threatening electrolyte imbalance, which can be immediately corrected by serial testing.
Tuesday 24 June

13.00-15.00

Special Interest Group (SIG) on Primary Care
Management and leadership in primary healthcare: coping with innovation and integration challenges

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Context
The creation of health centre groups (ACES) following a primary healthcare (PHC) reform introduced a new organizational structure and new management and leadership skills hitherto removed from professionals on the ground. These undertook management roles, often in addition to clinical practice, creating dual management systems and bringing management to the care delivery locus. By involving clinicians in leadership the management model fostered capacity-building and innovation, along with greater value for PHC users. The AVALACES project aims at analysing ACES’ management models and challenges encountered namely concerning decision-making, integration with secondary care and innovation capability.

Methods
In order to study management models in the current PHC organizational framework and their evolution from the onset of the reform, a survey was drafted for exploring managers’ perceptions and gain insight of their practices. First validated by a shadowing experience, and subsequently through implementation in ACES, the survey was aimed at managers at four levels of the ACES: the Executive Director (ED), the Clinical Board President (CBP), the Management Support Unit coordinator (UAG), and the Family Health Care Unit coordinator (USF).
A sample of ACES was selected according to convenience criteria and a total of 22 respondents participated in the questionnaire. A smaller sample of four ACES was then analysed in greater depth as case studies. In these ACES results were presented and broadly discussed from an action-research perspective, in order to validate results, to identify good practices and shortcomings, and to draft recommendations.

Results
Over 50% and 46% of participants believe physicians and nurses devote an adequate amount of time to improving their professional knowledge and skills, and nearly 64% that their ACES encourages continuous professional development. Over 50% of participants feel the need for information on new approaches for improving ACES management.
72% of participants agree that professionals’ training actions do produce effective improvements in care provided. Simultaneously, while 50% of participants agree that their ACES presently has a more innovation-friendly culture, 59% also feel that a more positive attitude from all professionals towards innovation is necessary.
Most participants agree that their ACES currently holds joint innovation projects with the hospital, although overall communication (50%) and referral processes (46%) with secondary care are mostly regarded as reasonable.
The community’s involvement and participation in the ACES is considered by all participants as a moderate or high priority improvement.

Discussion
Reorganization of primary care brought many changes to the way management takes place. Formerly management-detached professionals acquired skills suited to the new leadership roles, introducing the use of management tools in daily practice and greater openness towards innovation.
The expansion of leadership within the organizational structure and the involvement of clinicians brought management closer to care delivery and to PHC users’ needs, but many management challenges remain.
New opportunities for community participation and integration among levels of care emerged, although participants feel there is still room for improvement where internal and external communication and cooperation are concerned.
Learning incentives and management, participation in research, absorptive capacity and development of innovative practices are predictive aspects of the degree of ACES’ innovation culture, which also appears to some extent connected to each ACES’ evolution as a managerially autonomous organization since the beginning of the reform.
Preliminary results of a project of clinical governance promoted by the Local Health Authority (LHA) of the province of Pavia (Lombardy Region, northern Italy) for the years 2011 and 2012.

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Context
Italian NHS provides that, annually, LHAs share projects with GPs on clinical governance issues identified at the regional level.
These activities are financed with constrained economic resources, recognized on the basis of a payment of performance (equal to € 3.08 per patient). The purpose of these projects is to implement prevention activities and/or quality of care provided by GPs, with particular reference to chronic diseases. Through the initiative of clinical governance LHA can design and develop project initiatives, evaluating results and verifying effectiveness, coordinating and aggregating, in the meanwhile, the community of doctors throughout the provincial area.

Methods
In 2011, LHA signed with GPs a two-year Clinical Government agreement (2011-2012) aimed at evaluating overweight/obesity in adult population (aged >14) of the Province.
During the first year (2011) GPs participating measured Body Mass Index (BMI) in at least 25% of their patients, determining the possible state of overweight (BMI ≥ 25 <30) and/or obesity (BMI ≥ 30).
In 2012 GPs enlisted a number of patients, between the overweight and/or obese ones, equal to at least 1% of their total patient load; patients underwent to analysis with measurement of 8 parameters (abdominal circumference, systolic blood pressure, diastolic blood pressure, glycaemia, HDL cholesterol, triglycerides, BMI, smoking status). GPs also secured a counselling intervention aimed at promoting healthy lifestyles, proceeding, after 6 months, to recheck same parameters to assess possible improvements.

Results
LHA has for now analysed the data provided by 113 physicians of 244 participating. In 2011, 86 484 patients were surveyed (17.91% of the Total Eligible Population (TEP)), of which 38.762 men (16.66% of male TEP) and 47.722 women (19.08% of female TEP).
Table 2 shows percentages of overweight/obese patients, as a whole and divided per gender.
LHA also processed data collected during the second phase of the project, related to 2,000 patients.
For each patient 2 detections were made for each of the 8 parameters in study and respective results are reported in Tables 3 and 4.
For each variable comparisons were done between 1st and 2nd detection, grouping patients into 3 groups (patients improving, patients stable and patients worsening), and recording at the same time the average value of each change (Table 5).

Discussion
Project provides data useful to improve knowledge on prevalence of risk factors, a key element to ensure proper programming by the corporate strategic level.
LHA since long participates to a national program of detection of healthy lifestyles (PASSI Project) whose data are extrapolated in telephone interviews from small representative sample of population. Data resulting from this project, conducted on sample of population much more numerous, allows to obtain more precise data, as better shown in Table 2.
Moreover, analysis of data resulting from the second phase of the project shows a good level of effectiveness of counselling activity promoted by GPs.
Table 6 highlights a simultaneous improvement of all 7 parameters in the 12% of the patients.
Equally noteworthy is the finding of a smoking cessation in more than 10% of the subjects who were smokers at the first survey.
Do cancer networks foster integrated care delivery systems? Insights from a national study on the primary care services for cancer patients

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Context
The research analyses the impacts of regional cancer networks’ developments on the primary care services for cancer patients, whether and how there have been attempts to integrate the services’ planning and delivery at the local level. The spending review processes with the Italian NHS, in fact, pushed forward the clinical governance to achieve cost-effectiveness through both the reorganisation of clinical networks and of primary care services as the elective place for tackling chronic conditions. The study intends to analyse to what extent and how these reform drivers are working closely for integrating the health system delivery, focusing on cancer care.

Methods
The study delivers a national explorative analysis. A steering committee was established to oversight the research, made up of the national board of specialist oncologists and national scientific association of health district managers. The research was broken down in two parts to analyse the professional communities’ perspectives and the evidences. The latter was achieved by a desk research aimed to collect evidences of the primary care services delivery system at the regional and local level, based on the legislation, organisational guidelines and other reports (grey literature). The professional communities’ perspectives were analysed by a national survey submitted to the heads of the oncology units, the hospital clinical managers and the local health district managers. A judgment stratified sample was selected to identify 10 regions out of 20, based on the cancer network’s existence and development, and, within them, 10 local health delivery systems as research unit of analysis.

Results
The research shows a high fragmentation at different levels. Firstly, at the macro level: beyond regional policies claims, there is a high disparity across regions in terms of actual implementation. Whereas cancer networks are the best example of clinical networks’ policies, most of them are concentrated at secondary and tertiary levels of care and few experiences of integration with primary care have been retrieved. Primary care redesigning strategies are puzzled, between regions and local units. Secondly, with local health systems, even in the best case experiences of cancer networks, it has been observed that cancer networks are strengthening there sustainability internally, focusing on relationships with the central regional government, while the ties with the local units and the capability to join up services are undermined. The interests of cancer networks seem to be more focused on making their specialised expertise a competitive advantage compared to local services and professionals’ competencies.

Discussion
The value of this explorative research is twofold. Firstly, it tries to evaluate the clinical networks policies compared with the primary care services’ redesign. Whilst these policies should have had a common goal from a whole regional system perspective, they have been implemented separately, meeting their objectives, in some cases, but missing the point of integration within the local health delivery systems. Secondly, the research pointed out the conflicting perspectives between specialists and local health providers and professionals over cancer care. Beyond the acute treatments, there is an urgent need to find a consensus whether the elective place of care, and cure, prospectively, for cancer patients can be the primary care level or else. Managerial and clinical solutions to join up services should be further strengthened, by tackling into account the today improvements in cancer patients’ survival, which call for long-term care provision and the increasing investments of preventative care.
Tuesday 24 June

13.00-15.00

Special Interest Group (SIG) on Healthcare Workforce Management
Nurtured Learning on an Industrial Scale: new leadership in healthcare programmes

Jillian McCarthy
The University of Manchester, Manchester, UK

Context
The NHS Leadership Academy in England has commissioned a suite of five programmes, the first of its kind targeted systematically at everyone working within NHS funded care with the intention of developing outstanding leaders throughout every tier of the system.

A consortium of organisations including the University of Manchester, the University of Birmingham, KPMG and international partners including the universities of Harvard and Pretoria, and EHMA were commissioned in 2013 to co-design and co-deliver two of these programmes commencing in September 2013; the Nye Bevan Programme for executive leaders and the Elizabeth Garrett Anderson programme for senior healthcare managers.

Methods
The Anderson programme is designed and delivered using a blended learning approach with online learning (two-thirds) and face-to-face sessions (one-third). The Bevan programme follows a similar format although the ratio is tilted more towards face-to-face learning. The Leadership Academy in collaboration with the consortium determined that these programmes should result in outstanding leaders from all professional backgrounds who make a lasting impact in improving compassion and the quality of patient care. Despite the challenges of scale and reach (900 Anderson participants and 300 Bevan participants in the first year), the curriculum design concentrated on sustaining a personal, nurturing environment by dividing intakes of participants into cohorts of approximately 50 and, in turn, dividing these into smaller tutor groups and learning sets. The ratio of tutor/adviser to participant is 8:1 on the Anderson programme and 7:1 on the Bevan programme, thus ensuring personal support and coaching, as appropriate, throughout the duration.

Results
Early feedback indicates some favourable responses. The emphasis on experiential learning on residential days has sometimes proved challenging although anecdotal accounts of behavioural change within the workplace are already being reported. The virtual campus on which the online learning is delivered is a bespoke design built by an independent company, Line Communications. Working closely with Line technologists, faculty have developed the curriculum design into interactive scenarios, work-based activities, videos and self-contained learning activities in order to fully engage participants and appeal to different learning styles. Communication via online forums is supported by faculty tutors who maintain a strong presence on the virtual campus by seeding discussions and directing the learning to maintain focus and clarity. Technical, administrative and library support are available throughout the week for participants who may be experiencing any difficulties or requiring advice.

Discussion
Despite the scale, everyone is granted a personal learning experience as intakes are then divided into smaller cohorts. Participants are allocated a personal tutor, cohort director or set adviser for the duration of the programme (Bevan: one year; Anderson: two years; both part-time). On the Anderson programme, personal tutorials are regularly timetabled and take place by telephone, whilst group tutorials are facilitated by online software ‘GoToMeetings’. In both programmes, participants are guided towards work-based activities following theoretical learning in order to promote praxis and lasting change. Early indications suggest that the design is successful in ‘industrialising’ leadership development whilst ensuring personalisation to the individual, in a mirroring of the aim of all healthcare systems to embed industry best practice whilst tailoring care to the needs of individual patients.
Future Leadership - Organizational Commitment of Expert Physicians in General Hospitals

Gillie Gabay
College of management Academic Studies, Rishon Letzion, Israel

Context
Physicians are a critical human capital. Organizational commitment of expert physicians is at stake: There is a gap between how physicians imagined their clinical role and what they do in practice; Private hospitals are recruiting expert physicians from public hospitals; Conflicts arise between physicians and their managements regarding hospital emphases; Clinical autonomy is limited, etc. These changes may result in low commitment of leading expert physicians and consequently empty the future core competence of public hospitals. This study tested antecedents of organizational commitment among leading expert physician.

Methods
Sample:
750 leading expert physicians from 12 general public hospitals and
250 Residents from all specialties.
After Helsinki approval and the agreement of hospital management to participate in the study, hospital management communicated the research goals with department managers. Research assistants, trained and guided by the author, coordinated their arrival to staff meetings or journal clubs and arrived to staff meetings or journal clubs. Expert leading physicians and residents filled out questionnaires. Questionnaires were collected in two different envelopes marked with name of hospital and department, and passed on to the author for analysis.
Measures:
All measures of the study hold good psychometric properties and were validated in previous studies.

Results
Following descriptive analysis, ANOVA, factor analysis and reliability tests, a regression analyses were performed to test antecedents of organizational commitment.
The strongest predictors among experts were organizational trust which explained 23% of the variance in commitment in this study (F=78.7 beta=.48, sig=.000.)
Antecedents of organizational trust were also tested. The model explained 37% of the variance in organizational trust (R²=.363, F=11, Fsig=.000).
Four antecedents were significant. Hospital emphases (t=4.7, beta=.28, sig=.000) i.e., treatment coordination, number of patients in hospital, growth opportunities, quality measures and control, resources management, quality of care despite economic constraints and treating disadvantaged populations. General satisfaction (beta=.31, T=4.5, tsig=.000) i.e., supportive staff, autonomy in treating patients, etc. Perceived effect on clinical decision making (beta=.18, T=2.9, tsig=.004) i.e., choice of physicians, choice of medications, decisions regarding timelines, decisions regarding check-ups, etc.,) and satisfaction with profession (beta=.18, T=2.6, tsig=.010).

Discussion
Several managerial implications emerge from this study and will be outlined at the conference: a) How to meet expectations of expert physicians b) How to adjust and use hospital emphases and work environment characteristics to affect physicians involvement and motivation c) Which small scale changes will bring significant differences in the ability of hospitals to retain their critical human capital and deliver high quality medical services.
“New professionals as institutional entrepreneurs” - the construction of legitimacy for HR-innovations in health

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Context
The developed world experiences increasing pressures on the sustainability of their healthcare systems due to societal developments such as an ageing population and a decrease of available workforce (Bosley & Dale 2008). These threats have initiated large-scale health care reforms that have also been associated with considerable HR-innovations such as the introduction of new health professions (Dubois & Singh 2009; Wallenburg et al. 2014). In this research we use the concept of institutional entrepreneurship to analyse the introduction of new professionals in healthcare. By this we add insights to literature on HR-innovations as well as to sociological literature on professionalism.

Methods
This research was conducted as part of an ongoing European research project under the FP7 framework on the introduction of new professionals. We closely worked together with partners in nine European countries in order to deliver data for international comparisons on task-substitution. A mixed-methods research strategy was chosen in which six case-studies delivered detailed insights into the ways new professional roles (e.g. physician assistants and nurse practitioners) are introduced and work in healthcare settings. An ethnographic research design was used to analyse the work processes of new professionals. During the observations field notes were taken, which were elaborated on in more detail shortly after. All the data (transcripts of the interviews and observations) were analysed and coded by both authors.

Results
Our results show that the way new professional roles are introduced in heavy regulated and institutionalized healthcare settings is mainly determined by specific characteristics of the organizational context. This makes introducing a HR-innovation largely a situational event. How the work of the new professionals is valued and how their roles become institutionalized depends on the how they, as institutional entrepreneurs, construct legitimacy in their day-to-day work. New professionals construct legitimacy for their position through their regular work activities. For example, contributing to the continuity of care, being able to be of added value for the existing staff by being there and working night shifts and having good personal relationships at the department, contributes to the legitimacy of the new professional roles. We also show, however, that legitimacy is not only determined by the actions of institutional entrepreneurs since those actions interact and are influence by changes in the organizational context.

Discussion
Legitimacy of new professions is created and enacted in daily practice in an ongoing process of co-construction. By using the notion of institutional entrepreneurship, we have attempted to shift the traditional sociological focus on power struggles between occupational groups and its persistent emphasis on medical power to a more dynamic and ‘enabling’ perspective on human resource evolvement for health. The findings also add to current debates on institutional entrepreneurship which usually emphasize the ‘heroic role’ of purposefully and strategically acting social actors, as we have shown the importance of mundane work processes and organizational contexts. This study provides more in-depth insights in how HR-innovation processes work and reveals how institutional entrepreneurs are driven by, and act upon changes in the wider organizational environment - enlarging the legitimized role of new healthcare professionals. Additional research could facilitate comparisons of the way new professionals get legitimized and institutionalized across different countries.
Human resource management tools in healthcare: are they driving cultures?

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**Context**
Since the 90s, Italian healthcare organizations are organized by law into clinical directorates. This organizational model has introduced important changes both in organizational design and in terms of human resource management (HRM). HRM tools, in turn, not only affect deeply how the work of professionals is organized, but are also at the basis of new cultures, which can be more or less objective-, supervision- or formation-oriented.

The aim of this study is to produce evidence about the most commonly adopted human resource management tools within Italian clinical directorates, in order to understand how their mix affect the orientation of cultures.

**Methods**
Between 2008 and 2010 a semi-structured questionnaire has been administered to 66 Clinical Directors, belonging to 33 different healthcare organizations of the Italian NHS. The study, commissioned by the Italian Health Ministry, has led to important conclusions concerning the concrete development of clinical directorates.

Around 50 questions of the questionnaire have been further explored to investigate the development of human resource tools. These include "management by objectives" tools, aimed at relating individual performance to the achievement of specific objectives; supervision tools, aimed at providing control on the activities carried out as well as enhancing opportunities to share results with workers and to reach common solutions; and, finally, training tools, aimed at developing top competences of staff as well as the adoption of standard procedures.

The presence or absence of these tools have been translated into overall scores in order to assess clinical directorates' tendency to develop one or more of these cultures.

**Results**
The 66 clinical directorates studied present heterogeneous features, and only rarely seem to invest equally on all three cultures. On the contrary, the overall tendency is to favor one of them, at the expense of the others.

Moreover, interesting conclusions have been drawn on how this tendency is influenced by other characteristics of the clinical directorate such as, for example, its size, its composition, its geographical position and the type of healthcare organization it belongs to. This, in turn, suggests important considerations in general policy terms.

**Discussion**
The adoption of clinical directorates in the Italian healthcare system has drastically changed how work is concretely organized, also as a consequence of the introduction or development of specific human resource management tools. Currently, however, little is known about the concrete degree of adoption of these tools within Italian clinical directorates, and, therefore, about their actual orientation to the three cultures analysed. This study provides important notions on how the work of physicians and nurses is organized and managed in hospitals, with important implications not only in organizational terms, but also on staff's job-satisfaction and motivation. Indeed, the three cultures described are likely to have a strong impact on workers' well-being, which in turn is likely to affect their performance and patients' satisfaction. Future developments of this study will explore in detail this further relationship.
Improvement of the health management educational programs in the Republic of Kazakhstan

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Context
With the increase of autonomy of the state medical care providers, significant increase in the level of resources allocated to the sector, active integration of the health system in market infrastructure and the advent of new medical technologies demanded from the system a number of major changes in the regulatory framework and specific knowledge and skills from the new generation of managers. At the moment they include issues related to the legal status of healthcare organizations, their ability to receive and use the investments, to hire and fire staff and manage the organizations as "enterprises" rather than passive budgetary organizations.

Methods
As part of implementation of the project "Today the best - you are, tomorrow - all" was introduced the strategic planning in medical organizations in 2012. For medical organizations was developed the task - plan, in which was specified the main strategic directions within the State Program for the Development of Healthcare System of the Republic of Kazakhstan. For all medical organizations had been designed guidelines, through which the activities for 2012 was planned and conducted appropriate trainings.

Results
Indicators 2012-2013 has shown a positive dynamics in development of autonomy of the providers - the amount of hospitals passed to the status "with the Right of Economic Management" increased up to 73.9 %, while in 2012 was 40.6%.
The number of organizations that have implemented elements of corporate governance in the form of the Supervisory Board has increased up to 27.1 % compared to 7.1% in 2012. The number of organizations in which was established the Supervisory Boards, was 19.4 %.
Also was noted the positive dynamics in hospitalization management, the decrease in patient hospitalization by 22%, whose treatment was possible on an outpatient basis, the number of inpatient care increased by 21%, there is a slight decrease in the average hospital stay of patient, at 0.5 patient days. There is a decrease in utility costs and other expenses, at 5.02 %, with the introduction of resource-saving technologies.

Discussion
Ongoing trainings undoubtedly show their effectiveness, but in the future will be needed targeted short-term trainings for practicing managers. It is planned to conduct the short advanced trainings depending to the needs of the audience, required competencies and position holding by the manager, also will depend on the level of management effectiveness in medical organisation in which they work. A significant gap in healthcare manager trainings is the lack of systematic training of the heads of HR and financial departments, who hold a key role in improving the management of medical organizations. In this regard, was developed a system of short-term advanced training cycles and their implementation is planned in 2014 for the staff of HR and financial departments, and today the key issues of their trainings are the issues which plunge them into sectoral specific and basic legal documents necessary for them to work.
Wednesday 25 June

10.30-12.30

PhD Students Session: Karolinska Medical Management Centre / EHMA Research Award
From idea to implementation. The diffusion, adoption and implementation of HRM innovations in healthcare organizations

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Context
In this dissertation, research on the diffusion, adoption and implementation of Human Resource Management (HRM) innovations in Dutch healthcare organizations is reported. Healthcare organizations are being confronted with several challenges that increase the need for innovations in the way work processes are being designed and employees are being managed (Townsend & Wilkinson, 2010), i.e. HRM. Therefore, it is important to enhance our understanding HRM innovation processes in healthcare. Relatively many studies focus on product innovations in private sector organizations, but research on managerial innovations in healthcare organizations remains underdeveloped (Damanpour & Aravind, 2011; Länsisalmi, Kivimäki, Allto, & Ruoranen, 2006).

Methods
In this dissertation, a new methodology was developed to answer the call to conduct more contextualized research on organizational processes and HRM (Boxall, Purcell, & Wright, 2007): the contextualized process methodology. This approach incorporates iterative research methods and consists of two stages. In the first stage, the emphasis is on familiarization with the research context and topic under study. Based on scientific literature, explorative interviews and document studies a heuristic framework is developed. This framework serves as a starting point to conduct semi-structured interviews with different actors that are used to extend the heuristic framework with context specific elements. In the second stage, the extended heuristic framework is used to design studies that do justice to the context of the organization under study. In total, almost 200 semi-structured interviews were conducted. After completing the research, the findings are translated to recommendations that could help practitioners to improve organizational processes.

Results
Based on the extended heuristic framework, four issues were studied in-depth. First of all, the study on the role of HR professionals shows that they are often not well connected to organizational developments, which hinders the HRM innovation process.
Secondly, the study on the tension between cooperation and competition (coopetition) shows that large differences in perceptions about competition exists between different stakeholders in four hospitals, which affects the adoption and implementation of the 'Talent Management Pool'.
Thirdly, the roles of multiple institutional logics (business-like and professional) were studied during the adoption and implementation of 'Productive Ward'. The findings show that the presence of different logics in the project complicates the adoption and implementation, because this created suspicion among nurses.
Finally, an investigation of the motives for the adoption of e-learning and task differentiation in different hospitals is reported, showing that both rational-economic and institutional pressures are at play.

Discussion
Based on this dissertation, we can conclude that the context is of great importance for the diffusion, adoption and implementation of managerial innovations. The contextualized process methodology that was developed allowed us to tailor the research to the healthcare context. Four in-depth qualitative studies were conducted based on the extended heuristic framework that was developed in the first research stage. The results indicate that healthcare specific issues and tensions, such as the simultaneous existence of professional and business-like logics, are of great importance for innovation processes. Therefore, this study contributes to the scientific knowledge base on managerial innovation processes in healthcare organizations provides a basis for practical recommendations. The findings of this dissertation indicate that researchers and practitioners occupied with the diffusion, adoption and implementation of managerial innovations in healthcare should take into account context specific characteristics and developments in order to be successful.
“Service Provider”, “Co-owner” and “Critical Friend”? The role of Public Health in Clinical Commissioning Groups (CCGs)

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Context
This research aimed to explore how newly formed Clinical Commissioning Groups (CCGs) were tackling health inequalities (if at all). In 2010 the NHS in England underwent a significant reorganisation. New GP led commissioning organisations (CCGs) replaced Primary Care Trusts (PCTs) and public health was moved away from the NHS into the Local Authority. The Local Authority has been given the responsibility to improve and protect local population health and provide CCGs with population health advice, whilst CCGs have been given a loosely specified ‘duty’ to tackle health inequalities.

Methods
This research project took place between September 2010 and January 2014 as part of a PhD project. Fieldwork was conducted for eleven months from January 2012 to December 2012. Data was collected from three shadow CCGs in the North of England. Data collection included: approximately 198 hours of observations of CCG meetings; 22 interviews with CCG governing body members and individuals closely associated with the CCG; and the collection of relevant documents. Comprehensive field notes were taken during observations and analysed alongside interview transcripts using the software programme Atlas.ti.

