High Performance in Hospital Management

A Guideline for Developing and Developed Countries

Edda Weimann
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Springer

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Foreword

The task of delivering healthcare in a resource-constrained environment is becoming a challenge in the South African context. Hospital managers are expected to balance the burden of disease and the patient load against shrinking resources, while still maintaining quality of care. The weight of this burden is increasingly being felt in the public health care services, where there is a need to support a growing population of uninsured citizens and immigrants from elsewhere in Africa seeking care, and, for reasons both economic and related to the design and delivery of healthcare, the trend is compounded by an ageing population, a rising burden of infectious and chronic diseases and a global shortage of an adequately skilled workforce. The leaders of today would need to do something different to avoid a collapse of the system.

Leaders themselves will need to change in a transformational direction to improve the quality of care provided. Such a change in strategy comes with the realisation that there is no quick fix and that the transformation process takes time to embed and institutionalise. Transformation involves much more than any single event but instead is part of an overarching strategy, the core of which is to maximise value for the patient. However, this focus should not deflect attention away from the goal of ensuring that the staff who provide the service have the resources as well as a safe and pleasant environment in which to perform these duties.

The expectation of good governance and management extends beyond merely managing resources and people to include the challenge of understanding the context within which those with executive responsibility will have to function, how they will motivate and enable those from whom they seek a desired action, in addition, to interpret the customers' needs and how to satisfy them. A different model of leadership is needed to respond to this rapidly changing environment, a model in which leadership is shared amongst the employees, all working as a team towards a common vision through continuous improvement.

It is not uncommon for the leader of any organisation to embrace change so as to create a better future. This future, however, will be more than simply an extrapolation of current circumstances, but instead is part of a complex and discontinuous journey towards an unpredictable end. This end cannot be goal-less, but should present a vision that drives change strategically. In addition, leaders and managers need to achieve operational efficiency.

This book provides a guide and tools that enable leaders, including managers, to achieve the operational efficiencies necessary in order to work towards a shared goal of change and transformation so as to secure the best results for the organisation.

Dr Bhavna Patel
CEO
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Cape Town, South Africa

Foreword

This book will be of interest to managers, clinicians, nurses and other staff in positions of leadership in the hospital and health-care environment in general. The style of presentation, which includes case studies, diagrams and questions at the end of each of the ten chapters, makes it accessible to clinicians who would generally not have had any formal training in the science of organisational management. This book covers the principles of business management as they apply to the health-care environment. The intention of the authors is to make it relevant to both developed and developing country settings.

The primary perspective presented in this book is relevant to the private sector where profit, the competitive edge and market penetration are paramount. In Chap. 1, for example, on involving clinicians, nurses and patients to drive the hospital, the concept of a market-driven hospital is presented. In public hospitals, addressing the burden of disease rather than market share would be a paramount consideration. The principles presented in this book can however be appropriated to the context of a public hospital that is not only concerned with meeting the needs of the community based on the burden of disease, but also in the improvement of the quality of care and health outcomes among individual patients and public health.

A world with equitable and universal access to quality health care is one of the central objectives of the Sustainable Development Goals that were adopted by Heads of States at the United Nations in September 2015. This New Agenda, which calls for the achievement of universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all by 2030, will not be realised without high performance in the management of the health-care system. The ten steps to success in high-performance hospital management that are outlined in this book, if implemented, will contribute in no small measure towards the achievement of the health-related Sustainable Development Goals.

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Preface

> There are two primary choices in life: to accept conditions as they exist, or to accept the responsibility for changing them (Dennis Waitley)

Worldwide health care delivery and patients' expectations have changed significantly over the past few decades: Governments have realised that they need to improve the health of the population for the country to be economically successful. Meanwhile, the World Health Organisation proposes implementing universal health care to close existing gaps in service delivery and access to care. However, there are still huge disparities in health care delivery. Up until the present, numerous governments of developing countries have provided lower coverage for the costs of health care than in most developed countries. Consequently, citizens of developing countries make a higher number of 'out of pocket payments', which counteracts financial risk protection and can lead to disastrous financial situations for families.

In most European health systems patients are well looked after, although expectations and the satisfaction of health care consumers do vary between countries. Compared with countries such as the United States, European health systems show advantages in equity, family-friendliness, regular check-ups, treatment options for elderly people, therapy choices, approved treatment indications and no significant treatment disparities between private and public patients. A welfare citizen or migrant is entitled to receive a kidney or heart transplant if there is a medical indication. Likewise, while even at 80-years-old a patient can have a hip replacement. Drug and treatment options are broad. Family insurance schemes guarantee that children and a non-self-earning spouse do not pay a separate health care fee (e.g., in Germany). Employers are required by law to earmark a portion of their employees' monthly salary for health. Some countries have, however, restricted treatment options: in Switzerland each family member is obliged to apply for their own insurance; in UK hip replacements and transplants are not performed on elderly patients.

In addition, in hospitals a shift has taken place: the formerly near-almighty Head of Department, who decided everything by himself, has had to cede authority to a near-almighty CEO, who ensures that the hospital generates profits. Diagnosis-related Groups (DRGs), Healthcare Resource Groups (HRGs), Payment by Results (PbR) and improved quality standards have revolutionised hospital processes over the last few years. Developing countries such as South Africa are on the cusp of such changes, introducing DRGs into their new National Health Insurance (NHI).

However, the changes have had costs attached to them. The new DRG requirements have added to the staff's bureaucratic and administrative tasks. Expertise in caring for patients has been lost as skilled personnel have chosen other, more attractive areas such as executive hospital management or quality assurance. Many health systems are experiencing a severe brain drain of health care workers and doctors who migrate to countries that offer better working conditions and compensation. On the subject of length of work hours, significant improvements have been introduced for nursing staff and recently also for doctors. What can we do to make hospitals more attractive to patients and employees? What drives people to emigrate or move to other fields where their expertise is more appreciated? What can be done to keep experienced staff in our health care system and increase the satisfaction of patients and of staff?

A paradigm shift is needed to align market orientation with professional ethics. Patients have to be placed at the centre of all interests so that genuine 'patient-centred care' can be delivered. With all the profit orientation and resource constraints, an ethical debate must take place. Many employees, especially doctors and nurses are worried about this paradigm shift from being curative-supportive to becoming profit-orientated. Health care staff is in general very committed to looking after patients, and show high work morale. Nevertheless, the economic conditions in which health professionals work cannot be disregarded. In the future all citizens globally will need to be provide with a sustainable, affordable and efficient health systems. This can only be achieved if everyone is willing to contribute. Hence, further fragmentation of the health system with the redundancy of diagnostic procedures must be avoided as we have to use resources economically as well as in an environmentally friendly way.

Many hospitals are not yet professionally managed and even now operate according to a system that can only be called one of 'trial and error'. Management tools are not transparently applied at all levels. Visions and strategies are not developed according to the requirements and the set priorities; the employees are not aware of them and are therefore not motivated to buy-in.

The hospital staff needs to actively engage in change management processes and, even taking a step back, in a change of strategy, if necessary.

To carry out strategy changes successfully, employees have to be informed about the goals of the executive management. Processes must be sound, unobstructed, outlined, understood and implementable by the staff. All too often, CEOs and HoDs expect that a solely top–down approach will work. This is not the case. You have to engage with your staff and your stakeholders. Employees need to be familiar with the various tools of effecting change and trained in using them.

This book, entitled *High Performance in Hospital Management* addresses all who assume responsibility in our health care system. It proposes an overarching and integrative management and leadership approach as depicted in Fig. 1. Health systems only function well if hospital processes run smoothly. This book should serve as a guideline for developed and developing countries to highlight and apply management tools in addition to the soft skills, such as communication, leadership

Fig. 1 Holistic hospital management and leadership approach

and appreciation, on a regular basis. The aim is to achieve a high-performing hospital that offers an effective and satisfactory service for all health care consumers, with the available resources. Patients and referring doctors are important stakeholders, hence, hospital processes should be made transparent for them and so facilitate their contributing to the positive transformation of our health systems and our society.

In the following book we illustrate with positive and negative examples from everyday hospital life how business management tools can be successfully introduced and employed. Do not be afraid of a successful hospital, even though it does imply that you may have to give up power and your favourite habits and, instead to share with others. Only somebody who is ready to do that can be ultimately successful at transforming an organisation.

The ten milestones on the roadmap for developing a high-performing hospital are:

1. Engage your nurses, clinicians and patients to drive your hospital
2. Create a corporate identity
3. Develop your vision and communicate it
4. Face your competitors
5. Improve communication and appreciation
6. Creating positive attitudes towards change
7. Develop and communicate your strategy
8. Find the best staff and develop their skills
9. Manage your conflicts professionally
10. Be a visionary leader

Enjoy the journey.

Edda and Peter Weimann
Cape Town, South Africa

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1 Engage Your Nurses, Clinicians and Patients to Drive Your Hospital

Goals

– What can we learn from other health systems?
– What do the different stakeholders expect from their health system?
– How innovative is your hospital?
– Which managerial attitudes are not sustainable?

This chapter introduces different health systems and health care costs. Over the past few years a new market-driven orientation of hospitals has taken place. We elaborate on the Kutzin framework to improve efficiencies of health systems and highlight what the different stakeholders can anticipate with regard to a health system. In addition, the expectations of health care users in developing and developed countries are debated. The chapter ends with a questionnaire to investigate how innovative your hospital is and how you can engage in the innovation process.

When health systems are compared internationally, there is a huge variety among them regarding equality, quality of care, service and accessibility. Also even within countries, for instance in the USA and South Africa, service delivery, mortality and even life expectancy vary depending on whether patients are treated as public or as private patients. In South Africa, for example, the mortality rate among children younger than 5 years differs by a factor of 10 between the private and the public health care system. This is caused not only by the quality of service delivery and treatment options, which differ significantly, but also by socioeconomic factors and co-morbidities. Patients who are aged over 50 years have co-morbidities such as diabetes or hypertension and those who live in a non-supportive socio-economic environment are, for example, not eligible for dialysis in the public sector in South Africa.