Results
The relationship between the CCG and their Public Health Consultant (PHC) was in development at the time of data collection. Three different types of PHC roles could be discerned from the data; ‘Service Provider’, ‘Co-owner’ and ‘Critical Friend’. These roles impacted on the utilisation of public health by CCGs, the wider relationship between the CCG and public health and their focus on and approach to tackling health inequalities. These relationships were influenced by previous historical relationships, the local context the CCGs and public health found themselves working in and the impact of the reforms.

Discussion
When CCGs are constructing their relationships with their Public Health Consultants they need to be aware of the different ways of working with public health and how the relationship can impact on the connection with their local public health team. Relationship development is complex, often influenced by the wider historical context and previous ways of working. However, if CCGs were to use the ‘co-ownership’ model they would be able to develop a clear shared agenda between the CCG and local public health team, enabling the development of mutually exclusive targets for them to work towards. The ‘co-ownership’ role allows health inequalities to be jointly conceptualised, tackled and monitored across the two different organisations, enabling joint strategies to be implemented on the ground.
The impact of increased accountability on the evolution of nursing practice and profession

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Context
In the context of growing demands for quality, safety and efficiency in healthcare facilities several authors have recognized that healthcare workers express discontent at having to do some ‘administrative work’. An empirical study and a first literature review show that these administrative tasks are often not considered an accurate reflection of caregivers’ work and keep them away from patient care. Therefore, while diagnoses are shared what is considered ‘administrative work’ remains insufficiently explored. The thesis aims to qualify, identify and understand both objectively and subjectively this ‘administrative work’. This study examines how the need for increased accountability transformed nursing practice.

Methods
Which activities are considered to be ‘administrative work’? How healthcare workers perceive the usefulness of each activity? Do these administrative activities lead to work reconfiguration amongst nurses in France and in the USA?
To answer these questions, we:
- Conducted a systematic literature review to highlight the state of knowledge, identify an empirical object and examples of investigative methods (e.g., time and motion studies).
- Performed an ethnographic study using three forms of investigation: observations in situ or shadowing, in-depth interviews, and analysis of internal documents (e.g., hospital protocols, unit guidelines, job descriptions).
- Compared several hospital units, each with distinctive characteristics. This included two in France (Rennes; Assistance Publique-Hôpitaux de Paris) and two in the USA, (University of North Carolina Hospitals; New York Presbyterian), where the introduction of quality measure is older.

Results
1. The literature review revealed a link between the increasing demands in terms of documentation and the rate of staff turnover, burnout and dissatisfaction. Nurses expressed the feeling of having less time at the bedside.
2. However, several studies also presented objective measures of the time spent by nurses on documentation. They indicated that since the 1990s, the time spent on direct patient care activities has not decreased whereas the time spent on administrative tasks and documentation has become more prominent.
3. This contradiction shows the importance of understanding the meaning conferred on each activities. Thus preliminary fieldwork has enabled us to identify activities comprising administrative work, then generate a typology based on nurses’ perceptions.

Discussion
1. The typology highlights the complexity of practices. It also emphasises nurses’ different perceptions of administrative work. Fieldwork observations provided the opportunity to characterize the complex practices and perception as part of the socio-material context and to highlight the important role played by managers to give meaning to these activities.
2. The comparison between different units and between the two countries show the cross-cutting nature of the nursing practice. It also highlighted some organizational differences like the number of patient per nurse and the length of stay. And, finally it showcases some cultural differences such as the importance of jurisdiction.
3. The observational fieldwork indicated that differences of perception and practices should be investigated in the context of diverse socio-material infrastructure. Moreover, the role of frontline leaders was revealed to be fundamental and should lead to managerial recommendations for improving the organizational climate.
Factors that influence patient and public views about proposals for major service change: evidence from the English NHS

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Context
Health care systems globally face the challenge of meeting rising demand with diminishing financial resources. Decisions about how best to organise care involve several interlinked factors, including quality concerns, workforce issues, cost and patient access. It is argued that trade-offs need to be made between each of these. In England, whilst decision-makers seek potential health gains for patients, proposed service changes such as Emergency Department (ED) closures often face public opposition. This thesis examined the factors that influence the way local communities respond to such proposals, including their willingness to accept the trade-offs inherent in decisions about reorganising care.

Methods
In-depth interviews were carried out to explore whether patient and public views, including willingness to trade-off, differed in an urban area of England where service changes were being considered, compared with one where they were not. The analysis combined inductive and deductive approaches, drawing on socio-cultural perspectives of risk as an analytic focus. Participants were invited to select their priorities for emergency care, and to discuss aspects they might be prepared to have ‘less’ of (e.g. quick access to the ED) if it meant having ‘more’ of another (e.g. senior clinicians present in the ED). In the area where closure of the local ED was being discussed, interviewees included parents (n=5), older people (n=6), patient representatives plus individuals campaigning against service closures (n=9). Eight patients were also interviewed, all of whom received care for a chronic condition at a hospital in an area where changes were not being considered.

Results
Most participants were not willing to accept the trade-offs involved in decisions to consolidate services. This was principally because of a widespread belief that timely access is associated with better outcomes. Consequently participants were not prepared to accept a longer journey to hospital. Participants did not consider the anticipated improvements in technical aspects of care to be gains worth having. In fact, interviewees believed such plans would negatively impact care quality, partly because increased patient numbers at the remaining hospitals would result in greater pressure on staff. In addition, UK government policy emphasises the roles of clinical leadership and ‘evidence,’ apparently assuming that, if the public are presented with enough of the ‘right evidence’ by clinicians, they will be convinced of the need to change. However, in the study area where proposals for change were being considered, this approach proved counter-productive and instead fuelled hostility to the proposals.

Discussion
Where a service reorganisation was being considered, visible clinical leadership and detailed explanation of the case for change were insufficient to overcome the opposition of local residents. This was not only because participants perceived that consolidating services would decrease the safety and quality of care, but also because the proposals conflicted with their local knowledge and understanding of health care. There was no difference between the views of participants in the two areas, suggesting that these perceptions are widely held and not solely the consequence of the local ED being under threat. Policymakers cannot assume that local communities can be persuaded to accommodate service reorganisations which may compromise timely access. A range of practical implications will be discussed, relevant to health systems seeking to engage the public with proposals for service change.
Wednesday 25 June

10.30-12.30

Moving care closer to the patient
Delivering sustainable healthcare: moving acute care into the patient's home - an Australian perspective on an international challenge

Alan Lilly
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Context
It is an inescapable fact that the rising cost of healthcare throughout the developed world cannot be sustained. According to the World Bank (2013), GDP expenditure is averaging 10.1% across the world. This is in keeping with the European and Australia/New Zealand GDP cost profiles, whilst demand for timely elective and emergency care is growing in all health systems around the world. With a budget of $750m, Eastern Health is the largest metropolitan health service in Melbourne, Victoria and provides care to 750,000 people in 29 locations across 2816 square kilometres in Australia’s south-east. Sustainability requires a different approach.

Methods
In mid-2011, Eastern Health decided to invest in providing more services into patients’ own homes. With an increasingly ageing population, it was decided to reduce inpatient beds to fund a growth in ambulatory and community services and this was consistent with its five-year strategic plan. The Eastern@Home program was established to provide acute care for patients in their own homes right across the catchment area. This program is not about post-acute care; this is about substitution of acute inpatient care in a home-based setting. National funding encourages this shift in models of care and ensures that patients are able to receive care and services in their own homes without the risks of hospital-acquired infections, falls, medication errors and the like, often inherent with hospital-based care. Staffing in the service was restructured to engage with key medical, nursing and allied health staff and to maximise patient selection and flow.

Results
There are many qualitative and quantitative benefits associated with the program’s introduction. The service is now seen as the “gold standard” for ambulatory care in Victoria and the program has been a reference site for many organisations around Australia.
Since implementation, the following key results have been achieved:
• a 68% increase between May 2011 and May 2013 in Eastern@Home bed equivalent (multi-day) occupancy in the community;
• a 290% increase in the first 12 months of the establishment of a (same-day) Eastern@Home program for same-day patients since June 2012;
• an 8.27% reduction in inpatient Average Length of Stay from 2010/11 to December 2013.
In addition, new treatments have been developed as the program has experienced a paradigm shift from the hospital inpatient focus to care in the patient’s own home and through segmentation of care, this acute care is provided at just 40% of the equivalent inpatient cost.

Discussion
The implementation of the Eastern@Home program, as part of a broader strategic direction to expand ambulatory and community services in Eastern Health, has been highly successful. Whilst the nature of the change, the time frame and the closure of inpatient beds gave rise to staff and media concern, a retrospective review confirms that transition to the new model of care was the greatest of all concerns. Engagement with clinical nursing, allied health and medical staff has been central to its success in conjunction with strong leadership from the key nursing and medical champions. Patient feedback has been effusively positive. Alongside other patient flow improvements, internal audits have identified that the number of “inappropriate inpatients” has reduced and patient flow has increased across the Eastern Health system including reduction in waiting times for elective surgery and emergency care assessment, treatment and admissions in Eastern Health’s three Emergency Departments.
Ambulatory Medical Care - A successful bedside to boardroom model through collaboration between front-line clinicians and hospital administration

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Context
Scarcity of hospital beds is a major challenge to clinicians and hospital administrators. In 2006, despite rising emergency admissions, the Department of Medicine & Geriatrics of the United Christian Hospital (UCH) faced a reduction of in-patient beds due to hospital service reorganization. To cope with the challenge, senior clinicians of the department put forward a proposal to hospital administration to reduce avoidable hospitalization through conversion of in-patient service to ambulatory mode of care. A new United Ambulatory Care Centre was established. Medical procedures and other complex multidisciplinary care could be delivered in ambulatory setting to shorten or avoid in-patient stay.

Methods
An evaluation of the effectiveness of ambulatory medical care was carried out by reviewing hospital bed utilization statistics. Benchmarking with other medical departments in Hong Kong with similar service scope and complexity was performed. Data on emergency admissions, medical in-patient bed numbers, average length of stay, occupancy rate and annual in-patient bed days occupied from 2005 to 2012 were retrieved from the Executive Information System of the Hospital Authority, Hong Kong. Descriptive data were presented.

Results
There was a continual rise in emergency admissions to all medical units under review from 2005 to 2012. In United Christian Hospital, the annual emergency medical admissions rose from 24,162 in 2005 to 29,182 in 2012. Over the same period, the in-patient bed number was reduced from 531 to 464. Despite these changes, the in-patient occupancy rate was reduced from 91.9% to 90.5%. This was paralleled by a shortening of in-patient average length of stay from 5.4 days to 3.8 days. The annual total number of in-patient bed days occupied was reduced from 185,669 in 2005 to 150,967 in 2012. In contrast, corresponding figures averaged from six other medical departments from hospitals of similar size and service scope in Hong Kong showed different trends during the same period. The occupancy rate and total in-patient bed days occupied continued to rise in these units despite an increase in medical bed numbers.

Discussion
Funding and space constraints in face of rising healthcare demands due to aging population and technological advancement seemed like an insurmountable problem for hospital management. Yet, observations by front-line clinicians uncovered a promising solution through conversion of in-patient service to ambulatory model to reduce avoidable hospitalization. After a series of candid dialogue among front-line clinicians and hospital administration including human resources, finance personnel and the hospital chief executive, the administration agreed to shell out an initial investment in infrastructure for a new ambulatory care centre. Clinicians then revamped the service and introduced different ambulatory care pathways in phases. Success of the initiative depended on accurate observations and analysis of the local situation, a common purpose and clear guiding principles, careful planning and conducive polices and most importantly, the trusting partnership between hospital leaders and front-line clinicians. The ambulatory medical care in UCH illustrated a win-win example in healthcare leadership.
Wednesday 25 June

10.30-12.30

Supporting Nursing leadership
Supporting Senior Nurse Leaders across NHS, Independent, Charity and Voluntary Sectors - The RCN Executive Nurse Network one year on

**Naomi Chapman**
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**Context**
The challenge of leadership at the most senior level of healthcare has been highlighted by several national reports of healthcare events in England. Set in the context of financial austerity and political spot light, nurse leaders are in highly visible roles which have both board level and professional responsibility and accountability. There was acknowledgement within the Royal College of Nursing (RCN) that Executive Nurses (that is nurses at Director and Deputy Director level) have specific needs both for professional support and to express their nursing voice at the highest level.

**Methods**
A rapid participatory appraisal of the expressed needs of senior nurse leaders was conducted by the network lead. Drawing from the information gathered in that process a strategy (2012 - 13) was developed for establishment of the RCN Executive Nurse Network. The strategy outlined a free to join network for senior nurses (such as Directors, Deputy/Assistant Directors and Heads of Service) across the UK. Within the network is a Chatham House Group which is open to Directors of Nursing or national leads that are RCN members and pay an annual fee to access four Chatham house network events a year.
A time limited internal Infrastructure Delivery Group was set up and an Overview group was established to provide strategic discussion and governance for the network.
Marketing was restricted to direct invitation of those Directors of Nursing known to the RCN and one national advert in year one.

**Results**
One year after opening the network has 150 members representing thousands of nurses from all sectors and all four UK nations.
Network aims:

- to provide support for Executive nurses across the UK
- to provide a supportive environment for concept development and discussion
- to provide an electronic and face to face environment for communication between Executive nurses
- to provide a conduit for the voice of Executive nurses and national strategy makers, using the resources of the Royal College of Nursing in order to influence and inform their national policy and strategy.

The network has password protected web pages and we have held four face to face Chatham house events.
National Opportunities: Members can identify when they join if they are interested in access to national opportunities and to date members have found places in a variety of settings including the NHS Supply Chain Board, national research projects and Care Quality Commission Panels.

**Discussion**
A group of senior nurse leaders will have potential impact on a vast amount of healthcare professionals and subsequent quality of patient care. Meeting the support needs of a diverse group of senior leaders is challenging but essential in difficult times.
The RCN Executive Nurse Network number and breadth of membership illustrates the demand for such a support. Whilst identifying senior nurse leaders across the sectors is challenging due to constant turn over and lack of a single national database, the rewards of individual contact, support and face to face contact have proven to be significant for the organisation and a unique forum for peer discussion amongst its members.
**Nursing leadership in France: the missing link?**

**Odessa Petit dit Dariel**  
EHESP, Paris, France

**Context**

In 2010, the Robert Wood Johnson Foundation (RWJF) and the IOM published "The Future of Nursing: Leading Change, Advancing Health" and made a number of recommendations. One of these highlights the need to prepare and enable nurses to lead change by assuming leadership positions across all levels. Yet while nurses can and should play a fundamental role in this transformation, their power and ability to do so does not rest solely on them. Indeed, government, nurses themselves and other healthcare professionals, healthcare organizations, professional associations etc. significantly impact nurses' ability to effectively develop their leadership.

**Methods**

Kouzes and Posner’s Leadership Practice Inventory scale (translated into French) was distributed online to all the Directors of Care (DC) (the highest position allied health care professionals can hold in a hospital and primarily held by nurses) members of the French Association of Directors of Care. This association includes approximately 400 of the 760 DCs in France.

**Results**  
(Data collection and analysis in process)

It was only in 2009 that French nursing education moved into higher education and the profession continues to struggle to earn recognition as a fully-fledged discipline, able to conduct and use research to implement evidence-based care practices for their patients. Whilst like many developed countries the profession in France has experienced evolutions in their scope of practice and their professional status as a result of societal changes, unlike many developed countries these evolutions have been much slower and the nursing profession in France has had great difficulty in mobilizing itself behind a common voice, seemingly destined to remain the physicians' handmaiden.

**Discussion**

The French healthcare system (underpinned by a powerful medical monopoly) and a government that has systematically ignored allied healthcare workers’ contributions to healthcare have made it challenging for nurses to develop a strong coalition able fight for better working conditions and allowing them to provide better care to their patients. Yet many countries that have seen their nursing workforce develop into a powerful and influential political voice have had to face similar difficulties (ex. the US). The question is, who and where are the nursing leaders in France and what are the leadership skills?
Wednesday 25 June

10.30-12.30

Cultural Change
Health leadership and resistance: virtue to virtue combat

Mervyn Conroy
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Context
Recent scandals in the health and social care sector emphasize the need to gain a better understanding of ethics, values and virtues in healthcare practice. The Francis enquiry into Mid-Staffordshire Hospital Trust found shortcomings in the ‘care, compassion and humanity’ shown by staff, that staff showed a lack of ‘respect’ for patients’ dignity, showed ‘callous indifference to suffering’ and demonstrated ‘a lack of candour in reporting poor standards of care’ (Francis 2013). If health professionals had resisted some of the changes that resulted in corruption to care practices then arguably this and other scandals would not have occurred.

Methods
Scholars have urged more dialogue between leadership studies and critical researchers in order to understand more about resistance leadership. In particular, issues of ethics, virtue and moral accountability are registered in the literature as needing more attention. In responding to this call the article empirically captures the notion of ethical resistance through a study of healthcare manager and clinician narratives over a period of 12 months. The narratives were collected from over 50 participants working in health and care through a series of semi-structured interviews.

Results
We argue that an understanding of ethical resistance has, to date, been missing from leading change theorizing. By framing resistance in this way new vistas on leading change theorising are opened up. In particular questions associated with the ethics of change leadership are posed so that the practice of change leadership is challenged to take account of the ethical status of a change programme in workplace settings.

Discussion
The theory and practice of change leadership is challenged to ask questions such as ‘What is the ethical status of a change programme?’ ‘Which ideology is embedded in the change discourse?’ ‘How do change leaders reconcile disparate ethics of practice? This paper responds to the call made by Zoller and Fairhurst (2007) to understand resistance leadership better and in particular the ethical dimension.
Leadership improvement in health organizations - is this a possible mission?

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Context
Leadership in health care has a special significance, because of the necessary changes that are expected with the aim of improving the system of health protection. Requests for reforms in the health sector are set in front of the entire health care system, all organizations are required a strategic approach to planning for changes that lead to improvements in the realization of the primary task. Leadership role and responsibility in this process is extremely high. Leaders prepare the organization for changes and aid them to cope with these in order to make them able to implement the process of changes

Methods
Researching new methods for improving the health institutions as "patients" takes place within the Section of Psychoanalytic and Group-Analytic Approach to Understanding the Psychodynamics of Institutions, Organizations and Society of the Society of Group Analysts Belgrade. Group of interested professionals in the health system, or close to it, are in the process of further education in the field of organizational consulting, which provides the opportunity to "cure" the institutions and consequently better management. Methods that can be applied are analysis of the organizational role, the study of drawing as depiction of unconscious contents in the organization, etc.

This work presents examples of the application of these methods and their potential. Methods imply hiring an external consultant or a consultant team. This kind of process consulting supports the problem analysing and more importantly, the process from which clients themselves learn about their own skills, mistakes and abilities is initiated

Results
The existing network of health institutions in Serbia consists of more than 150 primary health care institutions, more than 40 general hospitals, 30 specialized hospitals, more than 15 institutes and four clinical centers, which represent very complex systems with several thousands of employees and are in the organizational transition, economically unenviable situation and very complex relationships between individuals and groups within them. Along with them it is necessary to take into consideration the network of the National Health Insurance Fund and other institutions (Medical Faculty) from whose operating the quality of health care depends. In this way the number of leaders in the health system who need to carry out the necessary change was estimated, so we are talking about at least 1,000 people in top management positions. The leaders are expected to use different methods of employees' motivation and to replace the word "managing" by "motivation".

Discussion
Resistance, insecurity and control dominate atmosphere in many institutions of the health sector, a trust, positive economic outcomes are hardly achievable goals in present circumstances.

Consultants deal with situations of extreme importance: sociological and psychological characteristics of the organizational and managerial matrix, opportunities for improvement in the existing organizational conditions, and the impact of acquired experience in the theory and practice of the here and now. Anxiety did not bypass the health sector and is not withheld within the boundaries of a country, political system or economic level of development. Distrust in managers and application of their solutions is deeply rooted in the health sector and their role is often associated with the position of the scapegoat. Being powerful does not mean to perform the work well, but to be good in a complex game of avoiding pitfalls, winners and losers, which must not survive as a matrix of operation.
Culture and criticism: perspectives of hospital leaders in England to the Francis Inquiry Report into the failings at Mid-Staffordshire NHS Foundation Trust

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Context
In February 2013, a government-commissioned public inquiry published its report into serious failings in care at an English hospital (Francis, 2013). The inquiry, chaired by Robert Francis QC, explored the contribution of the culture and behaviour of the NHS - including commissioning, supervisory and regulatory bodies - to the events at Mid-Staffordshire NHS Foundation Trust. The final inquiry report contained 290 recommendations aimed at changing culture and practice across the NHS in England. These included recommendations aimed at: the boards and leadership of hospitals; establishing and assuring safe staffing levels on wards; and external regulation and supervision of hospitals.

Methods
We analysed board papers from a sample of 37 hospitals in England, examining their discussion of the Francis Report, using this to design a questionnaire which was sent to chairs and chief executives of all 158 acute hospital trusts in England in November 2013. The survey yielded 53 responses (33%). We selected five hospital trusts as case studies, using a random sample from three regions in England. We conducted in-depth interviews with 49 senior managers and clinicians at these hospitals in December 2013. We explored organisations' response to the Francis Report, actions taken aimed at improving quality of care, and the response of external bodies to the Francis Report. Interviews were recorded and transcribed, and data analysed using a framework deduced from the six themes used in the inquiry report. Survey and interview data analyses were synthesised, and a report published in February 2014 (Thorlby and others, 2014).

Results
We found that 82 per cent of trusts reported taking new action in response to the Francis Report, most commonly reviewing and increasing nursing staff numbers, as well as initiatives to improve the handling of complaints, the development and scrutiny of additional data sources to track the quality of care at ward level, and initiatives to engage staff. Hospital leaders also reported making efforts to change the culture of care within their organisations, but reflected that external bodies had intensified requests for assurances about quality of care, and that interactions with external bodies were at times perceived to be overbearing and ‘top down’ in the wake of the Francis Report. Hospital leaders also described a legacy of the Francis Report as an increased focus on quality as an organisational goal and increasingly difficult trade-offs between meeting quality goals and keeping in financial balance.

Discussion
Many of the themes in the Francis Report appear to have been heeded by our case studies, namely that a patient-centred culture be enabled within hospitals, with boards avoiding an undue focus on financial balance at the expense of patient care. While the range of initiatives to track and improve quality of care described in interviews was encouraging, people's perceptions of the often overbearing behaviour of external regulatory and management bodies was disheartening. The development of ‘cultural barometers’ for hospital trusts suggested by the Department of Health in its response to the Francis Report (Department of Health 2013) might usefully be extended to local health economies to ensure that the culture of the wider NHS system is changing. The findings relating to culture, the tension between quality of care and achieving financial balance, and the regulatory and performance management environment will be relevant to health systems in other countries.
Wednesday 25 June

10.30-12.30

Delivering excellent quality 1
Multi-professional approach to the prevention of errors related to the management of polytherapy in the elderly at home. Preliminary results of a project of Risk management being implemented at the Local Health Authority (LHA) of the Province of Pavia

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Context
Errors managing polytherapy at home represent a great burden for the elderly. Many studies agree that the number of drugs taken is an independent predictor of hospitalization, mortality, adverse reactions. Nearly 10% of all hospital admissions for ≥65 patients could be induced by adverse drug reactions. It can be presumed that in Pavia province more than 2,500 patients aged ≥ 65 may undergo hospital admissions related to mistakes in polytherapy. To tackle this problem LHA of Pavia implemented, in 2013 and still on the course, a project aimed to improve the management of polytherapy for the elderly at home.

Methods
This project starts from results of a previous Risk Management project developed by LHA in 2012. By that project LHA identified failure modes (indexed by Probability Risk Index (PRI)) able to determine medication errors in patients ≥65, treated at home in polytherapy. Seven failure modes with a PRI >100 were identified. By this new project LHA aims to overcome these failures through a series of interventions involving, in a working-group, different actors that interface to patient at home. A working-group was built involving 7 GPs, 1 Geriatrician, 18 Nurses. Three subgroups were established that worked separately to the same goal, to find the best communication strategy for the problem. Later they worked as focus group to prepare the best information material on the correct management of drugs at home, to be deployed into the system.

Results
Deep analysis carried out by the working-group about reasons of the seven failure modes in study, allowed to identify the followings strategies to be improved:
- Continuous education to caregiver / patient by nurse through brochure on home medication management;
- Increased interactions nurses / prescribers with focus groups;
- Continuous monitoring of drug interactions through pharmacovigilance system operating at the LHA.

Interventions were carried out in accordance to the following timetable:
- January -February 2013: dissemination of previous results and building of teamwork;
- March- June 2013: analysis and identification of goals to be improved;
- July -December 2013: predisposition of Brochure for caregivers/patients.

Pharmacovigilance system is operating. Dissemination of the brochure to the actors involved so as the settlement of Focus Groups about integration between Prescribers and Nurses will operate starting from first semester 2014. Health care professionals of more than 35 organizations accredited to supply nursing home-care and more than 400 GPs were involved.

Discussion
At the present stage the Brochure for caregivers/patients is under distribution. It is aimed to be used by health care professionals to educate patients and caregivers at home. In the second half of 2014 it will be possible to start measuring effects of change. Currently even if the implementation phase is not yet complete, it has been already registered a better approach to the problem by all players. Nurses have learned to work in interprofessional and interdisciplinary groups, have deepened knowledge about risks related to polytherapy, have improved relationships with GPs to manage patients and caregivers, have developed strategies of health education on pharmacovigilance.
A National System for Measuring Quality at the Emergency Departments in Sweden

Mats Granberg
National Board of Health and Welfare, Stockholm, Sweden

Context
As part of the structural changes in Swedish health care system, emergency care has been centralised to fewer hospitals, which has increased demand on the remaining 70 units. In many regions, this increase in demand has created problems with long waiting and other quality shortcomings. During the election campaign to the Swedish Parliament in 2010 the minister of social affairs promised to introduce a 4-hour maximal wait at the emergency units and the National Board of Health and Welfare was commissioned to develop a national system for monitoring waiting times and other valid quality indicators for E&A-departments in hospitals.

Methods
Three enquiries have been sent to all hospitals with the aim of measuring and comparing actual waiting times. The inquiries also covered mapping of the emergency departments with respect to their content, organisation and staffing as well as IT systems and waiting times. A proposal for national quality indicators has been developed in collaboration with a team of experts.

Results
During 2014 a system for national measuring will be tested, and in 2015 it will be introduced as a part of the Swedish national patient registry (NPR). The system focuses on the following indicators:

- Total time in A&E
- Time to initial assessment by physician
- Re-attendance within 72 hours
- Left department before treatment
- Patient’s perceived information about waiting time
- Patient’s perceived quality
- Patient’s perceived pain relief.

The enquiries show that waiting times vary greatly between clinics and that patients at the largest hospitals in major cities has the greatest risk of having to wait long. The surveys also indicate that there has been deterioration in waiting times between 2010 and 2013.

Discussion
The structure of the Swedish health care system contributes to that many patients who have a semi-urgent need chooses to visit an emergency departments, which creates difficulties for the departments to give all patients a reasonable waiting time. Another noted problem, which also affect waiting in the emergency departments, is lack of beds for patients who shall stay at the hospital.

The system will improve the basis for monitoring and controlling the activities of the E&A-departments. It provides a tool to compare different hospitals and as such give county councils information for how to direct efforts and resources to take care of the most serious problems.

Since the follow-up will be a part of NPR, it will also be possible to carry out more in-depth analyses of the relationship between acute care, primary care and planned care as well as studies of which patients that seeks emergency care and for what problem.
Wednesday 25 June

12.00-14.00

Health managers’ (theses) Session
Case study: strategic management and strategic implementation based on the concepts and instruments from R.S. Kaplan and D.P. Norton

Monika Schäfer
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Context
In her Master's dissertation, Monika Schäfer describes and discusses processes and instruments for implementing a business strategy. The implementation of the business strategy for the "Research and Development" division of the Careum Foundation is based on the findings of R. S. Kaplan and D. P. Norton.

Methods
To implement the business strategy, three instruments were developed and introduced: the strategy map, the balanced scorecard (BSC) and the action portfolio. The balanced scorecard is the key instrument for strategy implementation. It enables performance to be measured by taking four perspectives into consideration in accordance with Kaplan et al. (1997):

a) the financial perspective
b) the customer perspective
c) the perspective of internal business processes (process perspective)
d) the innovation perspective, including potential

The balanced scorecard was used to define metrics and values that enable the strategy implementation and value creation of an organisational unit to be assessed. To analyse the cause-and-effect linkages between the four BSC perspectives, a strategy map was developed.

Results
This Master's dissertation shows how the action portfolio is used to plan the strategic initiatives and how strategy implementation is set in motion with the aid of the BSC and action portfolio. On this basis, a description is provided of how strategic controlling is implemented and how the strategic initiatives are assessed and deliberated.

Discussion
The challenges in managing change processes are discussed. The strategy process is considered from the perspectives of strategic management, organisational development and human resource management. The main areas of strategic human resource management are discussed from the point of view of "management by objectives".
Integrated care by population management. Wanted: managers with guts

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Context
Deliver high-quality care at a lower price with a high-level patient satisfaction. That is the challenge for healthcare facilities in the coming years in Europe. In the Netherlands there is currently insufficient ownership of the overall results of care within a population. There are several organizational, cultural and financial barriers which need to be overcome. Health care is too fragmented: between areas, sectors, departments etc. Recently, several initiatives have been taken to reduce this fragmentation and put the interests of the patient (population) first. In these initiatives organizations take a joint responsibility by establishing a set of services and interventions addressing health care needs in the population. This is known better as Population (Health) Management. This study was designed to contribute to the development of the model of population management through a better understanding of the relevant factors for organizing and implementing population management in health care.

Methods
Our study focused on the Population Health Management (PHM-) Framework of the Care Continuum Alliance. We applied data triangulation by comparing the framework with principles for integration (Suter, 2009) and the Expanded Chronic Care Model (Barr, 2003). We concluded that these concepts/models show much coherence. The PHM-framework distinguishes itself by its detailed operational guidelines. The deducted twenty relevant factors (arranged according to the six dimensions of integration by Fulop, 2005) were presented to and challenged by a Dutch expert panel. Three well established foreign examples of population management have been analysed to validate this set of factors and show how they are shaped in practice. The final list of factors has been used for a field study. The managers and directors who have taken the first steps in implementing Population Management in a specific region have been interviewed in order to establish whether they considered the factors relevant and applicable.

Results
Our study resulted in identifying twenty relevant factors for establishing Population Management, arranged by the integration dimensions of Fulop: system integration, normative integration, organisational integration, functional integration, service integration and clinical integration. The factors included population identification, population health assessment, population risk classification, engagement and communication, interventions and outcome monitoring. The interventions included a wide range of prevention and care coordination to disease and case management.

The field research conducted in a region in the Netherlands resulted in two questionnaires. One questionnaire can be used to facilitate conversations in the initiative phase of organising integrated health care/population management. The second questionnaire can facilitate further strategic conversations in the design phase.

Discussion
In the Netherlands several pilot projects of Population Management have been initiated (2013) by the government. It would be interesting to further investigate the applied implementing strategies. Not only to validate the model, but also to analyse the interdependencies and the extent in which factors are relevant or critical for success. A further field of exploration could be the extent in which country characteristics affect the outcomes of this study.

Perhaps the most important factor has not been included: managers with guts. Integrated Health Care and Population Management needs - in our opinion - a new kind of managers. The kind of leader who has guts to put the interests of the patient population first and the consequences for their own organization in second place, everyone being prepared to make it a common problem and withstanding the reflex to revert to a solistic manner of action.
Implementation of a computerized physician order entry process within the electronic patient file

Andreas Windel
Psychiatric University Hospital Basel (UPK), Basel, Switzerland

Context
In 2006 the Swiss Federal Council defined the following greater objectives regarding its e-health strategy: Efficiency, quality, safety as well as economic strengthening. With the introduction of the electronic patient record the Psychiatric University Hospital Basel has begun to implement the set e-health goals. The sub-project “Introduction of the computerised physician order entry” means another step towards the standardization of treatment processes within the in-patient wards. For this reason it is part of the strategically important objective of customer orientation. The quality management model EFQM (...) forms the methodical basis for the implementation of this improvement project.

Methods
The standardization of the medication process (Prescription, dressing, dispensing, and documentation) within the scope of the electronic patient record is one possible measure to make the treatment cycle within the in-patient division of UPK more consistent, transparent and safer. To what extent a process improvement has been achieved, was investigated with the help of user enquiries and assessments of fault reporting before and after the introduction of the computerized physician order entry. Software systems supporting physicians to process drug prescriptions electronically have been on the market since the 1970s. Survey papers and primary studies refer to a reduction of the medication error ratio. Literature addresses change processes in regards to social aspects. These show the ambivalence between technology and man when introducing CPOE systems. Adherence to guidelines, communication, patient care and staff satisfaction can be favourably influenced. Positive cost-benefit ratios for individual clinics however are not evident, as the results cannot be generalised.

Results
The computerized physician order entry process has been introduced in all in-patient wards and has been standardized throughout the entire clinic. Due to the implementation of this medication tool misinterpretations of prescriptions because of hardly legible handwriting, not clearly defined package sizes and dosage forms could be eliminated. In addition medication records for reporting, recurrent in-patient stays as well as for statistic evaluations regarding provision and research have become more quickly and easily available and are yet another part of the process optimization. Initially the implementation proved difficult due to characteristics of the system and technical problems on the one hand as well as partly lacking acceptance by the physicians on the other hand. During the project implementation a high degree of significance was attached to people-oriented and organizational aspects. To date no evidence of a decrease of medication errors has been generated, since the assessment period has been too short and was hence not significant enough.

Discussion
Based on the results of the realized user enquiry, the clarity and user guidance of the system will have to be improved next. In order to increase the application’s acceptance profound training in all wards as well as for senior physicians will be pursued. Assessments of drug and drug interactions among the prescribed drugs as well as direct integration of laboratory data can improve the medication process significantly. For the purpose of a continuous process optimization a further evaluation of the system will be conducted within a year’s time. It is intended to collaborate with other clinics which also use the computerized physician order entry and to seek a common benchmark. Using such comparative key figures would optimize the efficiency and safety of the process. The introduction of the electronic patient data and the computerized physician order entry are a complex and ambitious project which intervenes profoundly in the clinical process. Professional project and change management as well as active support of the management and senior physicians are critical success factors for a sustainable implementation.
Wednesday 25 June

16.00-17.30

Governance
Enhancing the performance of boards and governing bodies in healthcare: a synthesis of the evidence about board governance, board effectiveness and board development

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Context
There is a need to reduce the variation in organisation performance in healthcare (for example, as measured by the quality and safety of care provided and by efficiency and productivity) for which boards and governing bodies hold ultimate responsibility. By exploring how boards can add value here, we hope that this research will benefit patients and improve service efficiency and effectiveness. We know that there are knowledge gaps about the composition and characteristics of effective boards in healthcare, their impact and about the range of tools and techniques available for developing effective boards.

Methods
This realist literature synthesis study aims to add to existing knowledge by: (1) Providing a theoretical contribution to board governance in the healthcare context; (2) Offering insights into effective board composition, structures, processes and behaviours; (3) Furthering an understanding of how healthcare boards can affect organisational performance; (4) Summarising and analysing the range of board assessment tools and development interventions available. The study adopted a realist approach to an evidence synthesis of a diffuse literature. We tested, honed and refined the research questions and emerging findings with a joint expert advisory and stakeholder group. We followed four main steps: (1) clarifying the scope and developing testable propositions (2) searching for evidence (3) extracting the data and appraising the evidence, and (4) synthesising the evidence and drawing conclusions. After eliminating for duplication and criteria for exclusion, 670 texts including journal articles, books and reports were selected for full review.

Results
Frameworks that have developed from theory and from practice were categorised into the three elements of composition (board structure), focus (what the board does), and dynamics (the behavioural dimension) and the potential conjunction between board theories and practices was explored. We found some important distinguishing characteristics in the healthcare sector. These include:
- Social performance (public value) as well as financial performance is a core purpose
- Non-profit board members sometimes invest more time and are more predisposed to 'managerial work' than their for-profit counterparts
- Public boards may suffer from 'institutional isomorphism'
- Accountabilities on public boards may be blurred
- Existence of hybridised corporate and philanthropic models of governance
- Relatively little involvement in the setting of strategy as opposed to endorsement of strategy
In relation to the impact of boards on organisation performance, contingent factors are important and there is positive empirical support for having physicians on the board.

Discussion
We found no simple theory about how boards should operate. The use of certain models for boards may be more appropriate than others, depending upon the priority in terms of organisation outcome. On the whole, evidence lends further support for a theory about the dynamics of an effective board in relation to high challenge, high trust and high engagement, modified in the light of our developing understanding about the linkages between different contexts and desired outcomes.
There is some evidence that investment in board development affects organisation performance (for example improved board member confidence, greater board engagement and challenge, better financial results). In the light of our analysis of board theories, board practices and the impact of boards on organisation performance, we identify specific areas where board development approaches should be more focussed including strategy, understanding of clinical quality, competing theories and the importance of contextual factors.
Governance of quality of care in an institutionally layered context

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Context
In the Netherlands, responsibility for the quality of care has been given to the Board of Directors which the Healthcare Inspectorate is meant to supervise. So the Board of Directors and the Inspectorate are explicitly given a leadership role in quality of care, both in legislation and in the policy debate. However, many other actors, such as insurers, professional organizations, knowledge centers, consultancy firms and the ministry of Health are also involved in the broader governance structure, which the Board of Directors and the Inspectorate have to relate to. This governance structure can be described as institutionally layered.

Methods
The research question of our paper is: How can we understand the concept of governance shaped in the institutionally layered context of Dutch health care and what does this mean for the attribution of leadership? A qualitative research design was used to conduct this study. We firstly build a theoretical framework from the work of Ezzamel and Reed (2008) to understand ‘governance’ as a multi-level regulative practice. Secondly semi structured interviews (n=18) with stakeholders were conducted. Topics discussed during the interviews pertained 1) the meaning given to governance of quality, 2) the background of the discussion on governance, 3) the division of responsibilities between actors involved in healthcare quality and 4) views on and experiences with the interactions between responsibilities. Thirdly, we collected and analysed policy documents in order to understand and describe the socio-historical evolvement of the regulation of Dutch health care quality into a layered governance structure.

Results
We analysed our data using the three theoretical perspectives by Ezzamel and Reed (2008); the rationalist perspective, the perspective of ‘governmentality’ and the institutionalist perspective. We will show that these perspectives are not just relevant to differentiate between schools of thought in the scientific debate, but that respondents in practice draw on these three perspectives as well. Moreover, they change between these perspectives regularly when talking about their own role or the role of other actors. However, it is important to note that different views on governance and leadership arise from these three perspectives. For example, whereas from a rationalist perspective responsibilities and leadership is clearly distributed, from a governmentality perspective this leadership is much more dispersed. This mixing of perspectives can lead to role confusion, however we will show that it can also enable actors to work on quality and safety effectively.

Discussion
The governance of quality and safety happens in an institutionally layered structure. Conceptualizing governance and the attribution of leadership from different perspectives gives actors more possibilities to work on quality and safety in such a structure. This way the layered structure can be used as an advantage instead of being the cause of role confusion and fragmentation.
Enacting corporate governance of safety and quality: a dramaturgy of English hospital boards

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Context
Recent high-profile reports of serious fallings in the standard of patient care in the English NHS have reawakened concerns about the effectiveness of hospital boards in discharging their oversight duties (Francis 2013). While official guidance identifies a number of board practices as potentially important in safeguarding health care quality and patient safety, significant gaps remain in our understanding of what boards actually do in this regard. An empirical focus on board oversight of quality and safety has resulted in an under appreciation of the social, symbolic and ritualistic purposes of board activity (Millar et al, 2013).

Methods
We utilised a case study design of four purposively sampled NHS Foundation hospital Trusts, undertaken between September 2012 and October 2013. Data gathering comprised overt non-participant observation of 16 Executive Board meetings (64 hours in total) and documentary analysis of board papers and board related artefacts. Detailed qualitative field notes captured the way in which decisions about quality and patient safety were deliberated. Data gathering and analysis focused on how board oversight of quality and safety was enacted, to present a dramaturgical analysis of hospital board practice. Inspired by Erving Goffman’s seminal work on the dramaturgy of social interactions within presentations of self (Goffman, 1959), it draws on the notion of performativity as developed by Martin Hajer to understand how board decisions with regard to quality and patient safety are scripted, set, staged and performed (Hajer, 2005).

Results
We found considerable local variation in hospital board governance of quality and patient safety, with distinct rituals and symbols enacted for different occasions and for different parts of each meeting.
The analysis of ‘scripting’ highlighted how board members played an active or passive role in relation to oversight of quality and safety.
The analysis of board room ‘settings’ identified artefacts (board papers; minutes of previous meetings; tabled reports; presentations) used to influence board decision-making.
The analysis of ‘staging’ focused on when, where and for how long quality and safety issues were deliberated. We also identified dynamic ‘cues’ for appropriate board behaviour in terms of formality and physical environment.
The analysis of ‘performance’ focused on the intentional efforts by board members to shape interpretations and decision making in the direction of a preferred outcome, specifically related to ‘poor performance’ and preferred strategies for improving quality and safety.

Discussion
The dramaturgical approach identifies a range of symbolic factors that influence hospital board decisions and oversight of quality and patient safety. We identified significant differences between the four hospital boards in this regard, indicating that different boards engage with patient safety in different ways with important implications for how patient safety is addressed in each organisation. These social, symbolic and ritualistic practices may support other aspects of board goals in creating positive discourses (e.g. establishing competence, confidence and legitimacy) and so may necessarily be blunted in their instrumental capacities. Further, our approach indicates the potential importance of specific practices in the discharge of board governance of patient safety, which may help to explain the lack of consistent relationships between interventions and outcomes found in large scale quantitative empirical work in this field.
Wednesday 25 June

16.00-17.30

Clinical Leadership
Developing Clinical Leaders: The London Darzi Fellowship Programme

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Context
The importance of clinical leadership in the development of health systems is being increasingly recognised across Europe. The Darzi Fellowships in Clinical Leadership are one-year opportunities aimed at enabling aspiring clinical leaders to develop their leadership experience and change management skills in developing new ways of working in service delivery and commissioning. The programme seeks to link the latest in academic leadership theory, advanced adult learning approaches and work based experience in which to practice and apply tools and techniques in delivery of a change project. The programme is set within a rapidly shifting policy context for health services leadership.

Methods
Participants are drawn from the main clinical disciplines: medicine, nursing, dentistry and pharmacy. Although the majority are medical, usually in senior training positions or early career posts in NHS organisations across London. Fellows are given the opportunity to work as a change leader for twelve months based in hospitals or primary care organisations. Mentored by an identified sponsor, fellows lead on a variety of priority service change projects. During the year Fellows participate in a bespoke (university accredited) leadership development programme that aims to support the organisational and leadership skills necessary for their future roles as clinical leaders. The programme delivery includes formal taught modules including academic modules as the fellows graduate with a PG Cert Leading in a Clinical Context from Leeds University Business School; action learning; coaching; group-based learning; and design surgery support for live projects within their NHS Trust or Clinical Commissioning Group.

Results
The programme delivers results that provide fellows with insights into the realities of clinical leadership, into key ways in which the health economy is changing, and into leadership capabilities demanded by these realities and changes. They include an appreciation of change management, designing interventions, cross-team working, organisational development, leading projects, and specific leadership styles and approaches. In addition, consideration is also given to the practical skills needed to get their projects delivered, including managing projects, assessing risk, negotiating with stakeholders, influencing peers and resolving conflict.

The impact of the programme hinges on the future ability of participants to lead change. Evaluation indicates that a sound basis has been made to achieve this. The programme is now into its fifth cohort of clinical fellows and a variety of internal and external evaluation results demonstrate the impact that the programme had had on the Fellows, their trusts and healthcare outcomes.

Discussion
Some of the main challenges the programme has faced have been around ensuring a consistent quality of work-based learning opportunities and support. There have also been tensions between the delivery and learning outcomes of projects. Refinements to the design of the programme have been made to ensure greater ownership and engagement of sponsors. The importance of place-based clinical leadership and development of support networks amongst fellows are important factors for the wider impact and sustainability of the programme. The programme design directly draws upon research evidence on the development of productive relationships between clinicians and managers, and the strong association with improved service quality.
Perceptions of junior doctors on management and leadership

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Context
The importance of clinical leadership in health care is increasing. Junior doctors are future leaders, and will have a key role in improving the quality of care. Most medical schools provide little or no structured management development for junior doctors. Learning leadership and management is often unplanned and informal. It is suggested that senior managers have difficulties to articulate their managerial role in relation to medical profession, even when physicians themselves. The physician-manager role is felt by junior doctors to be unclear. The aim of our study is to explore junior doctors’ perceptions of management and leadership.

Methods
The University of Helsinki, Finland, runs a mandatory management development programme for doctors in specialist training. After the programme the participants are expected to have the knowledge, skills and attitudes required of frontline managers in health care. The programme uses an e-learning platform for the documentation of learning. Assignments performed during the programme form an electronic portfolio, which aims to support the professional and personal development of the learner. The participants include a personal management philosophy in their portfolios. The junior doctors are instructed to reflect on how they see management and leadership in health care, what aspects of leadership and management they want to include in their role as a medical specialist, and their views on good and bad leadership. The study was approved by University of Helsinki ethics vetting board and the participants signed an informed consent form. Totally 30 management philosophies were analysed with qualitative content analysis.

Results
Our preliminary results indicate that junior doctors consider the quality of medical care to be the most important management responsibility. Care should be based on clinical guidelines and other evidence. Consequently, to take responsibility for competence development of subordinates was considered crucial. Some junior doctors emphasised the importance of societal responsibility and equality as to access to scarce resources. Junior doctors value leaders who are able to take responsibility, have good communication skills and create a relaxed atmosphere, are easy to approach and are fair as decision makers. Some junior doctors found an analogy between the principles of service management and individual patient care.

Discussion
Reflective writing in portfolios formed a rich qualitative material. Our results reflect the perceptions of junior doctors with no previous experience in a formal management position. The results can guide the design and improvement of management development programmes for junior doctors.
Wednesday 25 June

16.00-18.00

Session on e-Health Implementation
Shared Electronic Patient Record Systems: Contrasting Approaches from the UK and New Zealand

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Context
The potential for information technology (IT) to improve the management and delivery of healthcare has been recognised for many years, but the realisation of these benefits is often fraught with difficulties. Both the UK and New Zealand have long established, integrated, publicly funded national health systems. In the UK leadership of IT developments has tended to be provided centrally whereas in New Zealand centralised direction has been focussed at the strategic level of identifying goals and standards. This paper examines the contrasting approaches which they have taken to the implementation of shared electronic patient record systems.

Methods
In the UK the recent, ill-fated, National Programme for IT was one such centralised approach which was intended to provide the framework for integrated patient records by negotiating significant contracts with a small number of major providers of IT services.

In New Zealand, the more tactical decisions about the implementation of appropriate and compliant IT systems are devolved to the 20 District Health Boards (DHB), which are responsible for the delivery of the healthcare within geographic regions of the country, and to individual health care organisations. Due to their limited resources DHBs now operate within 4 regional areas collaborating with their neighbours in developing and delivering shared services, including IT services. Work around shared electronic records has mainly occurred within 3 regions, centred on the major population centres of Auckland, Wellington and Christchurch, each of which adopted different priorities and approaches. Clinicians are an integral part of these implementations.

Results
The UK National Programme for IT is widely regarded as an overall failure, with missed deadlines, budget over-runs, contract disputes and critical reviews by the Public Accounts Committee. Some parts of the project are functioning but the overall goal of a national integrated system seems still to be some years away.

In Auckland work focused on Test safe, a shared repository system to consolidate and provide wider access to results of laboratory tests. This work was developed ‘from the ground up’ by clinicians with the IT staff and is being rolled out across the 4 regions. The lower North Island and Wellington have been implementing a shared record system based on the commercially available ManageMyHealth system from Medtech. In Christchurch the local healthcare providers collaborated with IT company Orion Health to implement a cloud based Shared Care Record View (eSCRV) system which provides controlled access to summary records by multiple providers.

Discussion
Although the health services of the UK and New Zealand have similar structure and face similar challenges, their approaches to the implementation of shared patient record systems and the outcomes of their programmes have been quite different. The UK approach of a top-down, technologist-led implementation programme is widely viewed as largely unsuccessful.

In contrast, the New Zealand approach of a bottom-up clinician-led approach within a strategic framework is proving to be successful. All the projects were developed with clinical leadership from the community benefiting from the projects, are ‘opt-off consent’ systems and have adoption rates by patients and clinicians of 95-99%. As all the projects were developed within the overarching strategic framework provided by the Ministry of Health, they will eventually be integrated into a national framework.

In conclusion, one of the key ways to improve the outcomes of clinical IT projects is to ensure they are led by clinicians.
Telemedicine in Europe: Are we addressing the right business models?