The UK is one country that provides universal health care ('universal health coverage') for all citizens by applying the *Beveridge model*, a welfare model in which

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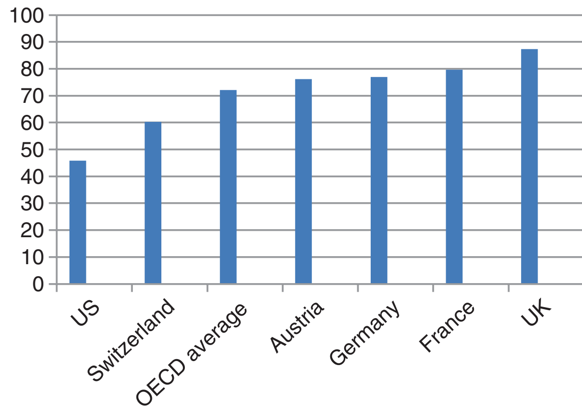

Fig. 1.1 Government expenditure (in %) regarding overall healthcare costs in OECD countries (OECD 2006)

health care is provided for all and financed by the government through tax payments. The British National Health System (*NHS*) is often cited as a model for a public health system that offers good service delivery. However, long waiting times for medical services and limitations (e.g., hip replacement, organ transplants) from a certain age are often applied in the British NHS. In the World Health Organisation (WHO) annual report of 2010 the implementation of comprehensive health care was identified as a major objective in improving the health care of the population worldwide. This should enable all citizens to have equal access to health service providers and services, without facing catastrophic financial situations. Health care costs are financed by payments in advance ('prepayment') as part of regular contributions; government levies such as taxes and *out-of-pocket payments (OOPs*; Fig. 1.1). Health care users in developing countries frequently have to cover health care costs as OOPs. South Africa has embarked on a major health policy reform, the *National Health Insurance (NHI)*, to close the huge service delivery gap between public and private health care.

The performance expectations of health system consumers tend to increase over time. This relates to medical advances, the demographic population development and the increased life expectancy, which contribute significantly to higher expenditure. To meet these requirements, there are various options: the state provides more financial resources, the service users pay more for health service delivery or the services delivered by the health system are reduced. A combination of all three options is also possible.

1.1 What Do the Different Stakeholders Expect from a Health System?

An analysis of the various stakeholders of a health system can highlight the potential policy options and constraints:

1. The state strives for a healthy population to drive the economy. Only healthy people can contribute significantly to the economic outcome of a state. WHO data clearly show that only a healthy population leads to prosperity ('health comes before wealth'). The percentage of gross domestic product (GDP) that each country provides for health expenditure varies, in particular, the percentage

Table 1.1 Healthcare expenditure total (percentage of gross domestic product [GDP])[a] and relation between private and public healthcare expenditure[b]

Country	2011	2013	Trend	Government expenditure (2013)	Private expenditure on health (2013)[d]
Australia	9.2	**9.4**	↑	**66.6**	33.4
Austria	10.9	**11.0**	↑	**75.7**	24.3
Botswana[c]	5.2	**5.4**	↑	**57.1**	42.9
Brazil[c]	9.2	**9.7**	↑	48.2	**51.8**
China[c]	5.1	**5.6**	↑	47.4	**52.6**
Cuba[c]	**10.8**	8.8	↓	**93**	7
Denmark	**10.9**	10.6	↓	**85.4**	14.6
France	11.5	**11.7**	↑	**77.5**	22.5
Germany	11.2	**11.3**	↑	**76.8**	23.2
Greece	9.8	9.8	≈	**69.5**	30.5
India[c]	3.8	**4.0**	↑	32.2	**67.8**
Mozambique[c]	6.6	**6.8**	↑	46.4	**53.6**
Namibia[c]	**8.6**	7.7	↓	**60.4**	39.6
Netherlands	12.1	**12.9**	↑	**79.8**	12.9
Nigeria[c]	3.7	**3.9**	↑	23.9	**76.1**
Russian Federation	**6.7**	6.5	↓	48.1	**51.9**
South Africa[c]	8.6	**8.9**	↑	48.4	**51.5**
Sweden	9.5	**9.7**	↑	**81.5**	18.5
Switzerland	11.1	**11.7**	↑	**66**	34
Tanzania[c]	7.5	7.3	↓	36.3	**63.7**
UK	9.2	9.1	↓	**83.5**	16.5
United Arab Emirates	3.1	3.2	↑	**70.3**	29.7
USA	17.1	17.1	≈	47.1	**52.9**
Zimbabwe[c]	No data available			No data available	

The table compares healthcare expenditure in developed and developing countries. The bold figures depict higher values and trends. Developing countries are highlighted in grey.
[a]Worldbank (2013)
[b]WHO (2013)
[c]Developing country
[d]Out of pocket payments

of public health expenditure in comparison with the total expenditure (Fig. 1.1, Table 1.1). Chronic under-funding of the health system should be avoided.

2. Patients seek high-quality health care with easy access to care. Financial risks protection for all citizens is mandatory.
3. Doctors, nurses and other health care workers appreciate good working conditions, fair compensation, an approving society and a low amount of bureaucracy.
4. The general goal of the pharmaceutical industry is to make profits. As in most cases new therapies are more expensive than the established ones, an economic evaluation of new drugs is performed by some health systems (e.g., in Australia, Canada) before they are approved for general use. The application of economically calculated cost–benefit reviews balancing common goals for the sake of individual well-being is a topic of ongoing ethical considerations.

5. Hospitals can be divided into ‘not for profit’ companies, which reinvest their profits back into the hospital, or in ‘for profit hospitals’, which can belong to hospital chains that have to distribute their profits to their shareholders. In several countries, a wave of privatisation of hospital care has led to the fact that most hospital beds are provided by private suppliers (e.g., in Germany). Some countries, such as Canada or the UK, have so far avoided providing hospital beds by for profit (private) companies. Table 1.1 highlights the fact that in developing countries people often have to pay higher out of pocket payments for their health in relation to developed countries. This results in financially disastrous situations for many health care users. Over the past few years health care expenditure related to the GDP has increased in most countries. The data depict the major contributor and trends.

1.2 What Can We Learn When We Compare Health Systems Internationally?

Internationally, we find different approaches for the optimisation of care and efficiency of a healthcare system for the population (Weimann 2013). The basic goals of a health care system are: treating the sick, keeping people healthy and protecting them against financial ruin caused by expensive treatment. The basic models to finance health care are the Bismarck and Beveridge Model, the National Health Insurance (NHI) Model, which combines the Bismarck and Beveridge Model, and the Out-Of-Pocket-Payment Model. Only a few, mainly developed countries have implemented health care systems. Up to the present most nations do not provide any kind of mass medical care. Therefore the WHO is promoting universal health care where citizens can access health care services without facing financial hazard.

1.2.1 Merging of Funds

More than 125 years ago, the Prussian Chancellor Otto von Bismarck invented the welfare state and introduced the world’s first public health insurance scheme for workers in Germany, which has in the course of subsequent decades developed into a social health system with universal health care protection for all. The *Bismarck model* still serves as a framework for health systems worldwide.

To achieve universal health care coverage for all citizens as prioritised by the WHO, risk protection through mutual financial support from rich to poor is proposed. Kutzin has developed a framework (Fig. 1.2) that depicts the main financial building blocks of a health system and highlights reform options (Kutzin 2001).

1.2.2 No Opt-Out Option for High Income Groups

Those who can afford more should pay more to ensure the social justice of a health care system. Market and economic considerations in some countries (e.g., Germany) resulted in high earners with low health risk profiles being able to choose

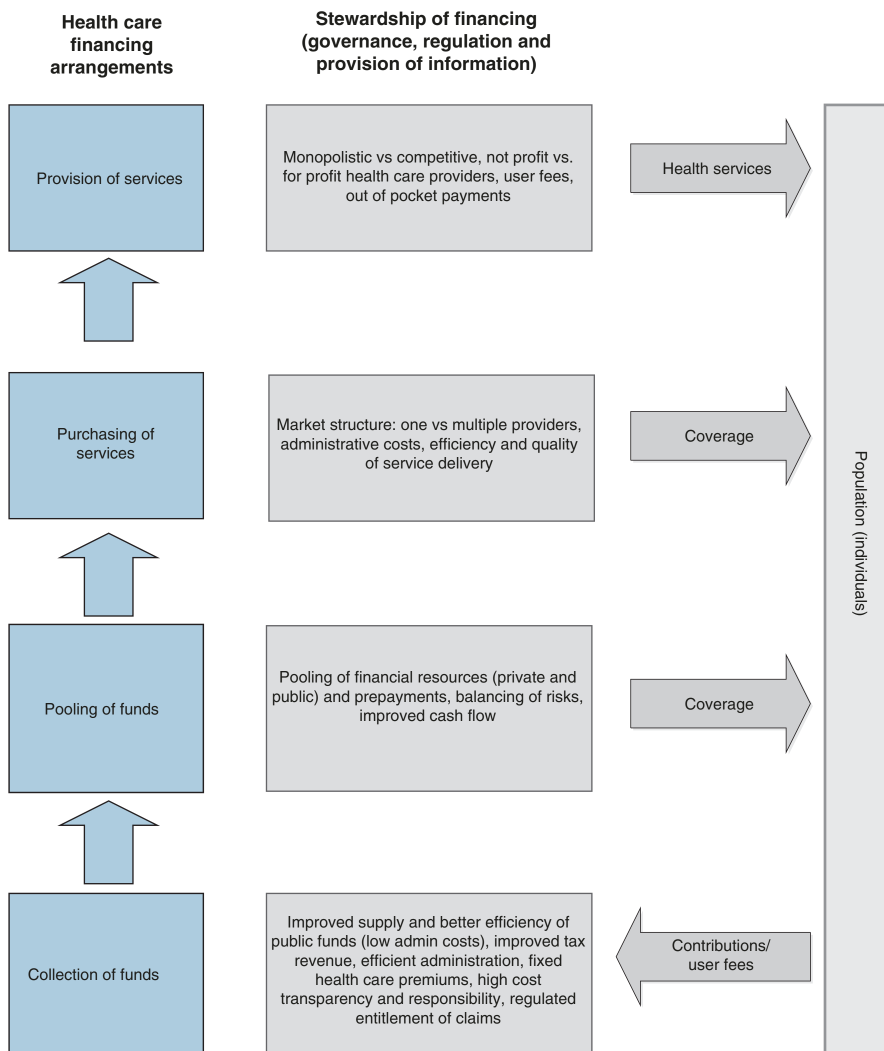

Fig. 1.2 Ways of financing health care (Modified according to Kutzin 2001)

cost-attractive private health insurance and 'opting out', thus breaking the solidarity pact and undermining risk pooling.