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Context
For decades many telemedicine (TM) projects, mainly within pilot or research context, were deployed. Although the hype and the proven fact that it adds both clinical and economic value, the reality is that most cases did not reach routine care. Many reasons can be responsible for that, most often due to the lack of a proper business-model. The MOMENTUM project, a thematic-network partially funded by the European-Commission, coordinated by EHTEL, and with a deep involvement of EHMA is addressing this problem. There is a need to understand better the TM business-models currently in use and why they fail so often.

Methods
The methodology used combines a literature review and the application of a survey to identify both TM development barriers and opportunities, and business-model issues (strategy, management, services, financing, etc.). This survey was applied in almost all European countries reaching the most significant TM cases. From this survey a set of good examples was chosen for further study. Here, the focus will be on business-models issues. The business-models used by these cases were analysed within the context of a maturity matrix developed to enable proper analysis; and to identify barriers and the necessary steps required to support the leap to routine care. The conditions required reaching successful deployment and what to avoid were carefully assessed. Among many issues, the importance of procurement and commissioning in the process is evaluated, as well as if the diffusion process depends upon the topology of TM services or on the competencies of the people involved.

Results
The most frequent TM failure reasons were identified: Lack of clear objectives (confusion between services and technology); Lack of leadership and coordination; Lack of training, more on the business and organizational side; Lack of business models (incentives, reimbursing schema); Lack of integration with the routine services. Additionally, it was found that this is both a private and public health services phenomenon, as it is an international problem. From the successful cases analysed there are mainly two different situations: either the TM services is the continuity of previous services (only using TM to extend it - like radiology or haemodialysis) or are TM services integrated in healthcare networks simply assumed as beneficial. It is very exceptional to have a business plan or reimbursing schemes supporting the decisions. Most of the TM project coordinators believe in their “non-existent” business-models, probably feeling that with more time and experience an innovative business-model will emerge.

Discussion
Momentum is showing the importance of management, leadership and business models in the development of TM services (and which core goals of EHMA are). It is therefore important to understand how to develop TM, considering that TM is an important and relevant channel to provide healthcare (with proper use of technology, reducing costs, enabling improvements in quality, empowerment of patients, etc.). However, are we sure to have the managers with the right skills to address the challenges of launching TM services? Are business-models incorporating real value? How can TM make it possible? TM services should be looked as a process requiring a business-model and an appropriate leadership and regulations, and the access to ease of use and low-cost technology. The learning from successful cases could further elicit to define a “Blueprint”, as a set of guidelines, which will improve the odds of TM projects.
Thursday 26 June

09.00-10.30

Delivering excellent quality 2
The use of the anaesthetic file indicator in French hospitals: Socio-material context and role of local leaders

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Context
In a context of increasing consideration for patient safety and service quality, healthcare systems are developing numerous indicators of performance. Their use and their impact can be variable, sometimes very different from what has been previously expected. Our study intends to identify "concrete" key factors from the work environment which would determine the use of an indicator in hospitals. We analyse its characteristic in terms of "affordances" (Gibson, 1977) and we mobilize the distinction between "real" and "perceived" affordances (Norman, 1999), which put the emphasis on the major role of local leaders in the appropriation of such tool by a collective.

Methods
In order to analyse the use of the DAN, an indicator for anaesthetic files in France, and to identify the managers’ strategies for its implementation, we proceeded to carried out 7 case studies. The 7 hospitals were chosen according to Yin’s (2008) suggestions for sampling cases: diversity in size, structure (public/private, teaching hospital/non-teaching hospital) and previous results at the DAN. In each hospital, observations have been performed in the anaesthetics consultation offices and the surgery area (from 1 to 5 days in each hospital). The researchers also performed in depth interviews (n=35) focused on practices using a guide based on the results at the DAN’s indicator. They, moreover, collected external and internal documents concerning the analysis of the results of the DAN and the improvement actions implemented.

Results
The comparison of the 7 case studies put the emphasis on two 2 important factors, part of the socio-material context, on DAN’s use:
Information system. The computerization of anaesthetic records in hospitals has a major impact on the score. It appears from our investigations that it is not only a result of a material constraint but also an "imbrication of human and material agencies" (Leonardi, 2011).
Social Climate. The capacity of the organization to create a consensus on practices depends on the relationship between professionals.
Both factors points to the key role played by local leaders. An important part of their activity consists in legitimizing the improvement actions implemented to reach DAN's objectives through arguments corresponding to the local needs or concerns. We identified three registers of argumentation:
A. Scientific
B. Democratic
C. Recognition

Discussion
This study underlines the importance of considering the socio-material context of local organizations and the affordances of tools to analyse the use and impact of an indicator on practices. It highlights the key role of local leaders (generally physician themselves) in the implementation of improvement actions. It also offers a new framework to consider their concrete activity. An activity of major importance which remains, paradoxically, underestimated by researchers as well as top managers in healthcare.
Improving forensic psychiatric care - preliminary findings from the introduction of standardized care plans

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Context
Standardized care plans are common within the somatic health care area. Psychiatric services have been less likely to implement these methods. The Division of Forensic Psychiatry in Region Skåne, Sweden, provides services to an area with 1.2 million inhabitants and treats approximately 100 in-patients and 200 out-patients. An extensive administrative and clinical reorganization is now implemented with the overall aim to assure a high quality of core treatment areas. The specific aims have been to: provide patients with an evidence-based and coherent psychiatric care, to reduce differences in treatment procedures and to facilitate high quality evaluations and clinical research.

Methods
Specific care programs for each target area were defined by staff work groups supported by expert panels. The programs specify the content, timing and responsible professionals of core treatment areas and also indicate how treatment outcome is measured. It also establishes when patients should be transferred from one service levels to another. Four process managers were recruited to supervise the adherence to the clinical and administrative guidelines, including care planning and documentation. The objectives of each care unit were redefined to support the overall mission of the program and a team-based working process was emphasized. All team members were trained in interactive sessions focusing organizational skills and administrative support as well as specific methods and procedures. To monitor and evaluate each intervention and give feedback to the patient on his or her progress, patient data are continuously collected through scannable forms and stored in a regional quality registry.

Results
There has been a continuous re-evaluation of the specific objectives and the strategic vision through balances scorecards. Several measurable results can be related to the reorganisation and implementation of the program and the standardized care plans. Treatment periods are now among the shortest in Sweden, with an average length of inpatient stay of approximately 1.5 years while rates of illness relapses and criminal reconvictions have been maintained. In order to evaluate changes in the patients’ quality of life, a baseline measurement has been made, which will be followed up once the program is fully implemented. Preliminary results from a review of all care plans indicate that patients have experienced an increased involvement in their own care process. In addition, shorter hospital stays, with more patients moving out of the wards to municipal residents, is increasing the autonomy and social role functioning of the patients.

Discussion
The preliminary results indicate that standardized treatment programs are viable for forensic psychiatric services and they can potentially reduce lengths of stay, increase patients’ quality of life and lead to reduces financial as well as human costs. However implementation of large scale programs are time and cost consuming and there are apparent risks of management challenges such as staff turnover, communication mismatch and organization fatigue, which will be discussed.
Thursday 26 June

09.00-10.30

Leadership for Citizen and Patient Empowerment
Towards user involvement in dementia care: people living with dementia in the lead

**Inge Bongers** 1,2, Liselore Snaphaan 2, Diana Roeg 1,2; Rens Brankaert 3

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**Context**

As the current healthcare systems are not able to deal with the sharp increase of people living with dementia, an innovative approach will be necessary to stay longer at home with dementia. Therefore an international project called "Innovate Dementia" is started with the aim to develop innovative, transferable dementia care models by a Living Lab approach. By putting people living with dementia in the lead as co-creators and testers of innovations, the developed innovations are more applicable in and suitable to real life situations. In this paper, insight is given how user involvement can be build up and implemented.

**Methods**

Four Dutch partners (Mental Health Care Organisation Eindhoven (GGzE), Technical University Eindhoven, Brainport Development and Municipal Eindhoven) intensively collaborate to create a Living Lab ecosystem (LLE). LLE is an open innovation environment in which user experiences reveal future directions of product development. Each partner has its own role and responsibility in LLE. GGzE is responsible for the set-up of user involvement. Users are defined as, people diagnosed with dementia, their relatives/cares and professional carers. These users are involved as co-creators and testers. To create and build up user involvement, a user platform is formed in which 1. The (unmet) needs of people living with dementia are harvested and investigated, by implementing standardized questionnaires, home observations and in depth interviews, 2. Input is given by users for developing products addressing such a need, by brainstorm sessions, focus group meetings and workshops 3. Innovations are tested and evaluated in their home environment.

**Results**

During the period of September 2012 till now, every month the Dutch project partners met each other, which resulting in a quadruple stakeholder network of more than 20 companies, 19 care institutes, 8 knowledge centres, 9 governmental bodies (www.slimmerleven2020.org). Furthermore, more than 100 users (clients, informal caregivers, formal caregivers) participating in our User Platform LLE. All clients/informal caregivers filled in a structured questionnaire about their daily living. More than 50 home interviews and observations took place, 12 focus group meetings were organized, 4 workshops and 3 brainstorm sessions were held, 3 innovations were developed, tested and evaluated at home by 40 persons living with dementia. To keep our quadruple stakeholder network informed about the project there has been built a website www.innovatedementia.eu. Furthermore, a web based database is set up to store/analyse qualitative and quantitative data and make exchange possible between the international project partners or stakeholders.

**Discussion**

Working with a living lab ecosystem in the dementia care is more difficult than in other sectors were users are involved because of the deteriorating effect of the disease and the large stakeholder network involved in the care of these people (e.g. informal and professional care givers, health insurers, municipalities). Although the mentioned results are still preliminary, the three elements of user involvement 1) investigating needs, 2) developing innovation for dementia care and 3) testing and evaluating innovations at people's own homes, are what make Innovate Dementia LLE unique. The LLE approach, first, will contribute to innovation in practice by pioneering new forms of user-driven research. Second, research from LLE will contribute to market innovation by producing breakthroughs in developing processes with users as co-creators and by products that will be easy to install, user friendly and that meet environmental performance standards in real life.
Coproducing Health in Leeds

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Context
The Leeds Hub of CIHM’s International Shaping Health Systems Network (a small mix of health leaders from a range of sectors) shared a belief that if people were partners in the design and delivery of health services; if healthcare worked with the assets of patients and service users; then health care could be transformed. Our challenge was to coproduce health across the City. We chose drug and alcohol services, as we knew it was a growing problem, and wasn’t a high priority in Leeds. Our ‘plan’ was to establish the systemic change of drug and alcohol services in Leeds.

Methods
The questions we identified for this work were
- What happens if we see the problem, solution and resource as OURS together?
- How can we get congruence between street and the strategy?
We took five months designing a whole system event that would catalyse change in the city. The design included securing the right mix (in terms of level and sector) of service providers and commissioners; and finding enough service users to participate. The design of the event was to model what we believed about change and coproduction. 200 people, half of whom where service users joined the 1-day event in Leeds Town Hall. 70 then joined a communities of practice, and set about prototyping change in the City. Using learning journeys to challenge our ideas; peer learning and action groups we created change in delivery. Local area commissioning events coproduced a new strategy at both a city and local levels.

Results
- A new strategy for the City with radically different approach to services city-wide and locally
- A new model of GP provision piloted for the city, partnering with service users and the third sector
- 'SPACE' a new user-led recovery space for drug and alcohol
- A volunteering scheme for recovering addicts
- A social movement group seeking voluntary minimum pricing for alcohol
- A group setting up a ‘dry’ pub in the city centre
- A Friday night youth club
- New multidisciplinary training for professionals working with older people with addiction
- A new alcohol worker in the student's union
- A Big Lottery funded bid
- New partnerships for ex-offenders in the Community Health Educator team
- A new social enterprise proposal from probation based on coproduction

And most importantly it changed attitudes
“They were taken aback...the picture of a drug user was nothing like the articulate well-presented person who they’d been speaking too”

Discussion
This is the only city-wide coproduction programme that we know of internationally. 2 years on it is sustained and projects are still emerging. Service users move in and out of the programme of work, but it has a life of its own now, no matter how much movement of people there is. We believe starting at scale made a real difference rather than starting small and hoping it would scale up. Having a neutral network as a home for the work, meant it was hard to oppose or to criticise as there was no lead organisation. We have learnt a significant amount together as peers, and can share the principles that we believe make Coproducing Leeds what it is today. We will be sharing our analysis of the ‘right conditions’ for coproduction and the potential for radical service change.
The role of middle managers in distributing leadership in the local governance of care and welfare

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Context
Across Europe, neighbourhoods are increasingly seen as appropriate governance sites for the integration of fragmented public services and citizen empowerment. This paper addresses the key question how leadership is being reconfigured in the local governance of care and welfare. Building on theories of distributed leadership (DB), we argue that leadership should not automatically be equated with the notion of an individual leader, but must be researched as a distributed activity enacted by a collective of local actors. Our qualitative study of Dutch neighbourhood collaboratives by care providers offers important insights into ‘how’ leadership is distributed and to what effect.

Methods
A qualitative approach was adopted to study discursive constructions of leadership in the Dutch public reform program, called “The Neighbourhood Based Approach”. The goal of this program was to integrate fragmented public services (i.e. care, housing and welfare) and to locally empower citizens. We specifically investigated language references to leadership that were made by actors in the program. Multiple methods were used to collect data including: informal interviews with middle managers and professionals; observations of daily activities of middle managers, such as training sessions and meetings with care workers and citizens; document analysis of minutes and strategic visions; and a survey with middle managers who evaluated the outcome of their projects and described daily dilemmas in distributing leadership. In total 15 days of observations were conducted. On the basis of elaborate field notes, a language analysis was made of recurring leadership constructions.

Results
Rather than a spontaneous bottom-up process, the distribution of leadership is steered by middle managers of care providers. Middle managers not only distribute leadership to wider collective of local actors such as professionals and citizens, but also reshape responsibilities in the process. Three important consequences of distributing leadership are: 1) responsibilities for citizens and professionals to organize care and welfare close by home 2) the repositioning of middle managers as coach, 3) new manoeuvring room for professionals in service design. The findings also demonstrate that DB is a two-way street: parallel to distribution, new centralization occurs via emerging coordinating roles. Hence, rather than leadership being evenly distributed (i.e. everyone ‘in the lead’), leadership is in fact enacted by a more select group of actors, including care professionals with coordinating tasks, middle managers with coaching roles, and ‘active’ citizens (i.e. a few ‘in the lead’).

Discussion
We conclude that DB has both a bright and dark sight. It provides opportunities for locally tailored services, but also carries the risk of overburdening citizens and professionals with new responsibilities for organizing care and welfare. Paradoxically, the distribution of leadership to local actors, did not result in the ‘decentring’ of middle managers, as is commonly expected. Although middle managers themselves frequently talked about a reduced role for management and the necessity of ‘letting go’, their new role as coach entailed a considerable workload due to the interactive nature of coaching activities. As facilitators of reflective dialogue and sense making, they seem to contribute rather than hinder the development of local governance.
Co-production in Healthcare: Unravelling Its Process

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Context
User-generated knowledge is increasingly recognised as an important type of knowledge in the design and production of public services. Introducing this type of knowledge in public service delivery by involving individual citizens and groups, is also known as ‘co-production’. In healthcare, the concept of co-production receives increasing attention, as the involvement of both patients and healthcare staff in the design and production of their services is seen as an important means to improve the (perceived) quality of care. However, insight into the process of co-production is scarce. The aim of this paper is therefore to explore healthcare co-production activities in-depth.

Methods
This article focuses on hospitals involving patients and healthcare professionals in processes of co-production in order to improve the quality of care on hospital wards. A qualitative study in five Dutch hospitals was performed. In-depth semi-structured interviews were conducted with members of the five hospital project teams, who were responsible for the content and progress of the co-production projects (N=24). In addition, observations were conducted during project team meetings and moments of patient and/or staff involvement (66 hours). To gain a more in-depth, triangulated view on the empirical data, we also analysed relevant documents. These documents included ‘actions plans’ of hospitals (which contained notions of the target group, purpose of the project, the way in which users and patients were to be involved), minutes of meetings of the project teams, and invitational letters to patients.

Results
Hospitals have different motives to involve patients and staff in processes of co-production; quality improvement is just one the reasons. Existing methods to involve patients were adapted to the local context. Quality improvement areas brought forward by patients were often already known. However, the process of co-production did contribute to quality improvement in other ways. The process of co-production stimulated hospitals thinking about how to realise quality improvements. Quality improvements were facilitated by this process as seeing patients and hearing their experiences created a sense of urgency amongst staff to act on the improvement issues raised. The experiences served to legitimatize improvements to higher management bodies.

Discussion
Different participation methods can bring patient’s experiences with healthcare services to the fore, which can be used for quality improvements. Our study shows that adapting existing methods to the local hospital resources is likely to be beneficial for a method to succeed within a given context. However, adapting and tailoring also facilitates risks. Tailoring activities such as using various criteria to select patients influences what is considered to be legitimate patient input. In addition, as the process of co-production is considered to be important, the method should consist of an organised trajectory in which patients and staff are involved and personal experiences are brought forward. Therefore, project teams need to critically reflect on the consequences of adaptations and tailoring actions, and their desirability, when carrying out quality improvement projects.
Thursday 26 June

09.00-10.30

Building Health Care Networks
How far can healthcare leaders reconcile primary care integration and provider competition in practice?

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Context
Across Europe, intense pressures for cost-containment in publicly-funded health care have motivated two policies. One is to develop primary and social providers as a substitute for some forms of hospital care; but this requires close coordination, even integration, of primary and social care services. The other policy is to promote marketisation (provider competition, more diverse providers) as means to create service efficiencies. Drawing on three recent research projects in the UK, and noting parallels and differences elsewhere in Europe, this paper considers how far these two policy agendas can both be sustained at once in primary care.

Methods
Multiple-method framework analysis:
2. Systematic comparison of case studies of how each policy has been implemented in practice:
   (a) How the implementation of marketisation policy impacted upon care integration
   (b) How the implementation of care integration policy impacts upon marketisation

Data are taken from three empirical studies (2006-2014) concerning:
(a) Commissioning of NHS services (4 case studies: tracer care groups include frail elderly people at risk of frequent hospital admission; mental health). (b) Integration of primary care (4 case studies, different sites to (a), frail elderly people at risk of frequent hospital admission as tracer group). (c) Diverse provision of primary care (5 case studies, different sites to (a) and (b), foci include out-of-hours primary care).

For each policy, we compare the intended policy implementation mechanisms with those empirically implemented in the above cases, and their compatibility.

Results
Providers which were, or expected to become, competitors were wary of collaborations which involved disclosing possible innovations in working methods. Local managers devised various workarounds to make the two policies more compatible in practice:
(1) Micro-commissioning: jointly commissioning health and social care providers at a very localised level.
(2) Construction of care networks to 'integrate' (coordinate) care across separate providers, both at inter-organisation level and through case management.
(3) Establishing local organisations through which referrals (to other primary and social care services, not only hospitals) would be centralised.
(4) Ad-hoc adjustments to DRG (or equivalent) tariffs; or tacit reintroduction of non-tariff methods of paying providers.
(5) Encouraging patients to coordinate their own care, but the more complex the patient's care needs, the less likely was she to be able to do this.
(6) Integrated provider organisations, both vertically (primary and secondary care) and horizontally (primary health and social care).

Discussion
Many of these inter-organisational tensions pre-dated the post-2008 financial crisis and marketisation policy. Nevertheless, the prospect of competition for contracts constrained working relationships among providers, and between providers and commissioners. These tensions were more apparent in services for conditions with long-term, ill-defined episodes of care (chronic care, multiple conditions) than in services that provided relatively discrete 'commodified' services (e.g. planned orthopaedics). Local managers were able to mitigate the tensions, at the price of some implementation deficit for both the integration and the marketisation policies.
The Evolution of Cooperative Leadership Networks in Competitive Healthcare Markets

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Context
The year 2006 marked the introduction of price-competitive policy reforms in Dutch healthcare. Currently, price is negotiable for roughly 70% of hospital care, forcing organizations to find ways to deliver high quality care at low costs. Since the introduction of the new healthcare system organizational leaders (i.e. board members) led a wave of cooperative initiatives such as mergers. However, several new players, predominantly Independent Treatment Centers, have also entered the market, increasing competitive pressure. The aim of our study is to explore the association between price competitive policy reform and networks of organizational leaders in different healthcare domains.

Methods
We use longitudinal Social Network Analysis to explore the evolution of networks of executive- and advisory- board members. We included roughly 20,000 board members of 1679 Dutch healthcare organizations from five different categories, namely: hospital care, nursing and home care, mental health, care for the disabled, and a miscellaneous category including amongst others maternity care and social work. Data was collected through annual reports between 2008 and 2012 and healthcare organizations were identified by their chamber of commerce number. From this original dataset we derived annual inter-organizational networks based on interlocking directorates (i.e. board members simultaneously working on the board of multiple organizations). We not only test how price competition is associated with the (cooperative) networks of leaders in different healthcare sectors, but we also consider the role of several organizational attributes such as type, size, and performance in the formation of leadership ties.

Results
Initial results show that cooperation among healthcare organizations, by way of sharing board members, has become increasingly common over the 5 year time period we analysed. The number of cooperative leadership ties has more than doubled in this period. We particularly find this effect for networks amongst supervisory board members and networks between executive and supervisory board members. Leadership ties formed by shared executive boards are less common. Cooperation is predominantly present across categories rather than within categories, suggesting that expertise from one type of healthcare organization could be transferred to other sectors of healthcare through its leaders. Also, organizations with strong ties tend to dissolve these ties and leave the market, which suggests merger behaviour. On the other hand, organizations entering the market and connecting various parts of the network could suggest spin-off or diversification strategies.

Discussion
Initial findings prove that pro-competitive policy reform has sparked cooperative instead of competitive reactions by healthcare’s leaders. Such behaviour is especially apparent across different types of healthcare organizations which highlight the interconnectedness of the different parts of the healthcare sector. This is a considerable finding for both policy makers reforming healthcare sectors and antitrust agencies enforcing antitrust laws which primarily focus their efforts on these categories. These exploratory findings also illuminate several promising avenues of research. The relation between competitive policy reform, cooperative ties between organizational leaders, and organizational outcomes such as costs and quality is one such example. Another is the interaction of networks of board members with networks of specialists and/or patients. A third suggestion for further research is the relation between cooperative ties among leaders of healthcare organizations and mergers and acquisitions or diversification strategies of these firms.
Thursday 26 June

09.00-10.30

Business modeling in healthcare
Designing telehealth into health service operations: the role of business models in system change

Duncan Ross, Chris Clegg, Lauren Beaumont, Lucy Bolton, Helen Hughes
Leeds University, Leeds, UK

Context
The view that business models create a type of system infrastructure is not new; Bouwman, de Vos, & Haaker (2008) state that a business model is a blueprint which describes and defines a service both by its intended value and sources of revenue, providing an architecture for the delivery of that service. The unique contribution of the Mainstreaming Alternate Living Technology (MALT) project is to explore the impact this architecture has on the design and operation of telehealth services.

Methods
The overall aim of the project is to understand current telehealth business models and to prototype alternative business model scenarios, that help overcome barriers to the mainstreaming of telehealth technology. The project is conducting research at four NHS sites in the Yorkshire region (UK) where telehealth is currently being used. A socio-technical inquiry approach is being taken to understanding the telehealth services at each site. A key principle of this approach is that all aspects of the system must be jointly understood and designed together in order to achieve successful outcomes (Clegg, 2000). Through a process of interviews and workshops it has been possible to map current business models and study their impact across the telehealth service at each site, identifying barriers and enablers to the successful adoption of telehealth technology.

Results
Although the research is on-going, the project has four case studies of telehealth, each an example of a procurement based business model (where the equipment is owned by the NHS provider, or commissioning body) with differing service designs. For example, some sites have chosen to commission external providers to resource telehealth processes (such as installation), whilst other sites have chosen to resource work internally with the creation of new roles. The three case studies this paper presents will illustrate the implications of different business models and service designs have on the organisation of work within telehealth services and the impact this has upon the successful use and uptake of telehealth. Further, the paper aims to explore what we can learn from these case studies regarding the design of new telehealth business models that assist the mainstreaming of telehealth within the NHS.

Discussion
We see examples of how business models impact on the design of services in other areas of industry. For example, current practice in aero engineering suggests that changes from manufacturing business models (where aero engines are sold, and under separate contract maintained) to service models (where the output of the engine is sold, such as Power by the Hour® operated by Rolls-Royce) have led to changes in the way the aero design community operates. The aero engineering design community now need new tools that enable them to predict the lifecycle costs of engines; new roles, that include the consideration of engine lifecycle costs and new relationships with service engineers, that allow them to understand, analyse and reduce lifecycle costs. The application of such an approach to business modelling in health services is providing new and exciting insights about the potential scale and spread of telehealth services.
Lessons for the NHS from a realist review of the literature on procurement and supply chain management

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Context
Operations management is arguably underlain by intensely political rather than purely technical decision-making. In the English NHS, despite the rise of managed professional business archetypes, healthcare professionals continue to dominate procurement decisions (Allen et al., 2009) and the current move to GP-led commissioning may well serve to formalise this dominance (Mannion, 2011). Against this background, this paper reviews and synthesises theoretical literature on procurement and supply chain management (P&SCM) with empirical evidence of its application in healthcare. The research provides intelligence and practical guidance for NHS managerial and clinical leaders with responsibility for generating £20bn in efficiency savings from commissioning.

Methods
This research employs a realist review approach, which emphasises the contingent nature of evidence and addresses questions about what works in which settings, for whom, in what circumstances and why (Pawson et al., 2005). A realist synthesis also emphasises an iterative approach between programme theory and predicted theory (Selim et al., 2009). It can be used to generate a theory map exposing the differences between programme theories and theories in use. This is appropriate given that a key aim of the proposed study is to illuminate differences between how NHS procurement and supply chain management might be carried out and current policy and practice. The synthesis addresses questions about how and why P&SCM practices are influenced by context and circumstances, the impact of these practices on procurement outcomes, and the appropriateness and effectiveness of approaches to improving P&SCM.

Results
Through interpreting the diverse terrain of P&SCM literature from a realist perspective, a resultant framework is drawn up to explicate the logic of ‘context-mechanism-outcome’ in the main strands of theory. This realist logic focuses attention on the generative forces behind how a particular procurement and supply chain practice, or intervention, might work. These theoretical insights are used to assess the policy and guidance relating to P&SCM in the NHS beginning from the establishment of the internal market, demonstrating that the attempt to restructure the previously hierarchical NHS into a market resulted in an incoherent mix of hybrid forms. The analysis is then extended to empirical evidence of the implementation and performance of P&SCM interventions in the NHS, which together with the following review of evidence of P&SCM interventions in other countries and sectors, demonstrates the contextual contingency of what works.

Discussion
The realist review approach is sensitive to the existence and analysis of contingent evidence. By positing that the expression of theory is linked to the ‘context-mechanism-outcome’ configuration, it focuses attention on the implementation of specific interventions rather than wholesale programme theories in practice. Understanding why and how different P&SCM interventions work in different settings, for different actors and in different circumstances within the NHS equips managers and clinicians with a ‘portfolio approach’ in this area of work. This means, for example, that commissioners may opt for tight contract specification when commissioning services from an experienced private sector provider or for greater focus on supplier development strategies when working with an emerging third sector provider and they may find different degrees of competition or collaboration more appropriate in different circumstances within the healthcare market. This guidance remains robust by being both theoretically informed and contextually relevant.
Thursday 26 June

11.00-12.30

Innovation
The role of Hospital Based Health Technology Assessment in the uptake of health technologies: evidence from AdHopHTA

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Context
The decision-making process on the uptake of healthcare technologies (HTs) is a topic of most interest within all modern healthcare systems. Specifically, the adoption process in hospital settings is of particular interest. Scholars have been searching on the role played by several factors, but there is a scant of knowledge on the role of Hospital Based Health Technology Assessment (HB-HTA) on this decision-making process. AdHopHTA, an EU project aimed to strength the use of HB-HTA, deals with this matter. We aim to present here preliminary results on the process for HTs uptake in hospitals.

Methods
A survey with closed-ended questions was carried out among Hospital Managers and Clinical Directors in a convenient sample of European hospitals with different organizational features, including the presence of HTA Unit or initiatives. 339 potential respondents from 122 hospitals were invited to participate. The aim of the research was to characterize the process of uptake of HTs in hospital contexts. Respondents were asked to provide information on hospitals' characteristics and process of adoption of health technologies. In particular, they were asked to specify the involved actors across all the decision-making process from its inception to the final decision on uptake. Moreover, they were asked to identify and rank relevant competences in the decision making process.

Results
One hundred sixty-five professionals affiliated to 85 hospitals participated in the survey. 65% of them declare that HTA activities or initiatives are carried out in their hospitals. Preliminary results show that the first proposal on uptake of technologies comes from clinicians regardless of hospitals' characteristics and functions for 63% of respondents. Final decision is taken by the Chief Executive Officer (62%) or other members of the Management Board, such as Chief Medical Officer (45%). On the contrary, organizational features play a role when competences in the process of adoption are identified and ranked. In particular, hospital size as well as the presence of HTA activities or initiatives affect the variety of competences involved in the process and impact on the relative relevance given. Specifically, hospitals with HTA functions or initiatives are more likely to consider organizational issues as well as technical ones. Impact of nursing competence is generally acknowledged as relevant.

Discussion
The study provides useful information for hospital administrators and decision makers. The understanding of factors that influence the decision making process on HTs uptake could help to design strategies/actions to promote a more inclusive competences in the final decision. It seems that Hospital-Based HTA, acting as a systematic assessment of possible technological solutions, could reinforce the involvement of all hospital stakeholders.
Transformational leadership versus transactional leadership and team performance in healthcare

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Context
Health care organizations need to continuously improve performance and quality, to benchmark care with the highest standards, as well as to push for innovation and clinical excellence. We posit that the manner in which groups of health professionals are effectively led and the extent to which they adopt team climate principles can impact on their performance, with far-reaching implications for patient care. Specifically, we hypothesise that transformational/transactional leadership is positively associated with, and predicts hospital teams’ performance, through the mediating role of team climate for innovation. However, transformational leadership explains a higher variance in hospital teams’ performance than transactional leadership.

Methods
Data were collected from 1,137 employees nested in 124 teams and from forty-four external raters in a Maltese general hospital. Transformational-transactional leadership was measured using the Rafferty and Griffin (2004) fifteen-item scale. Team climate was measured using the nineteen-item scale (Anderson & West, 1998). Team performance was measured using a tool adapted from the one used for primary health care (Borrill et al., 2001). The seventeen items referred to the maintenance of clinical competence, provision of information, setting of protocols, implementation of procedures, implementation of strategies for communication between members of unit such as regular meetings, conduction of audits and reviews, clarification of roles and responsibilities of unit members, and commitment to personal and professional development of staff. Analysis at the team level was justified on the basis of within-group agreement, non-independence, and reliability. Additionally, the external ratings of team performance achieved acceptable inter-rater agreement, reliability, and between-group variance.

Results
Team climate for innovation partially mediated the relationship between transformational-transactional leadership and team performance. The Sobel test confirmed the significance of the indirect path from transformational leadership to team performance via team climate for innovation as mediator (test statistic=3.334; SE=.028; p=.0009). It also confirmed the significance of the indirect mediated path from transactional leadership to team performance (test statistic=3.333; SE=.025; p=.0009). Finally the hypothesis that ‘Transformational leadership explains a higher variance in hospital teams’ performance than transactional leadership’ was also supported as the total effect of transformational leadership on team performance was .107 (.166) in contrast to transactional leadership, which was .082 (.117). The direct effect of transformational leadership was .063 (.097) whereas that of transactional leadership was .030 (.043).

Discussion
Despite the fact that transformational-transactional leadership and team climate enjoy scholarly attention, there is lack of empirical evidence that examines inside the leadership/team climate/team performance “black box” (Dionne, Yammarino, Atwater & Spangler, 2004, p.179). To contribute further in this field, we relate transformational-transactional leadership (Rafferty and Griffin, 2004) with team climate for innovation theories (West & Farr, 1990) by testing the mediating role of team climate between leadership and team performance.
Thursday 26 June

11.00-12.30

Clinicians in Leadership
Physician-Hospital Exchanges: The moderating effects of the Chief Medical Officer

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Context
Because of continuously rising healthcare expenditures and concerns about the quality of care, hospitals find themselves at the locus of the reform debate. Against this background, hospital executives are charged with the development of organizations in which high-quality care is efficiently delivered in an increasingly competitive environment. Physicians hold a centrally important function in hospitals and are critical to hospitals' organizational success. In this study we focus on the influence of medical leaders on physicians' perceptions of physician-hospital exchanges. More precisely, we address the quality of the relationship between self-employed physicians and the Chief Medical Officer as a potential moderator.

Methods
A quantitative cross-sectional survey was conducted on 130 self-employed physicians practicing at 6 Belgian hospitals (17.1 % response rate). To measure economic exchange the concepts of Distributive Justice (DJ) and Procedural Justice (PJ) were applied to the contractual relationship between physician and hospital. Noneconomic exchange was conceptualized ad measured by the construct of the Psychological Contract. A distinction was made between an administrative and a professional dimension. Our outcomes comprise key organizational attitudes (satisfaction, affective commitment and intention to leave) and two types of organizational citizenship behaviour: Direct Personal Participation (DPP) and Indirect Stimulating Involvement (ISI) when hospital improvement initiatives are considered. The moderating role of the quality of exchange with the Chief Medical Officer (Leader-Member eXchange CMO) in the relationships of (distributive and procedural) organizational justice and (administrative and professional) psychological contract breach and physicians' key organizational attitudes and OCBs was assessed.

Results
Our results showed a relationship between both psychological contract breach and organizational justice and physicians' organizational attitudes. In contrast to organizational justice, no relationship was found between psychological contract breach and OCBs. Quality of exchange with the CMO buffered the negative effect of psychological contract breach and reinforces the positive effects of organizational justice with respect to physicians' organizational attitudes. When OCBs are considered, only a relationship with organizational justice was present which was moderated by the quality of exchange with the CMO. Remarkably, physicians who experience low levels of LMX were less affected by perceptions of justice, whereas the work behaviors decreased as justice decreased among physicians that experience high levels of LMX. A detailed overview of the results is provided in the appendix.

Discussion
Our results demonstrate that physician leadership is of major importance to physician-hospital exchanges. Both economic and noneconomic aspects are important when considering physicians' key organizational attitudes. However, with respect to organizational citizenship only the economic dimension of exchange was found to be significant. The reciprocity dynamic can be enhanced by high-quality exchange with the CMO. Our findings highlight the need for additional research. In particular, since different types of OCB exist it would be valuable to consider the potential differences between the types of extra-role behavior. More specifically, given the centrally important clinical role of medical doctors and their corresponding impact on hospital performance this presents an interesting avenue for future research.
Leadership, accountability and inclusion in CCGs: the view from member GPs

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Context
The creation of Clinical Commissioning Groups (CCGs) was a significant component of the recent NHS reforms in England, with CCGs being given responsibility for allocating two-thirds of the NHS budget. They are membership organisations, led by locally elected GPs. The ambition was that clinically-led commissioning would be more efficient and improve services for patients. In contrast to other studies, we focus on the relationship between the leadership and their members, exploring for example the extent to which local GPs are engaged or included in their CCG and what impact the leadership is having on their clinical practice.

Methods
This is an ongoing, three-year study for which we are currently undertaking the second year of fieldwork. We use a case study approach, with a random selection of six sites who are representative of CCGs across England in terms of size, location and area deprivation. We will conduct fieldwork at the same time each year, for three years. Fieldwork includes: a survey to all GPs in the CCG; interviews with GPs, CCG managers and a selection of external partners such as the Area Teams and local authorities (analysed using qualitative coding software), and meeting observations. To date, we have fieldwork from the pre-authorisation period for CCGs (October 2012 - March 2013) and are currently conducting the second year of fieldwork (due to be complete by March 2014). Our results, and particularly our survey, can be used to analyse trends over time.

Results
CCG leaders have a dual role of commissioning secondary care and community services for their population whilst also supporting quality improvement in primary care. CCGs have taken different approaches to the latter, with varying degrees of success and buy-in from their membership. Across our case study sites, we encountered wide disparities in how the leadership felt they were performing compared to the perspective from local GPs. For example, only 40 per cent of local GPs felt that decisions made reflected their and their colleagues’ views, compared to 80 per cent of the leaders. Size of CCG was found to impact on perceptions of the leadership as did partnerships with neighbouring CCGs.

Discussion
The creation of CCGs as membership organisations was founded on the belief that in order to drive improvements in a health economy, change should be clinically-led and grounded in a shared, collective approach. However, our research found that CCG leaders over-estimate how engaged or included their members feel in decisions made on their behalf. This leads to questions about the effectiveness of the leadership to operate as a member organisation and what consequences this may have for accountability and the future of CCGs. That said, the prevailing feeling among GPs was that the new clinician-led model of commissioning would be more effective than the previous manager-led approach. We were however, able to identify key steps that could improve or sustain clinical engagement, including for example clarifying the relative roles of member representatives and communicating a vision for the CCG that describes how it is distinct from previous commissioning organisations.
Thursday 26 June

11.00-12.30

New challenge new skills
The changing context of professional work – How does it impact on professionalism?

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Context
In recent decades, tighter budgetary regimes, workforce shortages and technological developments have been among the factors providing incentives to transform professional work. Despite the substantial amount of research on professionalism, no comprehensive and systematic study has been conducted to capture the diversity of dynamics generated by political, organizational and market pressures on professional work and professional leadership in healthcare. The aim of this study is to understand better the extent to which recent forces that impact on professions in healthcare are associated with changes for professionalism and alter the prevailing professional archetypes.

Methods
We carried out a systematic review of published literature across five databases (CINAHL, Medline, Web of Science, Sociological Abstracts, Current Contents), focusing on literature between 2000 and 2012. Systematic screening of 734 papers resulted in final selection of 65 papers. A detailed template was used to extract the data. Six researchers were paired into three teams and the articles split among the teams. In-depth examination of each article and data extraction were done separately by each member of a team. When there was disagreement, the two researchers met to discuss their views and find common ground. For the analysis, we used the method of interpretive synthesis. This approach involved constructing a general interpretation grounded in the findings of separate studies and then integrating evidence from across studies into a coherent theoretical framework comprising a network of constructs.

Results
Changes in professionalism were captured on three dimensions. First is the nature and content of work. Recent developments show a departure from technical rationality and a move toward more diverse forms of knowledge as the foundation for professional work, the emergence of more reflective interpretative modes of practice that value situated knowledge, and movement toward realization systems in which professionals work collaboratively with diverse stakeholders. Second is work organization. Recent developments show looser demarcation of professional boundaries, a shift from the autonomous organizational form of professional work toward a more heteronomous form, and professionals’ increased reliance on the support of organizational systems, structures and procedures to perform their work. Third is the control of work. Recent changes are seen in more diverse control types that mix market, hierarchy and community mechanisms, a plurality of actors involved in the control of professional work, and the emergence of new technologies of control.

Discussion
Much evidence suggests that professionalism, in its traditional form, has been undergoing significant changes. This trend has fuelled an animated debate over the extent to which professionalism and its distinctive reliance on value-rationality and community as main organizing principles of professional work are being replaced by other forms of rationality. Although recent changes are often interpreted as a radical transformation of professionalism, our analysis suggests that, in fact, they may actually reflect a sedimentation or reconstruction process, with new forms of professional work overlaid on earlier ones. Rather than the demise of professionalism, our analysis shows a multitude of new institutional arrangements that retain the advantages traditionally attributed to professionalism and combine them with other mechanisms to address possible limitations. These developments point back to professionalism’s capacity to transform itself and to continue to ensure its key role in preserving a normative social order in work and occupations.
Reconfiguring health professionalism towards addressing multimorbidity

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Context
The health workforce is poorly fit for purpose when it comes to multimorbidity. Most professionals think and act as single-condition experts rather than addressing multiple chronic conditions. Consequently, multimorbid patients must consult a broad range of specialists - one for each condition - which is arguably the root of the unsustainable functioning of health systems. Societies simply run out of human and financial resources to adequately staff and operate these health systems, even when they succeed in achieving high levels of integrated care. Therefore, it is better to reconfigure the health professions as one way towards more sustainable health systems.

Methods
The aim of this abstract is to explore why the reconfiguring of health professionalism is timely and relevant, what such a reconfiguration would entail, and how policy makers could nurture such a reconfiguration.

The abstract draws mostly on an interdisciplinary literature review that includes (theoretical and empirical) evidence from public health, medicine, sociology, the administrative sciences and economics, all stressing the ways in which health professionalism could and should be reconfigured.

For illustration purposes, two examples of the initial reconfiguring in the Netherlands will be presented. The first example describes the work of the national advisory committee of Health Care Professions advising the Dutch Ministry of Welfare, Health and Sports about the desired development of professions and training courses in health care. The second one describes the changing thinking and acting of health and social care professionals working in the deprived neighbourhood of Utrecht Overvecht.

Results
- Epidemiological research shows that multimorbidity is the most common chronic disease;
- Increases in multi-morbidity are associated with great increases in costs of care, hospitalizations that should be preventable, and adverse events;
- Multimorbidity falsifies a disease-by-disease approach which is at the heart of current healthcare systems as reflected in its underlying specialist expert model, made of numerous mutually excluding professional domains;
- However, multimorbidity would call for a more inclusive organization; one that allows professionals both to combine, supersede and understand the complex interrelations between different conditions, and to apply knowledge, skills and techniques rooted in multiple health specialty domains;
- Health policy could initiate and support this reconfiguration of health professions by nurturing transformative change from within the health professions themselves;
- Developments within the Dutch healthcare system at national and local level indicate that the desired reconfiguration is getting momentum, is initiated at policy level, and actually piloted in practice.

Discussion
A reconfiguration of health professions is needed to get 21st century-proof health professions, and ultimately more sustainable health systems. The health professions are no longer fit for purpose, since they are based upon the acute single diseases of the past.

For health policy-makers, the key message is to stop exploiting the existing single condition based health professions. By introducing more intrusive regulation, management, and market mechanisms in health care, health policy is codifying the vested health professions in their way of organising health expertise and related processes of health service delivery. This is a counterproductive policy strategy. Rather, health policy-makers could better recognise and use the positive strength of self-regulating health professions. It seems better to start a constructive collaboration; one that leads to the professional adaptation to the multimorbidity challenge. The initial policy developments in The Netherlands are promising in this regard.
Thursday 26 June

11.00-12.30

Care Pathways
Following the patient's pathway - measuring waiting times in cancer care

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Context
In response to dissatisfaction among cancer patients with access and the way patients are involved in, and informed about the care they receive, the Swedish Government in 2009 commissioned the National Board of Health and Welfare to develop a national system for monitoring waiting times in cancer care.

Methods
A model with five measurement points with a patient perspective (Figure 1), from referral to treatment, has been developed. The measurement points have been defined and the model has been tested on three occasions between 2011 and 2013. Data for each patient that was diagnosed with cancer was collected from ten quality registers. Comparisons of waiting times for specified parts of the care process were made between different county councils, forms of cancer, different cancer stadiums, gender and age.

Results
- There are significant variations in waiting times between different forms of cancer (Figure 2).
- Regional variations in waiting times are significant (Figure 3).
- Patients with more severe cancer are prioritised.
- No systematic differences between gender or age groups were found.
- Variations among different professionals in the definition of ‘waiting time’ restrict the possibilities for comparisons between different forms of cancer.

Discussion
Measurement of waiting times in a process context contributes to a better understanding of the complex issue of waiting times and what causes them. To apply a perspective that emanates from the medical decision-making process shows what parts in the patients' pathway that can be considered to be bottlenecks. Such information makes it possible to streamline efforts to shorten waiting times by focusing on the parts of the organization that represents the greatest problem.

A patient’s perspective on waiting times means that the waiting times being measured should be based on the patient’s experience of waiting, i.e. measuring points shall represent points in time when the patient is present or informed. Such data are rare since waiting times usually are measured from an organisational perspective.
From Bedside to Whiteboard - the value and impact of collaboration in the Hospital Operation Centre

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Context
This work has been completed in a Specialist Children Hospital in the West Midlands. The concept takes the intelligence available to Clinical Lead Nurses responsible for a patient area and brings the people and the information together in a central place, the Hospital Operations Centre, offering opportunity to highlight issues about safety and acuity, staffing, occupancy and flow, and determine solutions that consider resources available and impact of optimising safety across a whole Trust instead of leaving one area vulnerable.

Methods
We used a step change process starting with a Clinical Coordinator utilising a Capacity prediction tool with a simple escalation plan to be followed when there were issues, followed by introduction of regular bed meetings, then invited a nominated Clinical Lead Nurse (CLN) who represented all clinical areas. Initially meetings were concentrated on areas with issues. This evaluated poorly as there was a fair amount of variance in style and content of meetings. We invited all Clinical Lead Nurses to attend to represent their own areas, and devised a whiteboard to collate the information but focussed on all areas looking at staffing, Flow, Capacity and Risk. Following further evaluation and knowledge we are now moving to look at safety rather than risk. We have developed a model of a fully informed HOC with a daily manager working with the Clinical Coordinator and the CLNs

Results
The shared knowledge has led to a greater understanding of the barriers to capacity and flow, and to the safety issues ward staff are aware of.
This has led to such improvements this year such as less days with patients waiting for beds at the start of the day from ED, much improved patient journey, more consistent compliance with ED performance, less variance in bed meetings and more focus on safety issues rather than being all about the bed numbers, a greater resilience in terms of staff being utilised more effectively across the whole trust. We have also introduced additional services such as PACE team - a High Dependency Outreach team, General Paediatric Consultant in CDU till late evening, a surgical admission lounge. All of these concepts have been borne from issues raised at the bed meetings.

Discussion
The Clinical Coordinator has always been at the centre of capacity and flow management of patients coming into our hospital. This concept of involving key decision makers from each area and bringing them together has enabled them to understand the individual area issues and how they impact on the Trust as a whole, it has moved away from silo thinking, and enabled us to ensure that safety is considered across the whole Trust. It has given the Coordinators a network of support and although the CLNs are office hours currently it has enabled us to develop a new way of working in that we are able to see a way forward for 7 day working at the corporate capacity management level, while remaining focussed on patient safety and experience.
Thursday 26 June

11.00-12.30

Patient Satisfaction - how ‘customer’ focused are we?
Economic and Noneconomic Physician-Hospital Exchange: Impact on Customer Oriented Behaviour and the Moderating Effects of Organizational and Professional Identification

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Context
Service quality depends to a large extent on the customer-orientedness of frontline staff. Our aim is to provide insight into the conditions under which frontline staff - and more particularly self-employed physicians - show customer-oriented behaviours. Since previous studies suggest that organizational members are more likely to show positive attitudes and behaviours if they perceive beneficial treatment of the organization, we investigate the relationship between perceptions of economic and noneconomic exchange and customer-oriented behaviours. Since previous research suggests that reciprocity is more complex than originally anticipated, we also investigate the moderating effects of organizational and professional identification.

Methods
A quantitative cross-sectional survey was conducted among 130 self-employed physicians practicing at 6 Belgian hospitals (17.1 % response rate). Economic exchange was conceptualized and measured by the concept Distributive Justice (DJ), noneconomic exchange was conceptualized and measured by the construct Perceived Organizational Support (POS). Our outcomes comprise three types of Customer-Oriented Boundary-Spanning Behaviours (COBSB): Internal Influence (II), External Representation (ER) and Service Delivery (SD). The survey was collated from previously published instruments, which have demonstrated sound psychometric properties in past research. Cronbach alpha's of the instruments were satisfactory ranging between 0.87 - 0.90. We used correlation analyses and linear regression to analyse the data. Since interaction effects have been found to be more difficult to detect in field studies an alpha level of 0.10 was used to estimate interaction effects of Organizational Identification (OI) and Professional Identification (PI). We plotted the interaction effects for significant moderators.

Results
Our results showed positive relationship between DJ and COBSB II (adjusted R²= 0.038, t= 2,348; p= 0.028) and COBSB ER (adjusted R²= 0.151, t= 4,589; p< 0.001) and a positive relationship between POS and COBSB II (adjusted R²=0.032, t= 2,258; p= 0.026) and COBSB ER (adjusted R²=0.220, t= 5,811; p<0.001). COBSB SD was not affected by DJ (p= 0.536) nor POS (p= 0.571). Organizational identification moderates the relationship between POS and COBSB ER (p= 0.045), and DJ and COBSB ER (p= 0.056) positively. The relationship between POS and COBSB II (p= 0.538) and DJ and COBSB II (p= 0.988) was not moderated by OI. Professional identification did not moderate the studied relationships.