To encourage patients to use resources in a reasonable way and to generate additional revenues, some countries have introduced service fees. The economic benefit is questionable, as the administrative costs are high, and the main burden lies with the providers as private practitioners, clinics, and hospitals. Consequently, user-fees were largely abolished in, for example, South Africa and Germany, as they have not proven to be economically viable. Other measures, such as co-payments, as practised in the Swiss health care system, would be another option for changing patients' behaviour. All policy-holders have to pay a so-called franchise fee. In Germany, one public family insurance scheme covers all family members at a base rate. In most countries each family

member has to pay their own fee. Sometimes, some health services, such as orthodontics, psychotherapies, etc., are not even eligible for reimbursement. Service limits and other co-payments can be covered by a separate voluntary insurance scheme (as in for example in Switzerland and Canada). In a variety of health care systems, a co-payment is requested for certain diseases and therapies, such as in vitro fertilisation.

1.2.3 Quality and Efficiency Increase

According to the WHO up to 40% of health resources are wasted in health systems. Austria, for example, has significantly fewer health insurance companies than other countries, resulting in lower administrative costs and consequently lower financial contributions. In almost all health systems, performance parameters and the cost of health insurance funds needs to be improved. Owing to the high administrative costs, allowances should be integrated into the existing system based on the *Kutzin framework* (Fig. 1.2) and satellite systems should be avoided (e.g., for government employees in Germany). The more efficient use of existing resources and improved integration of the various health service providers could increase quality and efficiency. Health care costs for service delivery should be made transparent for public and private health care users.

1.2.4 Leadership of the State and the Teaching of Values

Health systems in various countries, such as Thailand, Korea or in some former Eastern Bloc countries, such as Kyrgyzstan and Moldova, demonstrate that much can be achieved for the benefit of the population, when the requisite political will and leadership are present. Despite often difficult economic conditions, general insurance coverage for the population has been established over the last few decades. Not that these health systems have reached an ideal state. Success could have been achieved had there been the political will and had those responsible drawn up an agenda for health and that declared the general commitment to working towards this goal.

Even though Swiss citizens pay a large amount of their income into the health system and have several restrictions in place, they are satisfied with their health care system. The US health care reform, also known as *Obamacare*, tries to provide equal access for all, in accordance with WHO recommendations. This reform has been attacked by various political stakeholders, viewed as being too administrative and bureaucratic, reducing individual choices, but can serve as an example where the greater good is inhibited by a lack of a mandate needed for reforms.

1.3 What Do Patients Expect from Health Systems and Hospitals?

1.3.1 European Health Systems as a Model for Developed Countries

Various studies have investigated the views of health care users on their health system. Several studies have been published that analyse the National Health Services

in the UK. Some years ago the British government engaged the public, patients and staff into participating in redesigning family health and social care to meet the challenges of the twenty-first century. According to the results, patients asked for quick access to good, free and equitable care, and they wanted to have a say in their care (Coulter 2005).

European health service users, when surveyed, revealed that they expect good communication skills from their treating doctor, they want to be included in the decision-making regarding treatment options, and would like to choose the service provider, either a GP or a hospital, although most Europeans are unaccustomed to having a free choice. Often they do not feel sufficiently informed to make this choice. Citizens in Poland and Spain are not satisfied with the still paternalistic approach to decision-making (Coulter and Jenkinson 2005).

1.3.2 South African Health System as a Model for Developing Countries

The South African health system is characterised by a severe divide between the public and private sectors. The proposed NHI aims to bridge the existing health inequalities and offer equal access to affordable, quality health care to all citizens, irrespective of their socioeconomic status (Frogner 2010). The South African health system is characterised not only by a two-tiered system, but also by escalating costs. Further, while the costs in the private health sector almost doubled between 1996 and 2003, spending in the public sector decreased. Annual expenditure per capita on private care is estimated to be four times higher than in the public sector. In addition, a major part of public health sector spending is directed towards HIV/AIDS and TB treatment, to the neglect of other medical areas (Coovadia et al. 2009). Adding to the decline in the quality of public health services are the poor governance and management of hospitals, public underfunding, mismanagement, shortages of health professionals and deteriorating infrastructure (Keeton 2010). South Africa needs to invest in the training of health professionals: this is currently underdeveloped, indeed it is neglected. The use of measures that optimise efficiency and enable the treatment of patients according to their needs such as the *triage score*, are also proposed for the country. The escalating gap between the rich and the poor in South Africa is underlined by the increasing *Gini index* over the last decade (59.0 in 1993 and 65.0 in 2009), which indicates that the disparity is wider than under apartheid. The country spends 8.9 % of its *gross domestic product (GDP)* on its health care system, with a poor outcome that is emphasised by a low life expectancy (57 years in men versus 60 years in women) and a high neonatal mortality rate (19 per 100 live births in 2011). Most financial and human resources in the health care sector are currently located in the private health sector, which covers only a relatively wealthy minority of the population.

The NHI seeks to provide universal access to health care as promoted by the WHO. This is a system of health care financing that is aimed at ensuring that everyone has access to efficient, appropriate and good-quality health services in South Africa. It will be phased in over a period of 14 years and will lead to major changes in delivery structures, administration and management systems. South

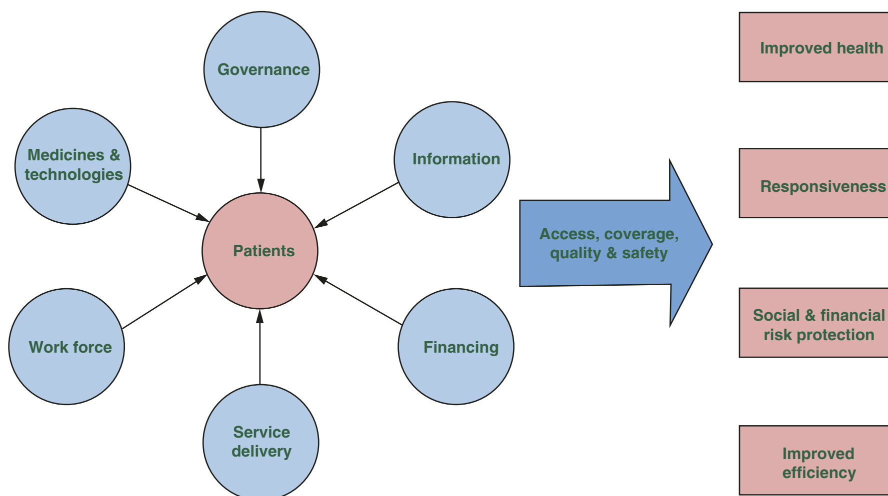

Fig. 1.3 The World Health Organisation (WHO) health system framework (WHO 2007)

Africa could reduce the burden of disease by 14.2 million disability-adjusted life-years (DALYs) and gain up to 184,085 lives by avoiding premature deaths under a single payer system like the NHI. However, this goal can only be achieved if service provision, equity and efficiency are improved. Thus, it is important to establish public support by reaching and including, as broadly as possible, the different stakeholders. This entails professionalism on the part of members of the public service, the functioning of government departments and agencies as well as the absence of corruption.

The WHO proposes a building blocks framework (Fig. 1.3) for health systems strengthening (HSS), the aim of such strengthening being to provide effective, equitable and good-quality health care and to maximise its accessibility for the population (WHO 2007). Although the WHO building block framework does supply health sector actions for strengthening health systems, the blocks in fact appear static and not interrelated. Further, the framework specifically addresses neither the role of the population in this process, nor the underlying social and economic determinants, nor the interactions that exist across each component. The building blocks, in short, provide an outline for the hardware, but not for the 'software' required to apply ideas and interests, relationships and power, norms, values and human rights to the strengthening process. A practical approach to HSS may, however, be applied through the use of systems thinking, which is a means of gaining understanding of the dynamics and the relationships of the various stakeholders that would be essential for successful interventions. Health systems are meant to be complex adaptive systems that aim to provide improved health, social and financial protection, as they respond to the expectations and current needs of the population.

Since public consultation and participation are valuable tools to be drawn upon in support of the successful implementation of new policies, a survey was performed to find out what these perceptions are (Weimann and Stuttaford 2014). The analysis of the responses to the survey revealed the public requesting for improved service

efficiency, equity, affordability and the equal allocation of resources between the public and the private sector. These findings substantiate the need for reform and fit with the aims of the NHI. The current state of the health system is described as neither accountable nor efficient. From the patient's perspective, there is a shortage of medicines, an uneven distribution of health services, and poor availability of equipment and of intersectional services. Basic service management appears to be inadequate. The respondents in this study are concerned about the quality of care they are receiving. Most of the concerns and inefficiencies have been picked up in the NHI's plans. However, several themes are identified here that are not yet covered by the NHI, these include, the need to fight corruption and have regular surveillance, the implementation of underlying ethical values for health care professionals and indicators for improved health services. In general, people judge the quality of care to be better in private hospitals, with faster treatment and shorter waiting times. The staff in private health care is described as being better organised, more attentive and more patient-orientated in comparison with staff in public health care.

The expectations of South African health care users accord with those of other countries, with some exceptions particular to this country. South African health care users regard it as vital to address the existing corruption in the public health care system and to implement underlying core ethical values to which those working in the health care sector must adhere. In addition, the lack of trust in government articulated by health care users should be addressed by policy makers and -implementers. South African health care consumers also suggest advancing the intersectional relationships within the health system for the benefit of the population. And, interestingly, they ask for a more holistic approach and capacity enhancement to establish an efficient working health system (Weimann and Stuttaford 2014).