Discussion
This study is innovative in that it is among the first to study the effects of economic and noneconomic physician-hospital exchange on customer oriented behaviours and the moderating effects of social identification. The outcomes of this study support the proposed conceptual model only partly. Earlier research in social exchange showed that individuals try to maintain a balanced exchange relationship with their organization. Our study confirms spill-over effects towards customers-oriented behaviours by demonstrating the importance of perceived exchange to self-employed physicians and therefore hospital administrators and physician leaders. Fostering organizational identification could enhance this dynamic. Surprisingly, COBSB SD does not depend on physician-hospital exchanges. This could partially be explained by the fact that physicians, as professionals are considered the advocate of their patient. Similarly this could explain why PI did not moderate the relationship with COBSB II and COBSB ER.
Patients' and relatives' complaints and managers' responses: the process in University Hospital

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Context
Patients assume that they will get the best possible care in the University Hospital, because the best experts work there. Unfortunately, things do not always go as expected, people are not always satisfied. The law of patients' position and rights in Finland provides the opportunity to express dissatisfaction with care and treatment. Based on this law patients or relatives can make complaints to get the case investigated. In this research we are interested those complaints handled and managed inside Hospital. Social workers are often involved in this process as counsellors and most of Finnish ombudsmen have academic social work education.

Methods
As social work researchers, we are interested in complaints as a communication process and a bureaucracy process, where the citizen meets authority in special context of health care. Our interest is to find out what kind of accounts patients, relatives, professionals, managers and head of the units use in complaint situations. Accounts aim to remove the conflict and they also have remedial function. We ask, if it is possible or not to find the solution acceptable to all parties by using the complaint-system? And what are the other options? This presentation is based on qualitative study of 229 cases of complaints and the given responses to them. The used method is thematic content analysis, which is also influenced by category analysis. The unit of analysis is patients' and health care professionals' means to justify their own experience and actions in a situation where moral order is broken.

Results
In our presentation we'll focus on managers' responses: how do they react to accusations concerning inappropriate treatment or behavior. Do they accept and admit accusations or deny them? And what kind of "tools" they use? Most complaints include accounts of care and treatment, communication and behavior and received or not received information or misinformation. In the light of both, complaints and responses, the process has tension. Patients and relatives bring out their personal experiences and emotions. Professionals and managers provide response that is based on medical fact knowledge. Health care professionals seem to be in problematic situation in the process of complaints as they receive many kinds of accusations on inappropriate treatment and behavior. Nevertheless the professionals do not reply similarly describing the behavior of the client. Clients' accounts are usually questioned in relation to professionals' accounts using medical documents in responses.

Discussion
Health care is developed to the production-centred processes and evidence based practice, which is especially in specialized health care the most important principle to justify the actions. On the other hand they are effective but on the other the challenge is patients' and also relatives' need of the individual care and treatment and the sense of empathy. It seems to be problematic that the verification of the behavior and treatment is not based on medical facts or on documented information. This might be the reason why responding to complaints on behavior and treatment does not have the same attention as the medical facts. Thus the evaluation of the realization of the patients' rights and position is difficult especially when it concerns professionals' inappropriate behavior.
"You won't regret it!" - Levers for healthcare managers to minimize patient regret in hospital choice

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Context
Management of healthcare providers encompasses the steering of stakeholders such as patients, staff and referring physicians. Considering the patient's perspective, hospitals mostly focus on satisfaction as a performance indicator that reflects the overall experience with the hospital stay. In contrast, indicators of patient's emotional assessment of healthcare-related decisions are barely analysed. However, marketing studies underpin the influence of negative emotions, such as regret, on satisfaction, loyalty and complaint behavior. Within the healthcare context, regret has been mainly linked to treatment decisions. This study is the first to comprehensively investigate the impact of patient characteristics on individual regret with hospital choice.

Methods
To ensure that an actual choice situation existed, this study was framed to patients who recently underwent elective, non-emergency joint surgery. Data collection took place via survey questionnaires. The literature suggests that patients' individual capabilities to perform an optimal provider choice are determined by their health literacy, perceived empowerment and trust in their treating physician. Those constructs were measured with validated multi-item scales. Furthermore, data on the degree of shared decision-making with the medical specialist before surgery, self-perceived health status and treatment process variables, e.g. length of hospital stay or chronic diseases, were collected as well. In contrast to the few other studies that analyse regret in hospital choice via a single-item measure, this study operationalized decision regret using the multi-item scale validated by Brehaut et al. (2003). By means of multiple linear regression analysis, a model tested the patient-related variables to explain regret with hospital choice.

Results
205 respondents completed the self-administered survey questionnaire (122 women, 83 men). The sample covered an adequate range of age (M=38.89, SD=16.886) and medical indications (knee, hip and shoulder surgeries). The decision regret inventory was found to be highly reliable (5 items; α=.924). Overall, patients generally did not show high levels of regret with their choice. The multiple regression model predicted regret with hospital choice from individual health literacy, perceived empowerment, trust in treating physician, degree of shared decision-making and self-perceived health status. These variables statistically significantly predicted regret, R² = .383, F (5, 198) = 24.531, p < .0005. Except for health literacy, which did not contribute to the model, all other variables added significantly to the prediction (trust: β= -.431, p < .000; health status: β= -.228, p < .000; shared decision-making: β= -.158, p < .020; patient empowerment: β= -.154, p < .007).

Discussion
The proposed model shows that interpersonal or process variables, such as trust or health status, are more influential on decision regret than individual levels of patient empowerment. In order to avoid regret with hospital choice, hospital managers need to ensure that either their own medical specialists or referring physicians deliberate patients in a highly respectful, trustworthy and communication-oriented way before elective surgery. These levers need to receive more attention by hospital management in addition to already established leadership practices such as process quality management. This study contributes to research by emphasizing hospital managers' need for careful and targeted leadership of internal staff and external partner network in order to avoid patients' negative emotions. By doing so, hospital management can mitigate further negative consequences, such as negative word-of-mouth. Educating and informing patients about their choice is important, but strategic network management with medical professionals is more crucial for long-term patient retention.
Wednesday 25 June - Thursday 26 June

Poster Session
A common health workforce planning model for Europe: is it feasible, is it useful?

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Context
The EU Joint Action on Health Workforce Planning and Forecasting has taken up the challenge “(...) to create a platform for collaboration and exchange between member states to prepare the future of health workforce planning”. Key drivers for this Joint Action are the expected shortages of health workers, growing health care demands against decreasing budgets, and the cross-border mobility of health workers. One of the main goals is to let countries share and exchange practices in health workforce planning, but it appears that not many countries actually apply (needs-based forecasting) models to support this.

Methods
The needs-based forecasting model, that is the backbone of the Dutch system of physician workforce planning since 2000, is applied to other EU member states. This model projects the supply and demand of (a certain type of) physicians that is available and required, and is designed to calculate what adjustments in the training inflow over time should be taken to achieve or sustain equilibrium between demand and supply. Basic data about the size and composition of the health workforce from EU countries are used to run the model for these countries. In addition, estimates are made for each country to estimate the relative change in the future demand for physicians. Outcomes of the model are analysed and compared for the EU member state countries.

Results
First, it appears that countries differ in their current equilibrium between demand and supply of physicians. Next, for most countries, the model indicates that adjusting (i.e. increasing) the training inflow of physicians is required to keep up or achieve equilibrium. This, however, substantially differs by the current and future position of physicians in each country, recognising their skill-mix expectation and policy ambitions. An interesting clustering of countries can be seen from the results of the cross-national application of the (Dutch) health workforce planning model.

Discussion
The question if a common health workforce planning model for Europe is feasible or useful cannot be answered straightforward. The Dutch model that is applied for multiple countries in this study, actually assess different countries on their challenges with regard to what is the 'optimal' number of available and required physicians in the near future. A main point is that the position of physicians in the health labour markets is changing due to the need to addresses skill-mix instead of separate occupational-based planning. This analysis also explores how skill-mixes can be modelled for health workforce planning as well.
Crisis managers’ response to large scale incidents: Social identity implications

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Context
Large scale disasters, caused by natural or human forces, require well-connected health systems actors for responses to be fast and effective. The focus on the evacuation and psycho-medical treatment of disaster victims in case of a mass emergency is paramount. The intervention, however, puts a strain on emergency services and can entail immediate or long-term consequences (e.g. ASD, PTSD). The present study explores the role of professional social identities for emergency service leaders’ (=crisis managers’) attitudes and reported behaviors in the face of crisis situations.

Methods
This study is embedded in a multi-country EU-project on psycho-social support in crisis management. Focusing on emergency service leaders’ perception of large scale incidents (natural or manmade) shall help to better understand crisis managers’ individual coping strategies, the institutionalization of mutual peer support and the need for additional support. It is assumed that strong professional social identities guide leaders’ attitude and behavior in situations that trigger social identity salience. Guideline-based interviews have been conducted with emergency service leaders on crisis intervention in large scale incidents. All interviews were taped and transcribed. The interviews have been analysed with the help of GABEK-WinRelan, a software and procedure for the analysis, processing and presentation of textual data. In total, 15 interviews with Austrian crisis managers serve as bases for the analysis.

Results
Crisis managers are more than willing to share their experiences and tend to speak rather openly about short and medium-term work pressure in the face of disasters. The willingness and ability to perform under adverse circumstances appear to be strong professional virtues. The perceived responsibility to continuously perform during the days and nights following an incident seems especially challenging for crisis managers. In general, performance expectations are perceived to be extensive. Crisis managers, however, highlight the importance of developing individual coping strategies.

Discussion
Mass emergencies confront emergency service leaders with complex challenges during and after a crisis. The leader has to demonstrate decision-making power and operational effectiveness in an uncertain situation with a high degree of interdependence from complementary professional forces. The provision and configuration of psycho-social care aim foremost at providing support to disaster victims. This present study aims at shedding light on professional responsibilities as perceived by crisis managers, the effective support available to crisis managers and scope for additional psycho-social support at the emergency service leaders’ level.
Dentists' perspective on patients’ contribution to quality management. Results from a national survey

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Context
Patient-dentist interaction is influenced by both parties’ expectations. Therefore, a higher degree of patient satisfaction regarding dental services provided by a dental professional may lead to a stronger relationship. Furthermore, feedback on patients’ satisfaction with dental care is vital for continuous improvement of the service delivery processes and outcomes. Assessment of patients’ needs and feedback requested from them can be used in a process that actively engages dentists in a continuous competency improvement. The aim of this study was to assess the contribution of patients to dental care through dental professionals’ perspective.

Methods
The study has a transversal design and uses a quantitative approach. Data collection was performed through questionnaires sent by postal services to all the individuals from the selected sample (n=1,200). The participants were chosen randomly, from each county, in order for the sample structure to be representative for the national structure. The subsample considered for analysis consisted of 120 respondents. Descriptive statistics were performed in order to properly assess dentists’ perceptions regarding the degree in which patients can contribute in ensuring quality of services. Contingency coefficients and Chi-square statistics were calculated between patients’ feedback and productivity in order to assess possible correlations.

Results
Statistical analysis revealed that 64.2% of the dentists knew that it is very important to involve patients in the process of maintaining quality, whereas only 3.3% thought that their implication doesn’t matter. But, before involving the patients in this process, the medical staff should be concerned with receiving the feedback from them. In this respect, more than three quarters (75.8%) of participants are concerned of this matter, including 69.2% who treat it seriously, while only 0.8% did not consider it of great importance. Regarding the existence of communication means between physicians and their patients, only 44.2% declare that these means fully exist. Also, more than 60% of the dentists considered the patients’ needs and suggestions to be crucial in the development of the services quality. Moreover, there is a statistically significant association between the existence of patient’s feedback on dental services and the increasing of productivity (Pearson Chi-Square Asymp. Sig.<.05).

Discussion
The Romanian medical reform has led to the promotion of quality management within dental health aiming to reach the European standards. Still, according to the legislation, there is limited information regarding the way quality management is implemented. Dental professionals need to be aware of the underlying interpersonal dynamics of their work. Moreover, they need to take into account patients’ contribution in order to help patients to have regular visits and hence improve patient management. There needs to be a permanent communication and assistance between dental professionals and patients. Our study confirmed that asking for patients’ feedback plays an important role. Future recommendations include improvement of communication skills and a greater involvement of the patients in the decision process.
Do hospitals consider ecological aspects in managerial decision-making? - A systematic literature review

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Context
Nowadays, sustainability issues are no longer discussed only in a political sphere. Whatever the type of company, the limits of industrial growth and scarce ecological resources become increasingly relevant for managerial decision-making. Hospital managers face numerous challenges ensuring an adequate provision of healthcare services, e.g. lack of finances, uncertainty and complexity in decision-making. Although environmental friendly behavior is sometimes seen as ‘nice-to-have’ and cause for increased financial pressure, it can solve some of these problems if applied properly. Summarizing empirical findings from the existing body of scholarly knowledge, this study therefore examines hospital managers’ effective consideration of ecological aspects.

Methods
To elucidate how ecological aspects are considered by hospital managers, a systematic literature review of existing empirical studies was carried out. The authors conducted the search within the seven most relevant data bases (Academic Search Complete, Business Source Complete, PsycInfo, Cinahl, Web of Science, Medline, Science Direct) covering business and economics, social sciences, and medical disciplines. The search terms covered a range of synonyms, which described the studies’ core aspects of ecological issues, management, and hospitals. In sum 14,411 search results were obtained. The articles were screened by title, abstract, and full text using appropriate inclusion and exclusion criteria. After removing duplicates, non-empirical, and non-English-speaking papers, 107 publications underwent a systematic content analysis to identify their thematic statements (e.g. environmental issues mentioned) and the background information of the publication (e.g. the author’s country of origin).

Results
The review shows that ecological aspects are not yet a major concern for hospital managers. Being a relatively young research area, first studies were only conducted in the 1990s. Even if the number of studies increased since 2008, the general amount is still comparably low. Furthermore, it became obvious that the focus of research lies primarily on waste management, which is especially a serious problem in developing countries. The reasons for that are insufficient state regulations and control as well as missing ecological awareness, willingness or knowledge of the personnel. Other ecological topics, like waste water handling, energy consumption, emissions, and resource efficiency of buildings and medical technology, are discussed in various conceptual papers, but only few empirical studies exist. Isolated studies deal with the greening of functional areas like purchasing, accounting or human resource management, mainly in developed countries.

Discussion
Summing up, ecological aspects find little consideration in hospital management to date, especially in developing countries. It is obvious that the major concern for managers lies in the provision of adequate healthcare services and environmental issues are subordinated to this primary goal. Nevertheless, careful environmental hospital management can offer financial advantages. This and other benefits are increasingly recognized as the inclusion of environmental instruments in operation procedures (e.g. life cycle assessment) or the rising number of studies conducted concerning environmental issues prove. Furthermore, research shows that more rigorous state regulation forces hospitals to change their ecologically harmful practices and to rethink their managerial decision-making. Hospital managers should promote the advantages of sustainable management to their stakeholders by making them aware not only of the extra effort and expense, but also of resource and cost savings. Thus, managers create a positive public image, differentiate from competitors and, moreover, secure environment’s existence.
Do patients in shortage areas feel underserved? A study on regional differences in primary care assessment from the patient perspective

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Context
Developed countries face considerable regional inequalities in the supply of primary health care (PHC) providers. Urban areas with high levels of supply clearly provide advantageous conditions. Most of the shortage areas are located in rural regions, where several restrictions hamper sufficient health care delivery. In many systems, health policy mainly pursues strategies that focus on the aspect of accessibility. However, differences in patients’ actual needs regarding other PHC aspects have not yet been clearly examined. The goal of this research is to explore differences in patients’ evaluation of PHC attributes according to the level of supply in different geographical contexts.

Methods
To evaluate the patients’ perspective on the supply of PHC, this study uses online and written questionnaires. Data are collected in 4 rural and 2 urban areas of Germany. Apart from the spatial aspect, regions differ with regard to their objective level of PHC supply, ranging from very well supplied to shortage areas. The questionnaire covers key attributes of PHC, namely spatial accessibility, costs, accommodation, comprehensiveness, continuity, coordination, communication and interpersonal relation. We measure patients’ perceptions of these attributes by the use of appropriate multi-item subscales from different validated PHC evaluation instruments. For all items demanding a rating, we apply a seven-point Likert scale. 149 respondents answered the questionnaire so far. Weighted assessment scores for the PHC attributes are derived from exploratory factor analysis. An analysis of variances (ANOVA) was conducted to examine differences among groups using spatial, socio-demographic and health-related categorization variables.

Results
The item sets show high reliability and adequate convergent validity. In general, patient assessments tend towards positive values, which is a common phenomenon in health care satisfaction research. However, evaluations of the different PHC attributes varies. Inter-personal attributes are assessed most positively, whereas accommodation and coordination of care reach the least positive levels on average. The ANOVA reveals differences in the appraisals of particular PHC attributes between the groups. Most significant differences are found between well-supplied urban regions and rural shortage areas. Accessibility is the only attribute, which is assessed more positively by the urban respondents. In contrast, patients in the rural shortage areas perceived the attributes of accommodation, comprehensiveness of services, continuity of care, communication and interpersonal relation significantly more positive. The study also found differences in the perception of the attributes between different age groups but only few varieties among patients with different health status.

Discussion
Whereas the relevance of age for the differences in patients’ appraisals is as expected, the spatial context influenced assessments in a somewhat counterintuitive way. Due to better prerequisites, urban regions are expected to meet people’s needs better and achieve higher levels of satisfaction with care. Despite provider shortfalls in the considered rural areas, people in fact do not perceive most of the PHC attributes as insufficient. Explanations for these results might be drawn from different considerations. The favourable perception of interpersonal attributes points to a stronger community orientation and high social competence of rural PHC providers. Overall, differences in expectation levels regarding health care may have a considerable impact on different evaluations of PHC attributes. This study emphasizes the importance of the patients’ perspective and actual needs in order to detect problem areas, design health care processes and eventually achieve acceptance of new approaches in PHC.
Does the liberalisation of EU workforce market increase emigration of Bulgarian nurses?

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Context
The expiration of the transitional period in 2014 turns Bulgaria into full member of the single EU labour market. On the one hand, this gives Bulgarian nurses many opportunities to work in the European market because of the shortage of nurses there, but on the other hand, this is an actual threat to the supply of nurses for our national market. Hence emigration of nurses is becoming a question of growing concern to healthcare managers and politicians in Bulgaria.
This paper aims to analyse the effect of EU workforce market liberalization on the emigration of Bulgarian nurses.

Methods
The study is based on critical analysis of the available statistical data for nurse professionals in Bulgaria and empirical sociological inquiry. The survey was conducted in the period 2007 - June 2012. Official nursing personnel data were taken from the annual reports of the National Statistical Institute of Bulgaria and the Bulgarian Association of Health Professionals in Nursing. Primary information was collected through direct group self-administered questionnaires distributed to 300 nurses - students in bachelor and master programs in Healthcare management in the Medical University of Pleven. Data were processed with the packages MS Office Excel 2010 and SPSS v. 13.

Results
About 50% of the nurses leave Bulgaria or the nursing profession during the past 20 years. In 2012 nursing workforce consists of 32 059 nurses and the nurse: physician ratio equals 1.2:1 which is the critical minimum for the healthcare system operation.
For the whole period 2006-2012 Bulgarian Association of Healthcare Professionals in Nursing issued 3279 certificates for practicing abroad. This means that an average of 542 nurses leave Bulgaria yearly. Emigration rates are expected to keep stable at about 2% of the nursing workforce which was the average for the past ten-year period. The situation is unlikely to change as previous labour market regulations were not a barrier for nurses as highly qualified scarce personnel.
Apart from higher remuneration and better work and living conditions, factors such as age, family status and foreign language skills are of greater importance for nursing emigration than market liberalization.

Discussion
Old EU members' apprehensions of cheap Bulgarian workforce flooding their labour markets are not relevant for nurses. The expiration of labour market transitional period in 2014 would not lead to substantial rise in Bulgarian nurses' emigration rates as those who are willing to work abroad had already done so.
Our survey results evoke the question already raised by other labour market researchers: "Brain-drain or freedom of movement?" Freedom of movement is a basic right of Bulgarian nurses guaranteed by their EU citizenship. It has certain positive aspects on individual level but its societal effects are negative. Hence urgent measures are needed in order to retain our qualified nursing professionals in Bulgaria and attract those who had emigrated back in order not to prevent reduction of the free movement into brain-drain.
Ethical aspects of application of informed consent as a balancing instrument at the market of healthcare services in Bulgaria

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Context
Information asymmetry between physician and patient is a key failure of healthcare markets leading to a dominance of the supply side. Informed consent is an attempt to balance market agents' positions and respect the autonomy of the patient. In Bulgaria the idea of informed consent is understood mainly in legal terms, but its practical application is related to severe ethical problems. The informed consent document is often signed formally without proper informing procedure. The aim of this report is to analyse the empirical data of informed consent procedures in clinical practice in view of its ethical aspects.

Methods
Analyses of the existing healthcare law and sociological methods have been used. The review of the legal literature ended up with constructing the normative requirements' framework. In 2011 standardized interviews were conducted by specially trained interviewers. Eight regional cities in Bulgaria have been included and 1340 patients from 14 medical and diagnostic-consulting centres responded to the questionnaire. The questionnaire consisted of questions concerning information about patient-physician communication, duration of medical examination, physician’s explanations about diagnoses, treatment and outcome perspectives and the attitude of the physician to the patient. Data were processed and analysed with the packages MS Office Excel 2010 and SPSS v.13

Results
The analysis revealed that physicians don’t spend enough time on explanation of diagnosis, treatment options, risks and side effects. According to 23% of the respondents physicians didn’t pay any attention to them and the entire communication was left to the nurse. Only 23% of the physicians spent enough time to listen carefully to patients' complaints and 5% refused the patient a hearing. For 32% of the patients the duration of medical examination was about 20 minutes. Another 43% even claimed that they were not examined at all. The majority of physicians (86%) didn’t explain logically and in details the diagnostic methods, the nature of disease, the treatment alternatives, unwanted and side effects of medication and outcome perspectives. For approximately 80% of the patients signing the informed consent is just a formal documentation procedure required by the law and has nothing to do with enhancing consumer information.

Discussion
In Bulgaria, the importance of informed consent is still underestimated. Its formal application as an instrument for physician's legal protection prevail which is in contrast to the general goal of serving patient's interests. This clearly shows that physicians don’t respect basic ethical standards and concept of agency. Physicians neglect giving full information about the treatment or they provide it in a way that the patient can't understand it. Additionally, patients do not recognize their role in the informed consent procedure and they do not defend their basic rights of health care. Important questions resulting from our analysis are: Does it all come down to applying moral norms in practice or applying therapeutic algorithms and guidelines for good medical practice? Should we control physicians through therapeutic algorithms and guidelines for good medical practice? How the information given by physicians affects medical practice and medical market?
Experiences and attitudes of crisis managers concerning psycho-social support systems during and after disasters in Europe

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Context
Worldwide populations are confronted with a growing number of disasters. A major incident is a type of an emergency event or situation, which can arise from natural hazards, human-made disasters or industrial accidents, which threaten or cause serious damage to human welfare, the environment and security. These events may have traumatic effects to people affected (e.g. victims, volunteers, emergency workers). Psycho-social support systems can help them to better cope with the circumstances. The objective of the study is to present a status quo analysis of psycho-social support systems during and after disasters in selected European countries.

Methods
The authors have chosen a qualitative research approach. Intervention team leaders (= crisis managers) from different rescue organisations and authorities were interviewed with regard to the status quo of psycho-social support systems in their countries. The 20 oral interviews with crisis managers from different European countries were analysed in using the qualitative method GABEK (GAanzheitliche BEwältigung von Komplexität). GABEK is based on the theory of “Wahrnehmungsgestalten” (Perceptive Appearances), which has been transferred to a theory of linguistic “Gestalten”. The result consists of different holistic pictures of complex social phenomena investigated.

Results
Based on the experiences and attitudes of the crisis managers the authors present an overview about the status quo of psycho-social support systems and their strengths and weaknesses in selected European countries. The presented research results are part of the international multi-disciplinary project PsyCris (PSYcho-social Support in CRISis Management) that is funded by the European Union with the overall objective to improve psycho-social support in crisis management. A distinction is undertaken into the provision of adequate support for victims, affected people, emergency workers (staff members and crisis managers) and other groups (e.g. volunteers). Different value systems of crisis managers, depending on the organisations they work for, are reflected in strategies for appropriate treatment of trauma and stress related disorders. Their attitudes differ with regard to the needs and the moments of treatment

Discussion
The offer and structure of psycho-social support systems in Europe depends on the experiences with disasters in the past and on the engagement of crisis managers in rescue organisations and authorities. The spectrum of services offered do not only vary between European countries but also in the provinces of the countries. Further differences in the levels of provision are seen in the priority of psycho-social support that is given by representatives of different rescue organisations and authorities.
Frontline Health Educators: Locus of control, Communication and Patient Adherence

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Context
Evidence suggests that patients need to be active participants in order to better manage their disease. ‘Process oriented communication’ (POC) rather than ‘content oriented communication’, allows active participation. Content oriented communication asks ‘what should patients know’. Process oriented communication focuses on behavioural changes and asks ‘how to assist the patient in implementing behavioural changes?’ Despite evidence regarding the high effectiveness of process communication, content communication is popular. Locus of control (LOC) may help to explain this gap. We examine if communication orientations vary by practitioners' LOC and by practitioners' perception regarding patients' LOC.

Methods
Sample:
200 Diabetes 2 practitioners (physicians, nurses, dieticians, health educators) in hospitals.
Measures:
- Cross sectional study.
- Previously used measures that hold good psychometric properties will be used in this study.
- Clinical outcomes assessed by practitioners are: adherence to medication recommendations, compliance to a diet program, compliance to a physical fitness program and stress management.
- LOC will be measured using Rotter's tool. Communication skills will be measured using the Finset and Majaaland Questionnaire which identifies the communication orientation of practitioners by asking them about their needs and challenges.

Results
Data are currently analysed.

Discussion
Effective communication of front line Diabetes practitioners is essential to successful public health practice. The understanding of practitioner’s LOC and perceptions will allow better tailored communication training programs for higher competence of practitioners in effectively implementing the desired communication orientation. Awareness to LOC in shaping training programs will help practitioners and patients to achieve higher adherence and enjoy a better managed Diabetes.
Health care managers competencies analysis

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Context
In the age of globalization and high technology of health policy pursued by the state depends on its competitiveness. In turn, the effectiveness of health care depends on the quality of health care managers decisions taken at various levels of management. In the implementation of these tasks is very important to develop key competencies of managers in health care. The transition to a competency model of professional education, primarily involves the development of joint requirements for the content of professional activities, addressing a wide range of tasks in the field of personnel management.

Methods
In this research we assessed the current level of competence of health care managers at different levels and identified training needs of the main sections of management. Conducted a sociological survey of medical staff at JSC "National Diagnostic Centre" (Kazakhstan) aimed at identifying gaps between existing competencies and must have competencies levels, identification of training needs, identify priorities for training depending on the level of management. Subjects of the study were managers at various levels, the criteria for inclusion in the study were prescribed in job descriptions personnel management functions in a given volume. Thus, it has been allocated 3 level management-line level, mid-level and senior managers. The questionnaire was interviewed 61 respondents.

Results
Questioning line managers and managers of middle and senior levels revealed gaps in the possession of competencies. For each level has its own set of competencies priority, but at all levels there is a lack of knowledge in such topics as planning and evaluation, personnel management. For middle and senior level are more important sections such as information and financial management and quality management, monitoring and evaluation. The survey also revealed a high demand for training on the same topics. Respondents themselves noted the need for continuous quality improvement through learning the necessary knowledge and skills. The study revealed a high potential for the development and formation of personnel reserve for positions of senior middle managers. Findings allowed us to develop practical recommendations to improve the competence of managers of health organisations. An algorithm enhance the process of continuous professional development.

Discussion
An indispensable factor in the development of management competence is undoubtedly experience, but at the same time one of the key elements is the continuous professional development. In this aspect, a specific role is connected with the quality of educational programs. One of the requirements for educational programs should be their evaluation, in terms of both the listener and the end user (in this case it is consumers and patients and superiors) routine assessment of competence manager (in order self-assessment and procedure 360 deg.). We consider that it is appropriate to assess knowledge "output" short- and long-term monitoring in the future to trace how the manager uses this knowledge in practice, disseminate their experience and, most importantly, how it affects the results of its activities.
Healthcare Quality Management in Accident and Emergency Unit of Maltese Hospital using Risk Management Framework

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Context
The main aim of this research is to improve quality of care in accident and emergency (A&E) unit of a Maltese tertiary-level hospital. This study adopts a risk management framework to identify risk factors that affect the quality of care, analyse their likelihood and impact, and develop responses to mitigate those risks.

Methods
This study uses a case study method and through involvement of focus group first a risk management framework is formulated. Second, risk factors are identified with respect to processes, human and materials resources, and infrastructures using cause and effect diagram. Third, the likelihood and impact of risks are determined using risk map/grid. Fourth, mitigating measures are derived through brainstorming among the participating health professionals.

Results
This study bridges the gaps through identification of risk factors, analysing them and developing risk responses with the involvement of healthcare professionals. This helps the health professionals to make decisions on implementing quality improvement projects through appropriate analysis of service level and efficiency. Additionally, this allows practising preventive approaches in quality of care.

Discussion
A&E is the point of patients’ entry in many tertiary care hospitals. Therefore, quality of care in A&E has strong impact on overall quality of care of a hospital. If the risks of non-achievement of quality in A&E are studied and appropriate mitigating measures are undertaken, not only one can improve A&E performance but overall hospital performance would be substantially enhanced. Although quality of care in A&E has been studied at length in healthcare literature, very little has been discussed on usage of risk management principles in dealing with quality management issues and challenges within A&E. The proposed framework could be adopted in any healthcare system for achieving superior quality of care through risk management principles.
How challenging is the implementation of quality management in dental offices? Lessons from Romania

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Context
In order to be effective, dental offices strive to implement quality management in their day-to-day activity. However, Romanian dental offices, at large, have not made full use of the existing quality management tools so far. Hence, the purpose of this study is to identify Romanian dentists’ perceived challenges when adopting quality management tools, as well as to assess willingness to adopt quality management.

Methods
Data was collected from a national sample of dentists. For the current study, 115 valid questionnaires have been analysed. Descriptive statistics were employed to achieve the proposed purpose.

Results
Of the total sample, 96.6% dentists perceive the importance of quality management as being high or very high. However, more than two thirds (66.9%) did not attend any courses on quality management during their medical studies nor during the previous twelve months (67.5%). According to the interviewed dentists, the main challenges regarding quality management, they are confronting with are: the resistance of their dental office personnel in implementing such a system (50.4%), the lack of financial resources (67.2%), no legal obligation to implement it (57.6%) and the shortage of information related to quality management (67.7%).

Discussion
We show here that the degree of implementation of quality management in Romanian dental offices is well below its perceived importance and relevance. We suggest that, in order to attain a higher degree of implementation, quality management activities should be better regulated, training should be provided and dentists should be supported in choosing the quality management tools that suit their office best.
How standardized is sequential care? The case of cataract surgery

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Context
Standardization promises to render medicine more accessible and cost-effective but if used wrongly it may induce the opposite effect (Timmermans & Berg, 2003). This study aims at investigating the current levels of standardization within hospitals for treatments holding high promise for standardization based on their evidence-based guidelines, - medicine, and - management. More specifically, we examine to what extent cataract treatment is really standardized in practice in different hospitals and look at the degree of fit between its organisational and operational aspects.

Methods
Data was collected in three Belgian hospitals. In total 124 cataract operations (113 hours) of seven ophthalmologists were observed. This research method was deemed best, as to fully understand and measure the complexities and integrity of the investigated process. Additional information was gathered by means of walkthroughs, structured interviews, visual material and a survey.

Our multi-source data comprises measurements at patient, physician, organisational and operational level. We specify the amount and kind of variation in the process, and test the degree to which the cataract treatment operates as a standardized process. Influence of variation on the efficiency of the process (i.e. operationalization of standardization) was considered to be the main outcome of the research.

Multilevel analysis was applied on different time measurements. The chi-square test were calculated, to compare categorical variables. Cramer’s V was used as measurement of association. Hierarchical linear regression analysis resulted in predictors for common cause variance.

Results
In cataract treatment, we find a highly standardized approach to the process (Figure 1). Qualitative and quantitative analysis revealed organisational design differences between hospitals. Hospitals with an eye clinic for cataract surgery used lower staffing levels than hospitals with a one-day clinic, both in the entry-/recovery area and in the OR.
Severity influences the total OR time (9.95 above average of 41.48 minutes; surgery times 8.32 above average of 20.71 minutes). Topical anaesthesia reveals significant shorter total OR times compared to general anaesthesia (21.63 above average of 36.23 minutes) and 7.11 above average of 14.93 minutes for the preparation time in the OR. Times were significant longer in hospital A for all outcome variables compared to hospital C. Common cause variation, such as the experience of the physicians (adjusted R2=0.263, P≤0.001) and severity of the cataract (adjusted R2=0.044, P=0.011), explained longer surgery times.

Discussion
Findings based on qualitative and quantitative analysis suggest that the cataract surgery fits, and is designed in line with, standardization and operates accordingly in a majority of the cases (e.g. eye clinics compared to one-day clinic). Hospitals design their processes in function of low turnover times and smooth transitions. Standardized material and protocols, according best practice and in function of maximizing the service level for the patients, are being used. Variation in the process caused on physician level (e.g. experience, work paste) and patient level (severity) were observed but cannot and should not be managed. However, some special cause variation was detected (e.g. in process design, human resources, forms of sedation) causing a difference in operational efficiency between hospitals.
Indicators of science and innovation as a key mechanism for achieving the competitiveness of medical science and education

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Context
State Strategy of the Health Development of the Republic of Kazakhstan identified as one of the directions - further development of science and innovative technologies in health system. This Strategy puts to the Ministry of Health and research organisations (medical universities, research institutes and research centers) as one of the main task - the introduction of new principles of management and financing of medical science. At the same time as one of the mechanisms for the implementation of this problem is the introduction of international indicators for evaluating the results of research in the field of health.

Methods
To develop a methodology for assessing the Kazakh medical research organisations and universities we analysed the methodological approaches to the assessment of research and innovation activities that are used in a number of authoritative global country ratings (Global Innovation Index, World Bank: Knowledge Assessment Methodology, SCImago Country Ranking), the university ratings (Times Higher Education World University Rankings, Academic Ranking of World Universities, QS World University Rankings, Performance Ranking of Scientific Papers for World Universities, University Ranking by Academic Performance, Webometrics Ranking of World Universities, Leiden Ranking) and the ratings of scientific organisations (SCImago Institutions Rankings, European Research Ranking. Based on the analysis we developed the technique of ranking scientific organisations and universities in the health care system of Kazakhstan.

Results
Given all of the above analysis of global ratings, we have developed a list of the most important indicators of research and innovation, which have been proposed as a tool for ranking institutions of science and education in the health system of Kazakhstan: 1. The scope of research, 2. Number of publications in international peer-reviewed journals, 3. Citation of scientific papers in the last 5 years, 4. Number of patents, 5. Number of scientific developments, 6. Level of commercialization of the research developments and translation of new knowledge and technologies in health system; 7. The level of participation employees and students in the organisation of international conferences and forums. Given adopted in global ranking approaches, the greatest weight prompted to install for such indicators as the number of publications - 20%, citing scientific papers - 20%, the number of patents - 15% and number of scientific developments - 15%.

Discussion
This ranking system based on internationally recognized criteria designed to facilitate domestic organisations of medical science to go to the international level and in recognition of the beam of the world scientific community.
Introduction of a Case Tariff Fee System and its Effects on Patient Satisfaction in an individualised patient-centred setting

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Context
For certain indications, methods of classical naturopathy are now being used in German hospitals originally dedicated to the treatment of acute conditions using orthodox medicine. Because the hospital sector currently represents the focal point of German healthcare, both professionally and economically, the introduction of the German Diagnosis-Related Groups (G-DRG) acts as an important stimulus to the process of applying business management principles to the country’s health service. The present study examines effects on patient satisfaction as a quality indicator of medical and nursing care in the setting of providing inpatient complementary medical treatment.

Methods
Between 2004 and 2008, randomised, blinded interviews were performed of 4598 hospitalised patients receiving treatment in an acute clinic for internal medicine focusing on naturopathy. The aim of this survey was to analyse the satisfaction with the provision of inpatient naturopathic treatment in the context of the prevailing system of hospital financing.

Results
Neither for the professions providing medical services, nor for those providing nursing services, were any significant differences detected in patient satisfaction between the two groups of patients (p > 0.05).

Discussion
Negative effects of a case tariff fee remuneration system on the doctor-nurse-patient relationship – which have been discussed and expected by some – could not be confirmed. The results of the survey allow the conclusion that the holistic care of patients can generate a considerable increase in patient satisfaction in the provision of inpatient services, even under the conditions of the DRG system.
Knowledge, attitudes and organizational determinants of adequate professional practices: the case of radiographic positioning

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Context
Internationally there is recognition that healthcare suffers from gaps in quality and safety of care. In this study, we turn to the case of radiographic positioning in Belgium. We focus on the use of Fluoroscopy-Guided Positioning (FGP) as a positioning aid for making radiographs. This is considered as undesirable since this increases unnecessary the patients' radiation dose. In many countries non-FGP is consistently applied without a loss of image quality and diagnosis capabilities, illustrating the practical feasibility of this technique. We focus on knowledge and attitudes of imaging staff with respect to applying non-FGP imaging and organisational factors.

Methods
Three case studies were performed in Belgian hospitals. A fourth case study is performed in February 2014. To develop an in-depth understanding of imaging practices, technologists and radiologists were interviewed (n=50), complemented with non-participative observations (200 hours) and image and document analyses. Building on the concepts of the Unified Theory of Acceptance of Use of Technology (UTAUT), we propose an empirically-grounded and refined conceptual framework for understanding how (non-)FGP imaging practices are situated within and shaped by contextual features. Knowledge and attitudes of staff and organisational factors are considered.

Results
Our preliminary results showed that knowledge is an important factor. Specifically a lack of knowledge and skills about advanced positioning techniques undermines self-confidence of staffs. In addition negative attitudes towards non-FGP positioning were present. Social influence of peers was articulated as an important factor. Staffs expressed concerns with respect to the impact on the work flow and work load. Finally, clinical leadership of radiologists and chief technologists was identified as an important organisational factor. Adequate supervision, regularly feedback and coaching increases the quality of the applied imaging techniques thereby enhancing imaging quality and reducing patient dose.

Discussion
This study is among the first to investigate the determinants of professional practice. Specifically we focused on imaging practices in Belgium. The outcomes of this exploratory case study illustrates the complexity of professional practices and confirms the importance of knowledge, attitudes and contextual factors. Therefore we argue that a holistic approach considering all these aspects is needed to improve imaging practices. Clinical leadership of physicians and supervisor was identified as an important enabler of high-quality care. This is considered as an important avenue for future research.
Leadership in healthcare - the profitable investment in the 21st century

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Context
We live in an age of constant and comprehensive changes that make organisations and individuals being flexible and adaptable.
The new generation manager is challenged not to be only a manager in the everyday routine tasks, but also to be a leader of people having common goals, a leader of the change, brought by 21st century.
In the healthcare sector, there are specific demands combined with increasing prospects, thus effective leaders are of crucial importance.
Modern management style requires resourceful thinking based on clear paradigms, skills and techniques that’re needed to motivate people for the achievement of important healthcare priorities.

Methods
Research method used:
The project included 50 managers from various hospitals, insurance companies, Ministry of Health, National Health Insurance Fund, medical centers, pharmaceutical companies, etc. in the country.

The method of analysis and synthesis of scientific literature includes:
• Sociological methods:
  1. Inquiry method;
  2. Documentary method

• Statistical methods:
  1. Analysis of quantitative and categorical frequency distributions;
  2. Variation analysis;
  3. Graphical analysis

Results
Current survey results are not available, as they are currently in a state of statistical processing.
We expect the results to be ready at the end of February.

Discussion
Discussion will follow up after the outcome of the results is known.
Leadership in Turkey's Health Care System: The Case of the Health Transformation Programme

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Context
Despite the fact that healthcare reform has been high on the political agenda of Turkey for the past 25 years, it was not until the implementation of Turkey's Health Transformation Programme (HTP) in 2003 that the realisation of health reforms has been possible. Since then, the Turkish healthcare system, under the HTP, has undergone a tremendous change in order to organise, finance and deliver health services in an effective, productive and equitable way. The HTP has resulted in radical restructuring of health service financing and delivery, leading to improved national health indicators over the past decade.

Methods
The information and analysis presented in this study are based on a review of the literature and on data obtained from secondary sources, including government reports, epidemiological data, academic publications and policy reports. Published and grey literature sources were identified using international databases as well as hand and internet searches.

Results
The preparation and enforcement stages of reform initiatives under the HTP have been completed and put into practice on a large scale. There are essentially four elements contributing to the effectiveness of this programme: 1) the presence of political and economic stability, 2) the dynamics of the EU, 3) the role of international organisations, and 4) political leadership, commitment, support, will, and determination.

Discussion
The Turkish healthcare system has undergone a radical change through the completion of the legislative and enforcement stages of a long-standing reform process relating to the healthcare system. It can be noted that "political leadership" is one of the most important factors that has enabled the reforms within the coverage of the HTP to be accomplished. However, leadership alone is not sufficient for the implementation of reforms - the presence of a suitable environment is also required. In fact, between the years 2003 and 2013, during which the HTP was mainly carried out, Turkey's social, political, economic and cultural environment was favourable for adopting healthcare reforms. The Turkey case demonstrates that sustained leadership is a critical factor in the success of health reform.
M&A - Transactions on the German Healthcare Market

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Context
Due to legal restrictions the opportunity to realize company growth by performing a higher number of medical procedures and emerging new markets based on autonomous management decisions is extremely limited. Industrial investors (Fresenius), international health consortiums (MediClinic S.A) and financial investors (Median) have identified German hospitals as economically attractive targets. M&A obviously are a highly attractive option for growth. Nevertheless, up to 70% of transactions do fail or do not meet the requirements.

Methods
The opinion of M&A decision makers, persons affected and M&A change agents was investigated by structured semi-open expert interviews (n=7; two hospital CEOs, two medical directors, one M&A consultant, one chief buyer, one chief controller) and questionnaire technique (n=83). The following research questions were evaluated by the interviews:
- Which success factors determine progression and results of transactions?
- Are there typical management failures?
- How could typical M&A risks and decision-making traps be avoided?

Results
As it turned out M&A are no silver bullet solution for gaining company growth successfully. Legal constructions e.g. cooperative society (gAG) guided by the stakeholder value leadership principle outmatch every other corporate form based on a shareholder value approach.
M&A aim to “Improvement of Market Position”, “Rationalisation and Cost Containment” and “Overcome of an Economic Crisis” Purchasing contributes most to rationalisation and cost saving.
Neglected Change Management and confounding communication are stated to be the most crucial M&A risks.

Discussion
The M&A market will not be limited to hospitals, but especially characterized by vertical and lateral consolidations and take-overs. Hospitals will take over rehabilitation clinics and nursing homes in order to take care of the patients along the entire treatment pathway. Rehabilitation clinics will take over hospitals with the aim to ensure being competitive on the market for referral doctors. Medical industries will buy hospitals and reha-clinics to achieve know-how in hospital management and in order to ensure markets for their products. Additionally it is conceivable that single hospitals will cooperate with the medical industry in terms of a "Preferred Deliverer Strategy" to develop innovative products and conduct pilot schemes.
Measuring adherence to medication in several ways

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Context
Medication adherence is the act of taking medication on schedule or taking medication as prescribed. There are a number of reasons why people do not adhere or comply with their medication regimen. The common factors that interfere with medication adherence are social/economic-related factors (age, race, economic status, medication cost), survivor-related factors (forgetfulness, treatment anxiety, misunderstood instructions, fear of becoming dependent on medication), medication-related factors (length of treatment, complexity of treatment, unwanted side effects), condition-related factors (level of disability, severity of the condition) etc.

Methods
Descriptive statistics were used to summarize patient demographics, adherence characteristics, medication variables, and the occurrence of discontinuation. Because the purpose of using refill records is to improve intervention efficiency and identify high risk patients, we focused on minimizing the false positive rate. Student’s t-test, a Mann-Whitney Rank Sum test, Chi-square test and multiple linear regression were used. The Mann-Whitney Rank Sum test was used to examine differences in adherence among patient subgroups. A significance level of P<0.05 was used when appropriate for the evaluation of the results.

Results
The number of subjects increased with age, with almost two thirds (64.7%) of subjects older than 55, which is consistent with the known drug utilization increase with age. This relation was even more pronounced in the group of subjects treated for arterial hypertension. In the total study population (n=635), noncompliant subjects prevailed over compliant subjects (n=370; 58.3% vs. n=265; 41.7%). The rate of medication adherence was lower in the group of subjects treated for arterial hypertension as compared with total study population, however, the difference was not statistically significant (p=0.501).

Discussion
The obtained results reveal that more than half of respondents (58.9%) experienced constant according to the prescribed therapy. No adherence with therapy has negative consequences on the health of the individual, and an adverse impact on the community.
The main reason of adherence is oblivion, suggesting that it is necessary to pay more attention to this problem. Patients should be informed of the importance of regularly taking prescribed therapy, and in agreement with them to figure out a good way to remind them to take the prescribed therapy. Of great help could be various applications for alerting on mobile devices that are now in mass use. After analysing the reasons of no adherence, we conclude that the adherence to the medication increases with age.
Modern approaches to solving the problems of providing by human resources in health

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Context
Creation of a competitive health human resources is based on the formation of an effective system for forecasting staffing needs and the implementation of effective mechanisms for monitoring and development of human resources for health (HRH). In this case, these activities must be systematic, that should be ensured by the activities of the National Observatory of HRH. As part of the creation of the National Observatory of HRH in the Republic of Kazakhstan we analysed providing by medical personnel in the health system.

Methods
The staffing assessment in the world are based on such factors as population, sex and age composition, mortality and others. Another way is to study the rules burden on professionals and volumes of services provided. The staffing of the health system in our research has been based on the analysis of existing approved standards loading using statistical reporting form of the Ministry of Health - "Information about health organisations".

The analysis was performed with respect to the medical staff, representing the most important part of HRH in terms of their role in the process of care, and the cost of training a full-fledged professional. When this has been studied as a general security HRH and Staffing outpatient organisations providing clinical diagnostic aid, and hospitals. In assessing the number of personnel security we assessed positions occupied and individuals occupying these positions in relation to the load indices.

Results
The results indicate the presence of HRH shortages for the number of staff positions established by the regulations in force, as well as the presence of increased load on the working professionals in the health system owing to combining the vacant posts. Analysis of the results is rather ambiguous, because on the one hand there is a clear shortage of doctors, but at the same time, on the other hand, there is a surplus number of medical positions according to the actual load on treated cases. The results indicate the shortcomings of the existing health system standards for the HRH providing and the need to review and update, as well as the introdution of efficient and effective mechanisms for the HRH monitoring and forecasting. International experience and WHO recommendations indicate the need of creation of for the National Observatory of HRH.

Discussion
Thus, the personnel policy in the health care system in Kazakhstan needs further improvement and implementation mechanisms of the effective planning and forecasting staffing needs, reviewing existing regulations ensuring HRH on separate levels of care and in the context of individual positions and specialties. Establishment of the National Observatory of HRH intended to strengthen, development and support knowledge base of human resources health, regular granted in respect of evidence for policy-making in order to strengthen all parts and services of the health system and improving of health services.
Multilevel approach and integrated health (care)

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Context
The multilevel approach challenges public health research to articulate theories of the causes of disease that bring together factors defined at different levels like macro, meso and micro level. To study presence and application of multilevel approach means in principle to study leadership and organisational systems within a health system and their impact on population health. Due to the large decentralization of health system Denmark is a good environment to study application of multilevel approach.

Methods
To study multilevel principle on broad "health" is extremely hard so, we decided to use Diabetes as disease example of study. With combination of quantitative and qualitative research methods we will rank municipalities of region South Denmark (22) by diabetes prevalence and select 10 municipalities for detailed analysis. Detailed description of health promotion activities, health care availability, hospitalisation data will be done based on municipal and regional records and further supplemented by interviews with key informants on each level. National policy documents representing macro level will be linked to identified findings.

Results
We expect first results around end of 2015. Theoretical work on diabetes and multilevel principle is however expected to bring first publications in early 2015.

Discussion
Integrated care seen by public health/health promotion eyes tackles one, crucial and very important element of the health system. To improve wider population health and fully apply the definition of public health by Winslow it is necessary to enlarge integrated care by adding the public health/health promotion level for keeping people healthy and the macro level representing structural policy decision making.
Perceptions of Nurses on the Role of Senior Hospital Executives on Quality Improvement Efforts: A Survey in a Hospital in Turkey

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Context
Support of the senior hospital executives and their leadership behaviors play a key role in improving the quality of care in hospitals. In the present study, perceptions of nurses on the role of senior hospital executives on quality improvement efforts were assessed. The relationship between senior executives’ leadership behaviors and other factors (strategic quality planning, reward and recognition, education and training, quality management, use of data) was also investigated.