1.4 How Can You Become a Top Health Care Provider?

Management and staff have to be aware of the macro- as well as microeconomic context in which their hospital is placed. They have to know their health system's constraints and possible solutions. The status quo must be analysed and evaluated to improve current processes. External views and critical voices should be considered. Self-reflection and innovation are two underlying main drivers in becoming a high performing hospital. Besides, existing organograms should be evaluated so as to see if they are effective, if they cover the needs of the various role players and if they use those enhancing processes. The next nine chapters provide you with the necessary tools to run your hospital or division successfully, thus avoiding the following mistakes:

1. Provide clear evidence of who is the boss in the hospital and who has a say.
2. Decisions of the executive hospital management ought never to be questioned.
3. Never change a path that is being pursued.
4. You are only allowed to critique behind closed doors. Otherwise, commonly articulated unhappiness and dissatisfaction is favoured.
5. Processes should not be changed as this only leads to confusion.

6. The satisfaction of staff is prioritised over the satisfaction of patients and referring doctors.
7. Everybody is replaceable, except for the hospital's executive management.
8. We value our workplace as we earn money and receive incentives.
9. The duration of occupancy and stay affects the career more than the qualifications and efficiency of a person.
10. Before we cooperate with the competing hospital next door, we would rather refer the patient to the nearest tertiary care or academic hospital.

If you adhere to these statements, your hospital will not advance to becoming a high-performing and competitive hospital. The questions below will highlight your ability to embrace innovation.

	Questionnaire Innovation	Yes	No
1	Is your hospital/department the economically most successful hospital/department in the region?		
2	Are representatives of patients and referring doctors present on the hospital board and do they have a say there?		
3	Is your opinion considered and acknowledged in the decision-making process?		
4	Is the continuous improvement process through transparent communication and process optimisation incorporated into the everyday life of the hospital?		
5	Are decisions that are taken by the executive hospital management made transparent, are they comprehensible, and can they be implemented by you and your staff?		
6	Do you get social recognition for working in your hospital?		
7	Does your hospital have a good reputation and do the patients feel well looked after?		
8	Does the hospital make enough profit and is it used to develop the hospital further?		
9	Are innovations and market-orientated developments carried out promptly within a certain time frame?		
10	Are you aware of the visions, strategies, processes, decision-making pathways and behavioural codes in your hospital?		

1.5 Summary

Hospitals are run within the broader microeconomic and macroeconomic contexts. Staff members have to be aware of the health systems' constraints and possible solutions. Liaise with your stakeholders on a regular basis and explore what they expect from your hospital. They are your target group. Engage your co-workers and subordinates in a continuous improvement process. You will find useful and applicable tools in the next chapters of the book, which will provide a holistic approach to tackling current and future problems. Enjoy the journey!

Solution to Questionnaire Innovation

1. If you answered more than eight questions positively, our congratulations. You are working for an innovative healthcare provider. Further improvements will probably be well received and acknowledged.
2. If you have answered more than six questions positively, your hospital is a service- and future-orientated provider. Support the further development by applying the steps outlined in the book.
3. If you answered fewer than six questions positively, do not be discouraged. Most hospitals fall into this category. Together with a visionary and innovative leader, you and your colleagues can improve the hospitals performance if you continuously apply the relevant measures explained in our book. Bonne chance!

1.6 Five Reflective Questions for Practical Application

1. Analyse different hospital processes (admission, discharge, patient flow, discharge management) and explore whether or not a patient-centred approach is being followed.
2. Does the classical separation among management, nursing and clinical services create obstacles to providing efficient and effective services?
3. Can you name three examples where you cooperate with other service providers?
4. Which major constraints are you facing this year in your health system (budget cuts, scarce skills, nursing etc.)?
5. How do private health care providers influence your business (e.g., depletion of scarce skills that move to the private sector; less revenue; service cuts as patients are using other service options)?

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2 Create a Corporate Identity

Goals

- What are hospital strategies from the top management?
- Which group of employees damages the hospital deliberately?
- What do employees need to be dedicated to a hospital?
- How can Porter's value chain be applied to creating a corporate identity for the hospital?

In this chapter we differentiate among corporate identity, corporate design and corporate image. This leads to the question: how can you motivate your co-workers and subordinates? The entire chapter gives you the competence to achieve a competitive advantage.

2.1 Corporate Identity: Bottom–Up Instead of Top–Down

Corporate *identity* reflects the character of a hospital. Its purpose is to make it unmistakably recognisable both inside and from the outside (Balmer and Greyser 2006). A hospital's corporate identity comprises a mission statement, the company's philosophy, operational guidelines and external symbols such as the logo (Stuart 1999). *Corporate design* (that is the external appearance of the hospital), refers to conduct, communication, philosophy, language and culture, all are part of it too and they are co-ordinated. By comparison, the *corporate image* is what is seen from the outside, how the hospital is perceived in its community. Ideally, corporate identity and corporate image correspond with one another (Andreassen and Lindestad 1998). However, only a few hospitals ever achieve this. When a private company is a service provider, the success of an enterprise increases through its corporate identity (Gotsi and Wilson 2001). In particular, companies newly on the market that are

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innovative and have clear goals, will appeal. They prompt staff, regardless of their rank or income, to be dedicated to the company beyond their working hours and to identify with its goals. Thus, corporate identity is lived by the staff bottom–up; it is not ordered top–down through directives issued by management.

A successful hospital should be run with the same passion, enthusiasm and perfectionism as a five-star hotel. To achieve this, care and attention to detail are given priority: untidy and run-down foyers and over-flowing ashtrays and waste baskets should not be tolerated. When a patient is admitted to a ward or day clinic or outpatient department, the admitting staff should have been previously informed about the patient and the reason for his admission. Hence, a personal welcome with a certain amount of background knowledge is mandatory: for example, the patient, Mr Samuels, 65 years of age, admitted for cardiac arrhythmia, referring physician Dr Bradshaw.

Case Study

Mrs Simons is admitted to the ward because of recurring upper abdominal symptoms. She is nervous and unsettled because this is her first time in hospital. After she has been greeted personally and given a brief explanation of what is planned and when her interview with the ward doctor will take place, her anxiety disappears. She consequently relaxes because she has now experienced the pleasant feeling of being in competent hands. She remembers her husband's stay in hospital some years ago when a sister called across the ward: 'Here is a Mr Simons. Does anyone know why he has been admitted today?' As a result, Mrs Simons was not then able to place her trust in the staff.

Conclusion: Invest time in the admission process and give guidance and information to the patient and the family. This should include the possible challenges that can occur during the hospital stay. It saves having to deal with complaints later.

In *integrative corporate identity management* various specific measures are conceptually linked, are strategically synchronised, and serve to promote the identification of the employee with the hospital. A corporate identity cannot be prescribed. It must be lived, not just by the staff in direct contact with patients, but also by the hospital management, the directorate, the Hospital Board and, in particular, the administration. The corporate image will reflect how well a hospital is accepted in the community it serves as well as how much appreciation the employees receive from their social contact. Not only should the hospital be proud of its employees, the employees should also be proud of the achievements of the hospital. If an employee and his/her family keep getting negative feedback regarding their employer in the community ('Oh dear, is that where you are working? I would only go there if there's no other alternative'), then they may eventually go looking for another job in the long run or give up on the job after a while and mentally resign (Sect. 2.2). On the other hand it is very encouraging for staff to hear from patients that they are satisfied with the treatment and with hospital processes.

Cardinal questions that are always asked include: what is *good hospital management*? can what is purely management be transformed into leadership? Firstly, it

seems to be important to have a good mix at the management level, thus, there should be no one autocrat who has the say, but rather an executive management team of which all the members have an equal say. Ideally, a supervisory board comprises executive hospital managers, health economists, a person who is in charge of ethical considerations and a patient representative. Preferably, members of the executive hospital management and the hospital board should have their family members treated at this hospital if they are ill – and not only because they will have the advantage of receiving special treatment but because they know that the level of care provided is high.

A further question that arises is, how can you set this hospital apart from its competitors? To this end, positive emotionality plays an important part. The staff must be able to have empathy with patients' concerns and be able to take action. An emotionless work-to-rule attitude is something that patients quickly pick up on. Another important element is the way in which the staff are included and whether employees can develop a sense of: 'This is my hospital, I am feeling empowered to drive it as I want to contribute to its success. These are our patients for whom we as a team are responsible.'

2.2 Work Motivation

> Don't try to flog a dead horse. You cannot succeed. (Author unknown)

Gallup, the US research-based, global consulting company, carries out regular public opinion polls on staff satisfaction in several countries. It has been shown over and over again that a constant proportion of employees work against a company or even actively damage it by their behaviour. This can be reduced by targeted measures even though it can never be eliminated. In a 2014 Gallup poll 31.5 % of employees were engaged, whereas 51 % were not engaged and 17.5 % were actively disengaged. Managers and executives showed the highest level of engagement (38.4 %). The proportion of engaged people is responsible for the success of an enterprise (Gallup 2014). The commitment of employees mirrors their emotional attachment to the company. According to Gallup, emotional ties correlate positively with the business indicators, fluctuation, or absenteeism. Dedication not only influences work performance, but also has an impact on patients' safety. Certain management 'soft skills' (Chaps. 5, 9 and 10) influence these key data significantly. Figure 2.1 shows results from the Gallup poll for selected countries.

What drives people to be either dedicated or not? Let us take a closer look at the Gallup questions with regard to the hospital and reverse them. 'If employees are a company's best asset, then their care and support should be a priority'.

The degree of agreement with the following 12 statements may reflect employees' motivation and thus also the success of a hospital:

1. *I know what is expected of me at work.* Only a few employees and even managers really know precisely what their superior expects of them.
2. *I have the necessary equipment to do my work properly.* Often there is not enough space and equipment for the hospital staff to complete the necessary

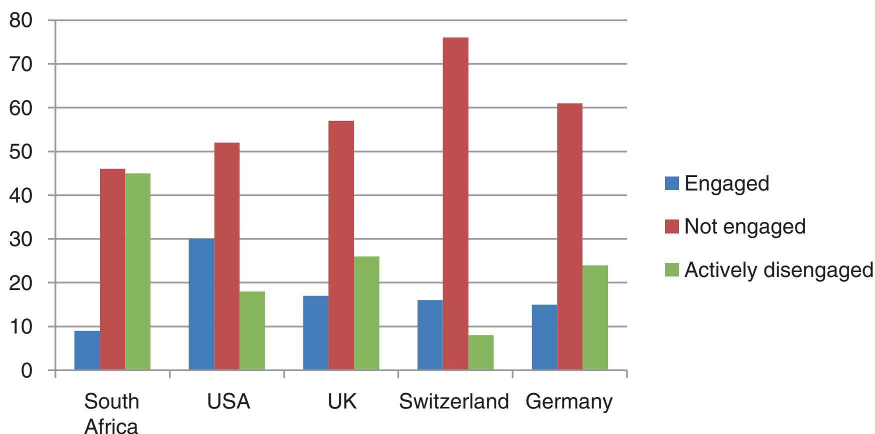

Fig. 2.1 Employees worldwide engaged in work (Adapted from Gallup Poll (2014))

administrative work. (Negative example: five interns and registrars share one office in which there are two desks and one PC).