Methods
This study was performed as a cross-sectional, questionnaire-based survey on 258 nurses who have worked in a JCI-accredited hospital at least for three years, so are familiar with the hospital and have more information about quality improvement efforts and role of senior hospital executives. Nurses spend up to 90% of their time caring for patients and are therefore most likely to feel the success of quality improvement efforts and the impact of these efforts on quality of care. The survey used as the data collection tool was adapted from a questionnaire developed by El-Jardali et al. (2008) and it was composed of seven sections: leadership, commitment and support, strategic quality planning, education and training, rewards and recognition, quality management, use of data and demographic information about the participants. The survey form used a five-point Likert scale.

Results
The nurses’ overall mean score for “leadership, commitment and support” was 3,42±0,82. While the item with the highest score was “Senior hospital executives have articulated a clear vision for improving the quality of care and services” (3,60±1,00), the item with the lowest score was “Senior hospital executives allocate available hospital resources (e.g. finances, people, time, and equipment) to improving quality” (3,26±1,18). There was a statistically significant positive correlation between “leadership, commitment and support” and all other variables. The relationship with the highest Pearson correlation coefficient was between “leadership, commitment and support” and “quality management” (r=0,681; p<0,001). It was followed by the relationship between “leadership, commitment and support” and: “use of data” (r=0,669; p<0,001), “strategic quality planning” (r=0,649; p<0,001) and “rewards and recognition” (r=0,535; p<0,001).

Discussion
Although nurses’ overall mean score for “leadership, commitment and support” was above the degree of “moderately agree” there was a room for improvement. Senior hospital executives can provide highly visible leadership in maintaining an environment that supports quality improvement, be a primary driving force behind quality improvement efforts, demonstrate an ability to manage the organisational and technological changes and allocate available hospital resources to improving quality. The existence of a positive relationship between the variable of “leadership, commitment and support” and other variables could also mean that senior executives have a positive effect on the other factors thought to affect quality of care. Therefore, objective criteria should be used in the selection of senior executives. Only people who are well-trained in health care management and have an ability to lead should be employed as senior hospital executives.
Physiotherapy within an integrative and interdisciplinary medical approach - Impact of the introduction of diagnosis related groups in Germany

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Context
The aim of the present study is to investigate the introduction of case tariff fee remuneration - as required by the current system - and its influence on patient satisfaction with the provision of physiotherapeutic treatment in an acute hospital aligned on a holistic, interdisciplinary therapeutic approach.

Methods
Randomised controlled study with a total of 4598 patients interviewed were used. No case tariff fee system was used during the years 2004 to 2006. The data were compared with the results of interviews that took place during 2007 and 2008 (use of DRGs). The results of this study are based on the largest survey performed to date of patient satisfaction with physiotherapeutic treatment in acute care focusing on a holistic interdisciplinary approach. In-patients being treated under DRG conditions were compared with a control group for whom the DRG system had not been applied.

Results
The target parameter of the study, which took more than five years, was the determination of patient satisfaction with the physiotherapeutic interventions. There were no significant differences between the two groups in respect of satisfaction with the physiotherapeutic treatments received. Regarding the outcome parameter encouragement to take more exercise, a significant change could be demonstrated under DRG conditions.

Discussion
The evaluation of the impact of activity-based funding is largely lacking so far. In addition to structural and process quality criteria, patient satisfaction is deemed to be an important goal and a central criterion for the acceptance of a treatment. This can also be the underlying explanation as to why the patients under DRG conditions are encouraged to take more physical exercise. Further studies are necessary to investigate patient satisfaction with physiotherapeutic treatment in other countries with a case tariff fee remuneration system. Was difficult to draw clear final conclusions.
Relational Strategies in the Healthcare and Medico-Social Sector: A Case Study of Coopetition in the Languedoc-Roussillon Territory in France

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Context
This research concerns the dynamic changes taking place in the management of Alzheimer’s disease in the French healthcare system through relational strategies. These changes affect the strategic way in which healthcare institutions relate with each other on various levels of organisational interdependency. As regards the relational strategies, the conceptual framework which will be explored, is at the crossroad of several approaches, in particular: competitive perspectives (rivalry: Porter 1980, 1985; competitive interactions: Smith et al, 1992), cooperative perspectives (relational view: Dyer and Singh 1998; strategic alliances: Dussauge and Garrette 1991) and coopetition perspectives (Brandenburger and Nalebuff 1996, Bengtsson and Kock 2000).

Methods
The empirical setting of my research is the Languedoc-Roussillon territory in France. This will be based on an exploratory case study that analyses the gaps in the management of Alzheimer’s disease in the health care and medico-social networks. My working conjecture is to initially investigate the evolution of relational strategies in the health care ecosystem in order to explore the interactions and interdependencies between the stakeholders in the value network and how the introduction of coopetition will affect the ecosystem. These issues have been addressed through a programme of primary data collection, structured around 27 interviews conducted with major actors in the medical profession, medico-social services, patient advocacy groups, policy makers and health care managers. This was supported by secondary data from a wide range of sources including reports, studies and archival sources. The data analysis is based on thematic content encompassing strategy and the full care-cycle of Alzheimer’s disease.

Results
The results have been categorized into two sections. The first is a gap analysis of the sector. This analysis highlights areas that are lagging behind in the delivery of health care and medico-social services. The analysis involves an examination of the nature of the gaps in the system, the causes of these gaps and the resulting consequences on the health care ecosystem. The second category of results deals with the evolution of coopetition in the healthcare sector through the analyses of the timeline of relational strategies in the health care ecosystem. This is supported by the full care-cycle model, which shows the stages and the links in the management of Alzheimer’s disease. Furthermore, by examining the value chain, I am able to show how the actors are involved in value creation, value appropriation, the distribution of value in the health care ecosystem and the reduction of inefficiency.

Discussion
A major solution that comes to the fore in tackling inefficiency in the health system and dealing with problems of inequality is to get the actors to cooperate while still retaining their competitive instincts. This is meant to encourage transversal operations between private practitioners and hospitals representing the public sector. Achieving this objective necessitates a reform of the health system so that there is a restructuring and modernization of the public and private sectors and their corresponding policies. The concept of coopetition in health care suggests that competing actors in the public and private sectors derive mutual benefits from a strategic and dynamic relational interdependence. Therefore, leveraging coopetition to develop a relational strategy for the health care and medico-social sectors in France requires an assessment of the sector’s network of actors: suppliers, customers, complementors, as well as competitors. Consequently, coopetition infuses a win-win mentality in the delivery of medical services.
Risk - and Systems thinking for Person Centred care

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Context
Good quality healthcare depends on different systems working together. The healthcare systems constitute the sum of the people, institutions and resources working together to maintain and improve the health of the people they serve. Risk management provides the framework to map, redesign and measure relevant outcomes of key processes within the organisation, while also ensuring that the voices of patients, as well as those of staff, management and other interested stakeholders will be heard.

Methods
A critical literature review was conducted, best practice examples from 10 case studies were and consensus generation interviews with 50 world leaders in health system research was carried out.

Results
Depending on the scope and type of risk assessment, processes should include clinical and non-clinical professional staff, management, facilities management, support staff – as well as patients and their families. Supported patient involvement in the entire risk management process may be perceived as challenging, but including the patient voice, from mapping processes and setting acceptance criteria to following up action plans, demonstrates a hospital’s commitment to openness and transparency and it helps legitimize the process. Unfortunately, tools that enable patients to become partners in the advancement of safe and compassionate care are not prevalent. However, growing evidence shows that patients can play an important part in reducing avoidable harm and improving healthcare quality in general.

Discussion
Healthcare systems need to recognise the evidence base of what really makes a difference, through effective and efficient methods for including patients in risk management and system design. To make the most of this opportunity: patients, professionals, providers and policy makers all have to work as partners with different but equally legitimate experiences to design and deliver care with individual service users at the centre. This will only be achieved if they implement a systems approach to identifying and managing risks and obstacles.
Survey on patient's satisfaction with health care services in hospitals in North Bulgaria

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Context
The main objective of health care reform in Bulgaria was to improve effectiveness and quality of health services. These problems have been intensively discussed recently. One of the main measurements of health care quality is patients' satisfaction. Patients move from being object to the subject of care. Surveys on patients' satisfaction are very important for the development of health care institutions. They can increase the respect in health institutions and predispose patients to active participation in the treatment process.
The aim of this paper is to investigate patients' satisfaction with health care services in some hospitals in North Bulgaria.

Methods
The study employed a combination of sociological and statistical methods. Data was collected using self-administered questionnaire distributed among 280 patients in 14 hospitals in North Bulgaria. All in all 256 patients took part in the study. The response rate was 91.4%. More than 80% of respondents were 41-60 years old; 63.3% women and 36.7% men. The questionnaire consisted of 15 multiple-choice close-ended questions, 12 of which focused on patients' satisfaction of personnel attitude, type and length of communication with nurses. Comparative analysis is used to assess the attitude of senior and ordinary nursing staff to patients. The survey was conducted during one year period (from December 2011 to December 2012). Approval by hospitals managers and ethical committee was received prior to the initiation of the survey. The statistical analysis was performed by Microsoft Office Excel 2003 and SPSS v.13.

Results
More than half of the patients (59.4%) were not satisfied with the time spent by the personnel for communication. We have found statistically significant differences in patients' satisfaction with the communication with senior nurses by the number of hospitalizations (p<0.05). The greatest number of categories "excellent" and "very good" has been found among patients hospitalized for the first time. The attitude of senior and ordinary nurses has been assessed similarly. None of the ordinary nurses has got unsatisfactory rating. Three patients (1.2%) gave unsatisfactory mark to senior nurses. We have found slight prevalence in the excellent marks in favour of ordinary nurses (46.1%) as compared to 42.2% for senior nurses. These findings can be attributed to better contacts and longer time spent by ordinary nurses with patients. The most satisfied were respondents between 41-60 years old but the differences in responses by age groups were not statistically significant (p>0.05).

Discussion
Our findings indicate the increasing importance of patients' satisfaction for improving the quality of health care in Bulgaria. The majority of patients under study assessed their communication with the nursing staff as excellent or very good. As a whole they were more satisfied with the care and communication provided by ordinary nurses as compared to senior nurses. Patients' opinion is becoming more and more important. Patients' expectations and demands to health care professionals gradually increase. Patients pay more attention on communication with the personnel and demand better attitude of health care providers, especially of nurses as they play central role in patients' treatment and recovery. The focus of communication should be on patient-centred care where the patient is an active participant in the whole nursing process. Surveys on consumers' satisfaction present a way of improving the quality of health care and the performance of health institutions.
The importance of cross-sectoral cooperation to prevent infections and the spread of MRSA in health facilities and the community

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Context
Annually there are approximately 600,000 nosocomial infections in Germany. Many of them are caused by the pathogenic agent Staphylococcus aureus, which is fostered by the inappropriate use of antibiotics over the past 20 years. Most critically are the risks for patients associated with Methicillin-resistant Staphylococcus aureus (MRSA), because the antimicrobial therapy in this case is limited. MRSA leads to prolonged and severe courses of disease, which causes labour-intensive and expensive consequences. To prevent the spread of MRSA in health facilities and in the community cross sectoral cooperation has to be forced. Networks can help to cope with MRSA-associated problems effectively.

Methods
To identify the value of cross-sectoral cooperation to avoid MRSA-infections and the spread of MRSA in the community a questionnaire-based study was conducted. The questionnaire contains on the one hand items which should evaluate the status quo of hygienic measurements performed in German Hospitals to avoid infections. On the other hand the cooperation between hospitals and the general practitioners was assessed, because a close collaboration is necessary to reach successful results of MRSA-eradication - after and before hospital admission. The MRSA eradication takes 14 days on average, while the average hospital stay in Germany is 7.6 days. For this study it was taken into account that the German hospitals differ in size, location and organising institutions. As a consequence of this the questionnaire was sent to 309 hospitals in Germany. They were addressed to hygienic personal and hospital managers, who should be strongly involved in infection prevention measurements.

Results
104 of the sent questionnaires were used for evaluation. This corresponds with a respond rate of 33.7 %. The results show that a cross-sectoral cooperation between hospitals and general practitioners is essential in the case of MRSA-eradication. 61.5 % of the hospitals state that over 50 % of the initiated eradication therapies could not be completed while the hospital stay. The started therapies must be completed by the general practitioners. Taking this into account, it is conflictive that only 17.4 % of the hospitals rate the cooperation with the general practitioners positive. The need for a better communication and coordination becomes apparent by considering the fact that 96.2 % of the hospitals feel confident with the fact that ambulant screenings and eradication therapies before hospital admission are essential. That underlines the need for collaborative measurements to avoid hospital infections and the spread of MRSA in the community.

Discussion
The fact that nearly 70% of the surveyed hospitals are organised in infection prevention networks underlines the importance of a cross-sectoral cooperation. For constructive and coordinated network actions the management at the sectoral borders is essential. The Germany health care system is characterized by sectoral thinking which can lead to destructive decisions for patients and can have security-relevant and financial impacts on the whole system. Especially in the area of infection prevention a coordinated network approach is crucial, not only because of the medical but also because of the huge financial impact of infections. Networks like the EurSafety Health-net, which is a regional cross border network between Germany and the Netherlands show sustainable successes which are expressed by decreasing nosocomial infection rates in the hospitals. These decreasing infections rates lead to cost savings which could be used for further investments in patient safety and quality.
The Importance of Cultural Alignment in Healthcare Organisations - The set-up of a National Advisory Group for Cultural Alignment (England) and support for a pilot organisation through a process of change

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Royal College of Nursing, London, UK

Context
The NHS brand in England is in a time of challenge with drivers around both clinical quality and financial austerity. The impact of cultural alignment or misalignment on the ability to achieve optimum patient care is a key factor in the process of continued improvement.

Methods
In response to both national reports and knowledge generated by work led by Dr Naomi Chapman at the Royal College of Nursing, the need to support organisations through the process of cultural change has been identified. The model for this support was decided to be a National Advisory Group for Cultural Alignment. This abstract outlines the formation, partnerships and terms of reference of this group in its first stage with a view to reporting its delivery stage at the 2015 EHMA.

Results
The National Advisory Group for Cultural Alignment is now established with core membership of key national organisations, key individuals and an initial pilot site in the process of cultural alignment. The core membership consists of:
Royal College of Nursing
The Pacific Institute
NHS Leadership Academy
NHS Employers
NHS Professionals
Angela McNab (Chief Executive KMPT)
Angela Hopkins (Executive Nurse)
Judith Park (Deputy Chief Executive)
Aims:
The process of Cultural alignment at each pilot site is optimised
Pilot sites able to share their learning
To pool resources and skills, preventing duplication at a national level
Pilot sites have a more positive experience as they can gain support from others
Information gathered from the pilot site experience informs a replicable model of cultural alignment.
We are working with our first pilot site with desire for three further sites. An interim report is due in June 2014 with final report due in summer 2015.

Discussion
The process of establishing this group has required time and national networking. The sign up and sharing already achieved by the core group is reflective of the recognition of the significance of supporting alignment of organisational cultural in healthcare organisations.
The introduction of the balanced scorecard – the transfer of a strategy to operational management of the state medical organisations in Kazakhstan

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Context
As a consequence of sweeping reforms in 2010, Kazakhstan has introduced newly Unified National Health System, which aims at increasing the autonomy of health care providers and competition among them. Reform is intended to lead to the creation of an efficient and transparent health management practice at all levels, the restructuring and reduction of hospital sector and increased emphasis on Primary health care (PHC). Increase of management efficiency in the PHC organisation is also possible through the introduction of balanced scorecard that increases the possibility of achieving the strategic goals and performing operational objectives of the divisions and employees of organisation.

Methods
During 2013, the pilot project on implementing the balanced scorecard (BSC) was conducted in 5 Outpatient clinics in different cities of Kazakhstan. The pilot implementation included: presentation and training of medical personal on the BSC in healthcare system; providing mentoring and supervision in designing and implementation the strategy map and key performance indicators of PHC organisations. After 9 months of implementation Structured Likert type questionnaires was utilized for all medical personal in piloted organisations. The questionnaire was covering several aspects of BSC introduction process, performance assessment, self-assessment and other domains related to developed KPI.

Results
In 5 pilot medical organisations was implemented the process of strategy formalization, developed strategic maps and defined PHC specific key performance indicators. As a result, was identified a common performance indicators - resource saving (electricity, water, communication services), the reasonableness of the direction toward narrow specialists, patient satisfaction with quality of service delivered and medical care, the introduction of the acquired knowledge into practice, tutorship; and individual indicators - expansion of highly specialized medical care services, percentage of developmental care of preterm new-borns with low birth weight, delegating functions of keeping pregnant woman to general practitioners, delegating functions of narrow specialists to general practitioners, etc. All surveyed personal (95.5%) noticed importance of changes and supports introduction of BSC. Management of organisations point out increase of motivation among personal related to introduction BSC based reward system.

Discussion
The next step of pilot project will be to assess the effect of the pilot implementation of the BSC in medical organisations (e.g., impact on the level of accounts receivable, complaints, the introduction of PFP, etc.) International experience and first results of the above-mentioned pilot project provide a basis for thinking about how to use this technology in the management of state medical organisations. Healthcare unlike other real sectors of the economy has a different target system and management structure, so the introduction and application of sector specific KPI could increase performance of organisation and ultimately improve quality of provided services and health of population. The use of the balanced scorecard by the medical organisations will allow to connect the operational objectives of each employee with the achievement of strategic goal on improving the nation’s health indicators.
The role of «key performance indicators (KPI)» as a management tool for medical science development

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Context
Efficiency of the strategic and policy documents realization is one of the most pressing problems for the health system of the Republic of Kazakhstan. Ambitious goals facing by government of Kazakhstan, require the use of effective tools in the management at the level of health system and health organisations. These tools - key performance indicators (KPI) - include the use of clear and informative assessment systems - the indicators that can help determine the achievement of goals and objectives, to evaluate the current status and help in the implementation of existing plans and strategies.

Methods
The problem of the development of indicators to assess the achievement of the result stood in front of the Ministry of Health of Kazakhstan, approved the concept of reforming the medical science of Kazakhstan for 2008-2012. We proposed 23 indicators, including quantity and quality indicators and performance indicators to measure the goals and objectives of the Concept - on the level of health system and medical research organisations. The main purpose of the selection of these indicators was to provide the Ministry of Health and research community by a small easy tool - set of key indicators, represented the current state of medical science. These indicators have been used for the past 5 years as a tool for regular (every six months) monitoring the effectiveness of implementation of the Concept. These indicators became the basis of the ranking research organisations on the contribution to the implementation of the Concept.

Results
The results indicate the dynamics of most reliable indicators of quantity, quality and effectiveness of the implementation of this strategic document. The most significant changes are noted for such indicators as the number of research programs, productivity of research and scientific publishing of the research organisations, number of scientific publications in international peer-reviewed (peer-reviewed) journals, level of training of scientific personnel management research and participation in the international conferences etc., as well as indicators of the level of involvement of researchers in the educational process and provide expertise in the development of practical public health research output. Use of KPI system has shown a number of problematic issues. It concerns the relation of indicators: calculation of absolute indicators at the difference between research centers on infrastructure and personnel potential does not allow to assess the contribution of organisations in the process of reforms.

Discussion
The KPI system of strategic document aimed ultimately at achieving competitiveness of national medical science must be integrated with the most authoritative ranking systems for universities and research organisations. To improve the efficiency of KPI achievement of strategic development of medical science necessary to ensure the proper motivation of all stakeholders - to create an effective system of ranking medical research institutes / universities (KPI of scientific organisations ) and introduce clear criteria for ranking research departments and research staff , including pay differentials labour personnel (KPI activity subdivisions and employees ) , based on the core KPI development of national medical science.
Toxicolist - a web-service to improve patient-safety

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Context
The appreciation of individual differences in the response to pharmacological treatment has resulted in both extensive research on various reasons for therapy failure and side effects, and in the introduction of therapeutic drug monitoring (TDM). The establishment of therapeutic levels requires large materials, and reliable information about exposure and symptoms. Similarly, making the diagnosis fatal drug-intoxication as a cause of death remains a challenge for toxicologists and pathologists. Drug-intoxication as a cause of death remains a challenge for toxicologists and pathologists.

Methods
In Sweden, nationwide databases for forensic pathology and forensic toxicology have been in use since 1991. We have applied a strategy to select, review and classify fatal intoxications and post-mortem controls. This project also includes the compilation of analytical results obtained from driving under the influence cases, TDM cases and from non-fatal intoxications. The situation is the same concerning these areas. There is currently no existing database, where such data are generally accessible and searchable.

Results
This strategy resulted in the publication of reference concentrations of 83 drugs in post-mortem femoral blood. We have published an additional compilation focusing on antidepressant drugs, in which also relative toxicity index for the drugs studied are reported. We are currently reviewing additional groups of drugs according to the same protocol.
An Internet database, called Toxicolist is already running, but it is not as yet made available for other users, since we still need to add data about additional drugs to make it interesting to wider groups. The database will offer search options so that each user can apply a search profile matching e.g. a case displaying particular circumstances and findings. At present, the database contains the results from more than 15,000 post-mortem cases, and several thousands of drugged driver cases as well as TDM-results from patients.

Discussion
Reference concentrations of blood drug levels are equally important as e.g. reference levels for various clinical chemistry tests of endogenous compounds. This information will improve the interpretation of forensic and clinical toxicology results, with impact on both medico-legal investigations and on death statistics. The levels in the TDM material are also important, particularly for a fair idea of whether or not a certain concentration is apparently elevated, or implies therapeutic failure. The compilation of results will also allow for establishment of relative toxicity index for the drugs studied, e.g. by comparison with the total number of detections of the drug in question, or by comparing intoxications of the particular drug.
What are the basic physicians' incentives in their therapeutic choice of drug products (Bulgaria 2012)

Toni Vekov, Siviya Aleksandrova-Yankulovska, Gena Grancharova, Makreta Draganova, Nadia Veleva
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Context
The commercial potential of any pharmaceutical company is the most expensive marketing and promotional instrument. It is bound up with the necessity of a qualified and highly-paid marketing personnel, transport and adherence to the physicians' requirements related to their evaluation of particular drug products. The choice of the most appropriate company's promotional strategy would be easier and should be linked to evidence-based information about the leading physicians' incentives in their preferences of prescribing particular therapeutic drugs. The aim of this study was to identify the basic stimuli of physicians for particular therapeutic decision-making among more possible alternatives.

Methods
During March to July 2012 standardized self-administered questionnaires were introduced to 1080 randomly selected physicians in five regional centres corresponding to different geographical areas, availability of medical universities and university hospitals, and provision of highly-specialised medical care activities. The main variable in the questionnaires included quality assessment of drug products, based on physicians' assessment of drug effectiveness, dose regimen, side effects and personal therapeutic observation and experience with a particular drug. Information about the impact of drug product price, trade mark, pharmaceutical producer and image of marketing agent was also gathered. The majority of respondents were general practitioners (570 physicians - 52.8%), followed by specialists in internal medicine (195 persons - 18.0%), cardiology (182 - 16.8%), endocrinology (58 - 5.4%), neurology (45 - 4.2%), and psychiatry (30 - 2.8%). Data processing was performed by statistical software package SPSS v.13.

Results
In physicians' therapeutic decision-making three basic incentives to prescribing particular drugs were identified: high quality of drug product (61.5%), respect to marketing agent (22.3%), and image of pharmaceutical producer (16.2%). Among determining factors of their decision-making the physicians underlined also the price of drug product (38.9%) which was assessed by comparison with concurrent products with the same international non-generic name and with the level of reimbursement of similar products. The physicians valued also the marketing pharmaceutical company agent and ranked his/her qualities: high competency (28.2%), good communication skills (21.8%), expressed correctness (20.3%), quickness of mind (15.6%) and nice appearance (14.1%). As the main missions of a company's marketing agent the physicians underlined the following: ability to competently present the quality of a particular drug (53.4%), ability to establish a good personal contact and confidence (26.2%), to conclude an agreement (13.3%), and not to be aggressive and boring (7.1%).

Discussion
In the process of planning and realisation of marketing and promotional programmes it is very important that marketing mix is conformed to good evidence-based information and focused on the basic physicians' stimuli for prescription of particular drugs. Our research identified three basic stimuli for physicians' therapeutic choice: quality of drug product, personal characteristics of a marketing agent, and physicians' opinion about drug producer. Each of these three incentives is determined by several important factors, such as therapeutic effectiveness, drug price, dose, side effects and physician's experience with particular drugs. Physicians value the competency and other personal characteristics of marketing agent. The image of drug producer based on scientific positions and reliability has an essential impact on physician's therapeutic choice. The pharmaceutical company should have a marketing strategy based on its own experience about the physicians' incentives for therapeutic choice. It is very important for successful company's marketing mix.
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