3. *I have the opportunity to do what I am able to do every day.* This is one of the key issues raised by young doctors in particular, such as interns and registrars. In the past, patient consultations and treatments were given priority, whereas currently effectiveness is measured by the number of doctor's discharge letters and prompt submission of International Classification of Diseases 10 (ICD 10) and diagnosis-related group (DRG) codes. Nowadays, the work is overloaded with administrative tasks. Alienation from the original occupational profile has taken place and can cause demotivation.
4. *I have received appreciation or praise for doing a good job during the last 7 days.* The motto: 'No praise means no blame' no longer applies.
5. *My superiors show personal interest in me.* Social appreciation in a hospital should be applied at all levels. A departmental head, hospital director or consultant who appreciates the staff and finds time and is interested in his employees personally will, in the long run, only succeed if s/he in turn finds appreciation for his/her work and engagement in the hospital from superiors.
6. *There is someone at my workplace who supports my development.* Mentoring plays an increasingly greater role. If a new employee joins the hospital staff, a mentor or coach (▶ Glossary) should be assigned who will accompany him/her and support the employee in future training. Targeted continuing professional development programmes, which are quite common these days, should be offered more frequently in health care delivery.
7. *My opinion seems to matter at work.* How often do you hear the following phrase in your hospitals: 'I am only a small fly/tiny dog. My opinion doesn't count.' Such an attitude has a negative impact on a hospital, for employees such as secretaries, receptionists or security staff often do not feel appreciated, and yet they have first contact with patients – and first impressions count. Hence, you have to focus on the image presented on the patient's first entrance: if a

secretary or clerk continually puts on the answering machine, at some point patients will stop calling during the specified and often very limited times and look for alternatives. Poor service awareness is often encountered with monopolist institutions such as university hospitals, provincial hospitals and large regional hospitals.

8. *The goals of the hospital make me feel that my work is important.* It is a challenging task for hospital management to reach and talk to all employees. This is only done in successful hospitals.
9. *My colleagues are motivated to work to the highest standard.* It is important which structures new members of staff in particular encounter. How are mistakes and complaints handled? Does a team manage to implement change processes that improve the operational output such as quality in addition to ensuring patient satisfaction? Are the department and executive hospital management teams actively engaged in creating a high work morale? (Chap. 6).
10. *I have an important 'go-to' person in the hospital.* Being grounded and accepted plays an important part in the well-being of employees. On the other hand, people who have mentally cut their ties may jointly work against the hospital.
11. *During the past 6 months someone in the hospital has discussed with me my progress.* It is important to the employee that performance reviews take place regularly, and the employee's achievements and evaluations are documented. Employee should not experience such interviews as simply routine for their superior. Standardised questionnaires for staff evaluations have already been introduced in hospitals. However, often it is a matter of going through the motions; the forms are simply filed and thus usually fail in their objective of implementing targeted employee development.
12. *I have had the opportunity to learn something new at work and to improve myself over the past year.* Professional development should play an important part for both new and experienced hospital staff. A hospital should ensure in all areas that staff can develop and will not at some point leave to join the competitors because they offer better development opportunities.

2.3 Positive Emotionality

The factor of 'empathy', that is applied positive emotionality when treating patients, is of crucial importance in order for a patient to feel accepted and well-cared for. Casual remarks such as 'No idea what Cardiology is thinking of to send you without a prescription' are quickly made, but stay with a patient for a considerable time and create an image of incompetence and lack of care. Only if everybody works together to achieve the common goal of treating patients at the best level can a health care provider be successfully run. This does not necessarily require more staff, money or other resources. You would have a similar experience with an almost empty coffee shop: although the same number of staff is present, service and attention are occasionally clearly worse than if all places are taken. If instead of one person, three

people do not exactly know what is going on, the patient's confidence in the treatment is undermined.

When health systems are analysed and compared across the world, different qualities of care are achieved, even when comparable budgets are used (Chap. 1). This can be shown when infant mortality and average life expectancy are compared in different health systems (WHO 2008). Huge amounts of money and resources can be invested in malfunctioning systems without changing for the better.

The website is – to a higher or lower extent – user-friendly and professionally designed. Usually, the most important feature is the *mission statement*, the self-defined task of the hospital. In most cases patient-centred care is advertised, patients finding themselves apparently in first and central place. Yet, when the patient enters the hospital s/he sometimes cannot get rid of the feeling that everything revolves around the staff's efficient work routines while the patient's needs are hardly given consideration.

Hospitals spend large amounts of money on external and internal consultancy contracts to create a corporate identity. Such corporate identity should ensure that the patient feels well-cared for in the hospital, but in fact this happens only in rare cases. Patients notice very quickly the low value placed on them. Why is this the case? The most moving words and well-advertised visions do not help at all if they are not implemented as part of everyday-life. The hospital's administration and management are frequently referred to in derogatory terms. The management is usually housed in a different building or at the top or ground floor of the hospital and, compared with the rest of the hospital, it is best equipped. The reasons given for this are the representative functions of the hospital, although a patient will only very rarely find him/herself in the CEO's office. From a kind of helicopter perspective, the top management issues directives while the Corporate Identity has been prescribed top–down. The patient's point of view is frequently only taken into consideration when a complaint is written to the hospital's CEO.

2.4 Recognising the Competitive Edge

> It is better to be a big fish in a small pond than to be a small fish in a big pond. (South African proverb)

It is important for a hospital to recognise and establish its own core competencies by asking the question: compared with our competition, in which areas do we have the competitive edge? To deal with this question we devote the following chapters to recognising core competencies and the competitive edge.

Anecdote: The Farmer and the Tree Trunk
Han Fei Zi, the Chinese philosopher, born around 280 BCE

A young farmer was working in his field when a hare came running and crashed – head first – into a tree trunk at the edge of the field. The hare died immediately. Delighted, the farmer picked up the hare, took it home and prepared a delicious meal. The next day, the farmer put aside his hoe and crouched next to the tree trunk. He was hoping that another hare would come and run into the tree trunk, but in vain.

And so he sat every day at the edge of his field and waited for a hare. In the meantime his field became covered in weeds.

This short story illustrates a very common attitude. After a chance success every effort is made to repeat that success. In the meantime the real tasks are neglected and actual competencies go unused.

A hospital's vision must be implemented by using appropriate strategies. Otherwise, both staff and patients will realise that the much vaunted vision on the internet page is simply marketing. This is associated with loss of trust, both inside and outside. Yet, trust is of central importance in medicine. Without trust in a hospital, in its doctors and nurses, patients are unable to commit themselves to a treatment relationship and improve the condition of their health.

A successful hospital will analyse core competencies and competitive advantages and use them as starting points for developing a strategy. The core competencies of a hospital should be documented, thus enabling the processes on which the institution's competitive edge is based to be highlighted and analysed. The first step in documentation is the so-called process map (Sect. 3.7.1), which visualises the processes in the hospital. Identifying such a value chain illustrates the processes by which the hospital stands out from its competitors to operate economically (Hines et al. 1998).

2.4.1 The Competitive Standing of a Hospital

Before a society becomes wealthier, it gets healthier. (Hans Rosling)

How companies or hospitals can achieve the competitive edge is illustrated in *Michael Porter's concept of a value chain*. Porter developed this concept as Professor of Economics at Harvard Business School and published it in 1985. As a leading economist in the area of strategic management he had already introduced his concept in the 1970s. This approach introduced a fundamental change: whereas in the past many decisions were taken based on gut feeling, more recently process orientation and optimisation have developed to offer an essential approach to working in a competitive and profit-orientated way. Only if the hospital works economically will it be in a position to make the capital investments needed for its future development. This applies not only to private hospitals, but also to public hospitals.

Definition
A process is defined as a temporal sequence of activities. For value creation a process must be both efficiently and effectively structured. Efficiency means that the result has to be better than the investment of factors. Flawed processes resulting in poor quality imply that the treatment costs are too high and the service quality is unsatisfactory for the patients and the referring doctors.

Compared with business processes in other companies, hospitals are repeatedly facing problems in the three major hospital areas: administration and management, medical departments, and nursing. Furthermore, the architectural structures of hospitals often counteract integrated processes and hence value creation. For example,

obstetrics, the neonatal unit, and the nursery may be situated in different buildings. The coordination of treatment and interdisciplinary communication is seldom direct and spontaneous, but has to take place via telephone and joint visits where not all the staff involved can be present. Private hospital groups overcome this obstacle by conceiving completely new hospital buildings with economically aligned care structures.

The current situation must be ascertained and documented, focused on the essential parameters, depending on the processes that need to be analysed. This is helpful in setting up a value chain and in recognising competitive advantages.

The following *five forces* influence the profitability of a business and determine its appeal:

1. Negotiating power of clients
2. Negotiating power of suppliers
3. Threat from alternative products
4. Threat from potential competitors
5. Competition within the branch of business

In the following, *Porter's value chain* is aligned to a health care centre by applying the five forces model.

- *New competitors:* new competitors require competition-orientated responses that inevitably deplete a hospital's own resources and thus reduce its profit margin.
- *New products, alternative products and services:* if genuine alternatives to hospital services are offered elsewhere on the market or by a competitor, the scope of one's own pricing becomes constrained. In health systems that have to apply DRGs, pricing outside of the budget is already very limited. The hospital may apply alternatives by engaging in additional contracts outside of the budget. For example, private patients could be offered individualised health services and hence increase the attractiveness of the health care provider.
- *Negotiating power of clients:* if clients can negotiate, they will do so. However, this can reduce profits and as a result the profitability of the hospital. If services are offered more cheaply in other health care centres or day clinics, this reduces the competitiveness of the hospital.
- *Negotiating power of suppliers:* if suppliers are limited and can enforce their power (e.g., medical technology companies, pharmaceutical companies, and medical supply stores) they will be able to increase prices and thus reduce profitability.
- *Competition within the branch of business:* competitive pressure, raises the necessity of investing in marketing, research, and development or of reducing prices – both consequently reducing profits. Depending on the particular specialist area, many inpatient services will be rendered mainly in outpatient facilities within the next decade; thus, the range of services offered by hospitals is going to change.

2.4.2 Competitive Advantages

The competitive advantage is the result of establishing a profitable position together with all the strengths offered by the hospital. In analysing competitive advantages the following *questions* should be asked:

- How can our hospital create competitive advantages and maintain them?
- What is the underlying reason why other hospitals and hospital groups are being more successful than us?
- Which competitive strategies should be followed with regard to our position and our expertise? The competitive position of a hospital is determined by the additional activities in innovative medicine, efficient treatment, marketing, waiting times and the interaction with referring doctors (doctors in private practice, health centres and other hospitals).

All activities contributing to the hospital's relative cost situation form the basis for being different from its competitors. For instance, a *cost advantage* can arise because of the following:

- Reduction to what is necessary and sensible in diagnostic processes ('lean health care').
- Efficient treatment processes (reducing levels of care from 'intensive' to 'high care' to 'low care' with a reduced ratio of nurses and doctors per patient).
- Continued treatment within the hospital group's outpatient centres.
- Cooperation with colleagues in private practice where services or support can be offered by the hospital (e.g., support with administration, direct access with electronic interface to make appointments for patients).

According to Porter (1985) the competitive advantage grows fundamentally out of the value a company is able to create for its buyers, value that exceeds the firm's cost of creating it. Meeting the competitive edge can be related to the following:

- Purchasing medicines, equipment, and material at favourable prices.
- Faster treatment with short waiting times.
- Excellent reputation and high patient satisfaction.
- Professional and organisational competence.

2.4.3 Role of the Value Chain

The value chain is a tool for systematically examining all processes in a hospital. It clarifies how activities are related and the role they play in the competitive advantage.

The value-added chain divides the hospital into strategically relevant activities, so as to analyse the costing and to understand the potential for differentiation (Fig. 2.2). Your hospital achieves a competitive advantage by performing one or

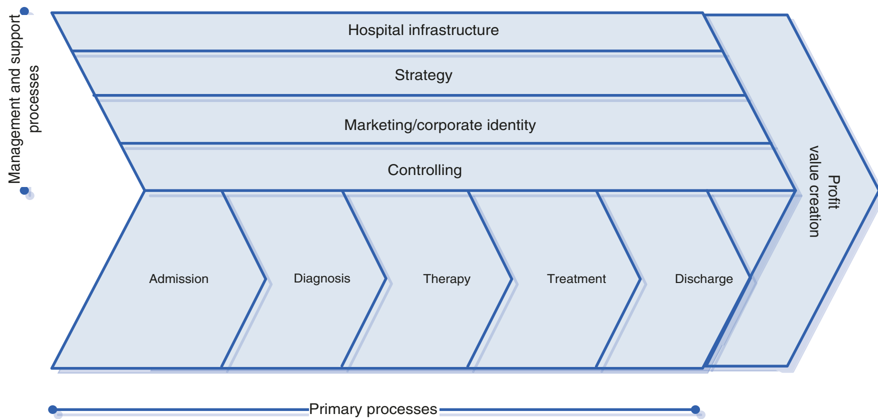

Fig. 2.2 Porter's value chain (Adapted for hospitals)

several strategically important activities more economically or better than your fellow competitors. Applied to a hospital, this could be described as follows:

- A hospital's value chain is part of a value creation system.
- Suppliers who manufacture the products they purchase have a value chain and deliver them with the relevant features (e.g., remedies, medicines, medical technology).
- The client (patient, referring doctor/hospital) defines the requirements for the hospital.
- Achieving and maintaining a competitive advantage relates to the overall environment you are working in (e.g., establishing a health centre if there is already another one in existence).

2.4.4 Competitive Strategies

In Section 2.4.2 we explained how a hospital can achieve a competitive advantage by being more cost efficient as well as more innovative than competitors. According to Porter, the following strategies for achieving cost advantage exist:

- *Differentiation:* a competitive strategy for creating customer loyalty by developing new services.
- *Focussed differentiation:* a competitive strategy for developing and occupying new market niches for specialised services.
- *Cost leadership:* a competitive strategy with the goal of becoming the most reasonably priced service provider on the market. To accomplish this, all possibilities of achieving cost advantages must be identified, balanced and then utilised (e.g., 'high/medium/low care', day clinics, separate facilities for outpatient services and specialised ambulances).
- *Efficient consumer feedback:* this includes the entire hospital. Inefficiencies along the value creation chain are eliminated by taking into account the user

requirements and a maximum client satisfaction level. The actions are related to vision, strategy, and the pooling of technical procedures within the cooperation that exists among patients, referring doctors and the hospital. This facilitates advantages that could not be obtained single-handedly. Examples are private hospital groups, private day clinics offering medical check-ups together with wellness and optimisation of the personal lifestyle or specialised medical groups for various diseases (fertility clinic, endocrinology and diabetes mellitus, life-style diseases, cardiovascular diseases, etc.).

Compared with other business processes, there is little scope for pricing in health care provision, in particular in public health care. Regulation is provided by the legal framework, DRGs, budgeting and the prescribed scale of charges and fees.

Hospitals, day clinics, and private practices are limited in the measures they can use to reduce costs. In the health care system the staff is the main expense. Therefore, savings opportunities are implemented here first, and consequently, staff will then be dismissed or reduced. In turn, this affects the quality of care and the working environment. If this is implemented too harshly, then the hospital may quickly find itself in a downward spiral. Specifically, well-qualified employees leave the ship first, because they have found another, more attractive field of work with a competitor.

2.4.5 Core Competencies

As part of the development of competitive strategies, *core competencies* play an important part. These are derived from the competitive abilities of a hospital that have resulted from the pooling and linking of available resources.

When the business processes of a hospital represent core competencies or contribute significantly to the development and expansion of the core competencies, they are defined as *core processes*. Accordingly, core competencies are relevant in increasing competitiveness and success. If your hospital performs core processes better than the competitors, the hospital achieves a competitive advantage. Core processes are characterised as follows:

- They are based on specific knowledge and expertise.
- They are not available on the market or are hard to imitate or replace.
- They produce new services or procedures.
- They generate an influx of new patients.
- They create benefits for referring doctors and patients.

As a rule, core competencies cannot be introduced instantly, but a hospital can use its competency and expertise as competitive advantages. This is why recognising core competencies is of strategic importance. Consequently, the following questions regarding processes and core processes must be asked:

- *High benefits for referring doctors and patients:* can added value based on the core processes be produced for referring doctors and patients?

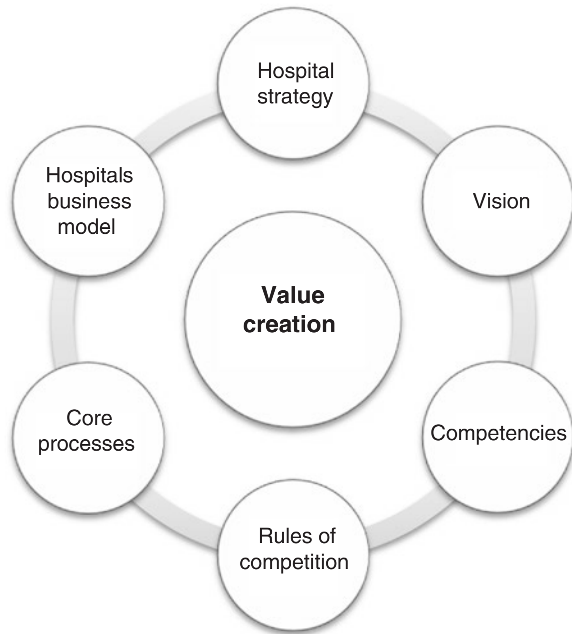

Fig. 2.3 Value creation cycle

- *Protection from imitation:* is the process exclusive to the hospital or can the process be easily imitated by competitors?
- *Differentiation:* does the core process result in a sustainable advantage over competing hospitals?
- *Diversification:* does the core process disclose new markets?

Even if core competencies cannot be introduced instantly, there are a number of activities and skills that help to develop them:

- Identifying patients' and referring doctors' requirements early
- Being innovative
- Efficiently offering services with a high degree of client benefit
- Offering treatments with new and superior technologies
- Satisfying patients and referring doctors quicker than the competitors
- Reacting quickly to changes in the market.

As part of the planning process of a hospital's strategy, it must be specified how *core competencies* and business processes are interconnected. Besides, it is necessary to define the business processes assigned to the development or support of core competencies and how the implementation of core competencies is controlled and preserved.

An overall picture of value creation is drawn based on Porter's value creation cycle (Fig. 2.3). Core and control processes, in addition to supporting and resource-developing processes, belong to the process landscape of the value chain.

2.5 Summary

Corporate identity cannot be prescribed top–down, but should be lived as a bottom–up approach at all levels, throughout the entire hospital. It is not enough and sustainable simply to place the hospital logo on all brochures, letterheads and notices. Corporate identity is linked to coordinated communication, behaviour and appearance and reflects the entire 'personality' of a hospital. Some private hospitals and hospital groups demonstrate leadership in this field. For this purpose, business processes must be identified and, where necessary, changed. *Porter's value chain* constitutes an approach to optimising the *core and business processes* and to aligning the strategies to that purpose, enabling a corporate identity to be established. Different tools, such as the *five-forces model and recognising core competencies* are available for improving the alignment of the hospital with the market and generating the desired competitive edge. In this way, corporate identity and processes are synchronised. The various tools should be systematically applied and goals need be communicated to the hospital employees. These measures contribute significantly to developing a corporate identity together with the staff, by creating the feeling of being part of the business processes and of playing an important role in the hospital, irrespective of individual responsibility. It would be ideal if corporate identity and corporate image were to align with each other.

2.6 Five Reflective Questions for Practical Application

1. What corporate identity do you have in your hospital? In what aspects is your hospital better compared with the other hospitals in your community? What would you mention to friends and acquaintances?
2. Which business processes can you identify in your hospital? How do you rate their improvement potential?
3. How can you use Porter's value added chain to facilitate the alignment of corporate identity and corporate processes?
4. How can you convey the corporate identity to your staff so that they will feel part of the business processes and realise the important the role is they play in the hospital?
5. Do corporate identity and corporate image correspond in the case of your hospital? Where do they conform, where do they differ?

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3 Develop Your Vision and Communicate It

Goals

- How do you develop a vision for a successful hospital strategy?
- How and when do you conduct a SWOT or ABC analysis?
- How do you develop successful project and project portfolio management?
- How can you apply lean management processes in your hospital?

This chapter enables you to move from your vision to the processes of running a hospital efficiently. To do so we introduce the SWOT analysis, touch on business engineering, business models and business processes. Hence, project management and portfolio management with the various steps are highlighted. The chapter ends with introducing lean management tools.

3.1 From Vision to Processes

> Our deepest fear is not that we are inadequate. Our deepest fear is that we are powerful beyond measure (Marianne Williamson, quoted by Nelson Mandela in his 1994 Inauguration Speech)

Don't be disappointed by unsuccessful projects and small or large failures. If you are a visionary person, you are faced with a tough piece of work in convincing others of your vision. It is even harder to put your vision into practice. In the long run, hospitals cannot survive without a sustainable vision. However, it is also very important not to lose touch but to remain grounded and realistic. Hospital management becomes implausible if it professes to the outside world that it provides first-class medicine and it pretends to be one of the best hospitals in the world, yet the simplest processes aren't working, and standard treatments are not even being offered.

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Case Study
At the get-together introducing a new head of department, the CEO of a regional hospital announces that hospital management has the vision of offering medical services at the level of a tertiary academic hospital. Some staff members and referring doctors are surprised about this ambitious project because a glance at various benchmarking analyses reveals that the hospital falls within the lower range of patient and referring doctors' satisfaction. Furthermore, some standard treatments and procedures are not offered at all. The general attitude of the attending staff is that the executive management should first engage in improving existing processes before publically articulating currently non-achievable goals.

In formulating a vision, the goal can be ambitious, but it should be achievable within a certain time frame. Competing hospitals should be seen as a challenge to analysing your own hospital's weaknesses and converting them to strengths instead of, for instance, devaluing your competitors to appear better. Before the executive hospital management presents its ambitious vision to the staff it has to do its homework. Partly, this is to define a business strategy and coordinate the processes needed. If the hospital is well positioned regionally, the staff will understand and support the vision of becoming the regional expert in specific areas within a certain period.

What enables you to develop a vision? On the one hand, you need to know and understand the market. Relevant questions might be:

What do our referring doctors and patients want?
Who are our competitors?
What are our and their strengths and weaknesses?

You should envisage the present as well as the future. This is easier if one is alert to developments in the region, in other cities, districts, provinces, or even internationally. Apart from that, contacts at the governmental level are important for executive managers. Advanced discussions of future developments should take place before being made public.

3.2 SWOT Analysis

Vision without action is a daydream. Action without vision is a nightmare. (Japanese proverb)

The first step in developing a vision is to analyse the present situation. A good tool for doing this is a strengths, weaknesses, opportunities, threats (SWOT) analysis. The strengths and weaknesses of a hospital or department become apparent by

contrasting internal and external factors as well as contrasting your own enterprise with the most important competitors. The purpose is to achieve competitive advantages by determining unused potential in a hospital or department. In the course of a situational analysis, a SWOT analysis can control the direction and development of a hospital and its processes. Using SWOT guidelines and key performance indicators (Chap. 7), hospital management can check whether the envisioned objectives have been achieved. Furthermore, management are enabled to evaluate by which measures they may be fulfilled in the future.

Before going further into the SWOT analysis we refer to the history of strategic analysis, using a quote from Sun Tzu's *The Art of War*:

> If you know the enemy and know yourself, you need not fear the result of a hundred battles.
> If you know yourself but not the enemy, for every *victory* gained you will also suffer defeat.
> If you know neither the enemy nor yourself, you will succumb in every battle.

The Chinese military strategist and philosopher Sun Tzu wrote the book *The Art of War* more than 2500 years ago. His remarks have inspired many famous commanders. The book describes many possibilities regarding how you can prevail over your enemies – not only in a battle – and be victorious. The quotation above can be applied to many areas of life and business. Sun Tzu's statements form the basis of many strategies as well as the practical application of a SWOT analysis.

SWOT Analysis

Strengths: internal factors

- On what are past successes based? What are their causes?
- Which future opportunities do a hospital and department have?
- What potential can be better utilised through new strategies?

Weaknesses: internal factors

- Which weaknesses and weak spots can be avoided in future?
- Which department and service produce the least revenue and have the highest number of complaints?

Opportunities: external factors

- What opportunities are offered within the health system?
- How can a new technology be utilised in the hospital?
- What opportunities are offered? For instance, what are our opportunities when introducing diagnosis-related groups (DRGs) into the health system?

Threats: external factors

- What difficulties exist with regard to the overall economic situation and development of the health system?
- How are competing hospitals moving forward?
- What acute threats exist?

These SWOT elements or steps should enable you to analyse the current and future position in the market and to fine-tune your strategy. However, this is not a one-off process. To sustain success, SWOT analyses have to be conducted regularly

and conclusions should be drawn from changes. As a whole, the approach to a SWOT analysis is as follows:

1. *Hospital analysis:* looking for strengths and weaknesses.
2. *Community analysis:* looking for strategically relevant opportunities and threats, using moderating techniques and forming a group consensus. The results can then be grouped, structured and weighted. The strengths and weaknesses are listed in the relevant matrix fields.
3. Attempt to *maximise* the use of *strengths and opportunities* and *minimise* losses from *weaknesses and threats*. To that end, the following information is specifically requested. Consideration is given as to which initiatives and measures can be deduced from this information
   – *Strengths–opportunities (S–O) combination:* which strengths are linked to which opportunities? How can strengths be utilised so that opportunities are maximised?
   – *Strengths–threats (S–T) combination:* which threats can be countered by which strengths? How can the current strengths be utilised to avoid specific threats?
   – *Weaknesses–opportunities (W–O) combination:* where can weaknesses be turned into opportunities? How can weaknesses be developed into strengths?
   – *Weaknesses–threats (W–T) combination:* where are our weaknesses? How can we protect ourselves from harm?

The following example shown in Table 3.1 illustrates how the first two steps of a SWOT analysis can be implemented.

Apart from the hospital and environment analysis, a third step has to follow, as the SWOT analysis is meant to constitute the basis for restructuring and organisational measures.

Several strengths can certainly be used to realise an opportunity or avoid a threat. The greatest threats can presumably be found where a combination of weaknesses stands opposite one or several threats. Because of this combination, suitable strategies must be developed and synchronised. This is the most demanding part of the process. The core strategies are then entered into the four-area matrix (Table 3.2).

Figure 3.1 illustrates how an organisation can use its strengths to realise opportunities. Concrete and targeted measures that are consistently implemented are crucial to success.

The following *mistakes* can often be seen in SWOT analyses:

– Implementing a SWOT analysis without first having a vision. SWOT analyses should always be made in relation to a vision and should not turn into an abstract exercise. If there is no agreement regarding the target in the light of a common vision, participants may follow their own assumption about the hospital's vision, leading to poor overall results.
– External opportunities are often mixed up with internal strengths. They should be rigorously separated.

Table 3.1 Example of a strengths, weaknesses, opportunities, threats (SWOT) analysis

Internal factors	External factors
Strengths	*Opportunities*
Good infrastructure of buildings	High population influx through new residential area
Good ambience, high standard of facilities	New bus line improves access to the hospital
High proportion of private patients and out-of-pocket payments	
High market share in the surrounding area	
High number of cases with a broad professional coverage	
Solid financial situation	
Young, highly motivated team	
Strong monopoly in some specialist fields	
Own hospital's medical centre for private doctors	
Weaknesses	*Threats*
Competitor has better access to transport	Results of lump compensation negotiations for cases are uncertain and outstanding
High staff turnover	Introduction of minimum volume regulations in some surgical fields
Loss of confidence by the community because of ambiguous staff politics	
Low market share in the outskirts and other districts	
Strong local competition	

Table 3.2 Matrix representation of a SWOT analysis

External analysis (community analysis)	Internal analysis (hospital analysis)	
	Strengths	*Weaknesses*
Opportunities	*Strategic goals for S–O*	*Strategic goals for W–O*
	Following up on new opportunities that match the hospital's strengths	Eliminating weaknesses to make use of new opportunities
Threats	*Strategic goals for S–T*	*Strategic goals for W–T*
	Use strengths to avoid threats	Develop strategies to prevent existing weaknesses becoming the target of threats

S–O strengths–opportunities, *W–O* weaknesses–opportunities, *S–T* strengths–threats, *W–T* weaknesses–threats

– SWOT analyses are often confused with possible strategies: SWOT analyses describe conditions whereas strategies describe actions. To avoid this mistake, think of opportunities as 'favourable conditions' and of threats as 'unfavourable conditions'.
– Prioritisation is not part of a SWOT analysis. Hence, no concrete measures can be deduced from it. The next step is developing strategies and implementing them.

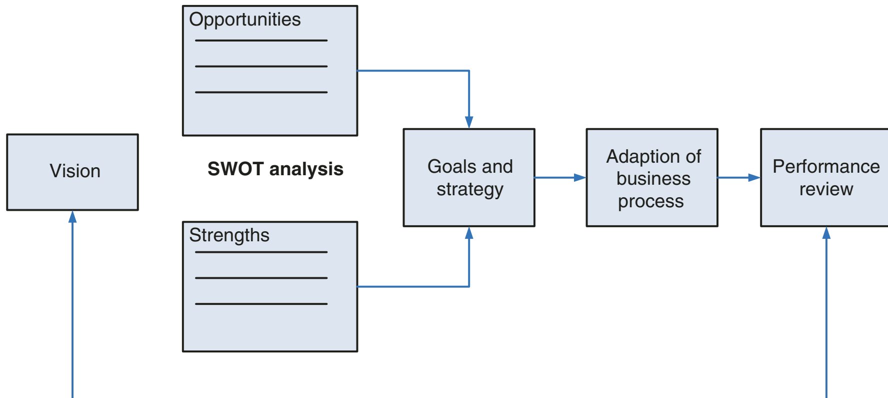

Fig. 3.1 Integration of strength, weaknesses, opportunities, threats (SWOT) analysis into strategic development and implementation

3.3 A Practical Approach to Business Engineering

He who remains at the coast will never discover new oceans. (Fernando Magellan)

The development of a SWOT analysis is recommended when establishing a hospital's strategy, but also for realigning departments. This depends on the vision that exists for the hospital. Business engineering (Chap. 4) is closely linked to the hospital's strategy, the demands of clients and the various interest groups (stakeholders). The strategy is determined by the competitive position. Using the applied St Gallen approach to business engineering, the connection between a hospital strategy and the business processes is explained below.

The transformational process, i.e., the process of change in business engineering is structured on three levels. These are the so-called 'hard' (structural) levels of business strategy, business process models and the information and communication technology. Then there are the 'soft' factors: leadership, behaviour and power. This situation is illustrated in Fig. 3.2. It shows hospital strategy, which is described here as business strategy. Changes based on this approach follow various *principles*:

– Change processes must follow a model- and method-based approach so as to structure all aspects with the necessary consistency and in a suitable sequence. The propositions are complex and an interdisciplinary approach must be followed.
– As part of integrated change management (Chap. 6 and ▶ Glossary), changes need to be included in the hospital's culture, together with the soft factors, such as leadership, power, and behaviour.
– Change processes must take into account the interconnectedness of clients and the hospital's stakeholders.
– Only when implementing change at all levels the intended innovation will become effective.

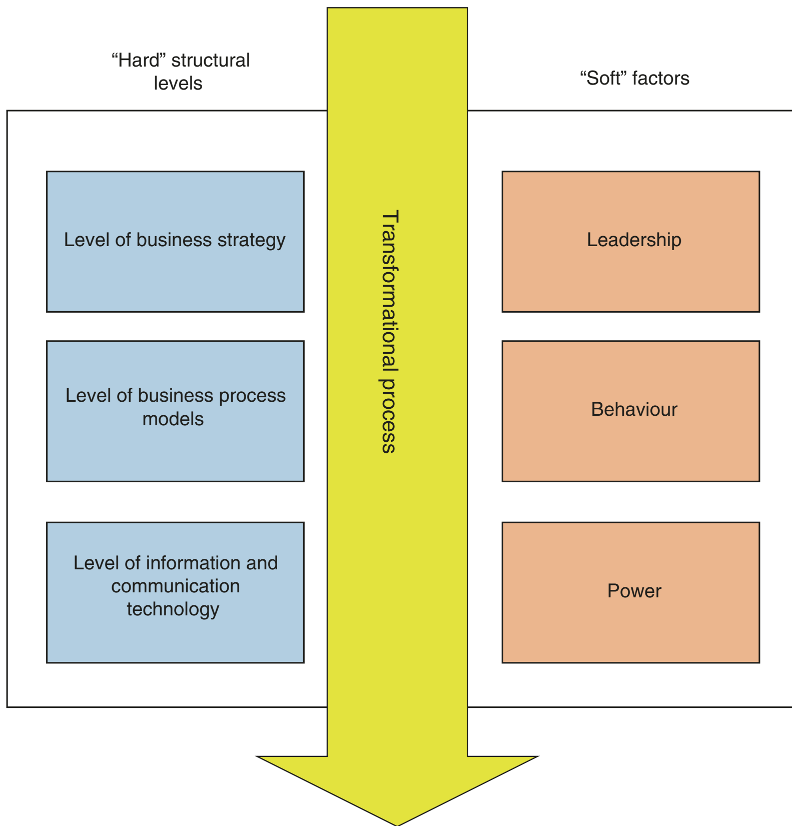

Fig. 3.2 A practical approach to business engineering

– Restrictions due to technology must be considered when changing strategies and business processes.

Let us first discuss the first two levels (business strategy, business processes) and then analyse their role within business engineering (Chap. 4).

3.4 Hospital Strategy

Let us take a closer look at the business strategy or rather the hospital strategy. Owing to new developments and demands, change is a process that is permanently necessary. This often implies a change in strategy. The hospital's vision (▶ Glossary) plays an important part, in addition to its implementation in long-term (strategic), medium-term (tactical) and short-term (operative) measures and objectives. This is also referred to as strategy implementation (Fig. 3.3).

What do we mean by the term 'strategy'?

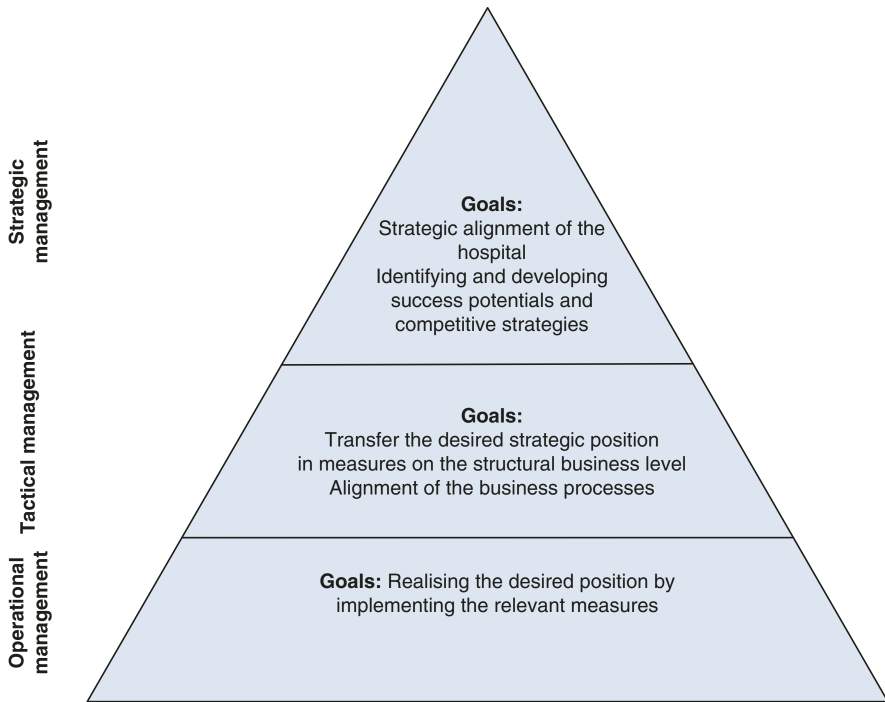

Fig. 3.3 From the strategic to the operative management of business processes in the hospital

Historically, it was linked to a meeting of military commanders, known as the college of strategists, in Athens in the fifth century BCE. At the beginning of the nineteenth century the idea of a strategy was integrated into the military arena by Clausewitz. Nowadays, the term ‘strategic’ is used as the opposite of operative. Operative means short-term, based on day-to-day activities. Compared with this, strategic implies long-term, not part of day-to-day activities. At times, strategy is used as a means of fulfilling a (business) objective, or a vision.

According to Mintzberg (1978), a ‘strategy’ can have five different meanings:

– *A plan:* intended, consciously planned guideline for one’s actions
– *A behaviour pattern:* consistent action, whether planned or not
– *A position:* positioning in a competitive environment
– *A perspective:* a specific perception of the world – self-image and world image
– *A manoeuvre:* a specific manoeuvre to outwit one’s competitors

We would like to define the term *hospital strategy* as the long-term planned practices of a hospital for the purposes of reaching its objectives. In this sense, a hospital strategy conveys how a medium- or long-term goal of a hospital is to be reached.

Similar to Porter’s value chain and the five-forces model (Chap. 2), the focus is primarily placed on positioning the hospital enterprise within its competitive

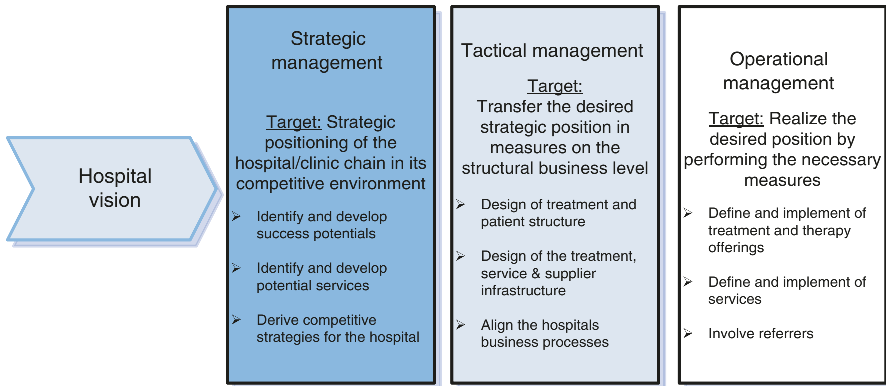

Fig. 3.4 From vision to operational management

environment. This positioning is often referred to as *strategic management* and must be distinguished from tactical and operative management, as shown in Fig. 3.3.

The measures shown in Fig. 3.4 can be implemented to achieve the hospital vision.

3.5 Business Processes in the Hospital

Changes in hospital processes are initiated by various role players and often affect other processes. Understanding business processes is the first step towards applying business engineering in a certain setting. As mentioned above, a *process* can be defined as a temporal sequence of activities. Beyond that, a business process in a hospital may be characterised as follows:

– It includes a repeatable sequence of activities with clearly defined input and output (e.g., writing letters, ordering medication at the pharmacy).
– It consists of several activities that are logically linked (e.g., admitting a patient).
– It requires certain resources (e.g., staff, devices, materials).
– It has a defined beginning and a defined end and should reach an economic objective.
– It possesses a certain operational organisation.
– It can extend beyond departmental or hospital boundaries.
– It fulfils the demands of patients and referring doctors.
– It produces a positive result for both patients and stakeholders.

An example of a typical business process in a hospital would be the request by a referring colleague for a hip replacement to be performed on a patient with a predisposing medical condition. The request would be followed by these steps: orthopaedics, communication of the findings to the referring doctor, recommendation of further treatment, and finally the account statement.

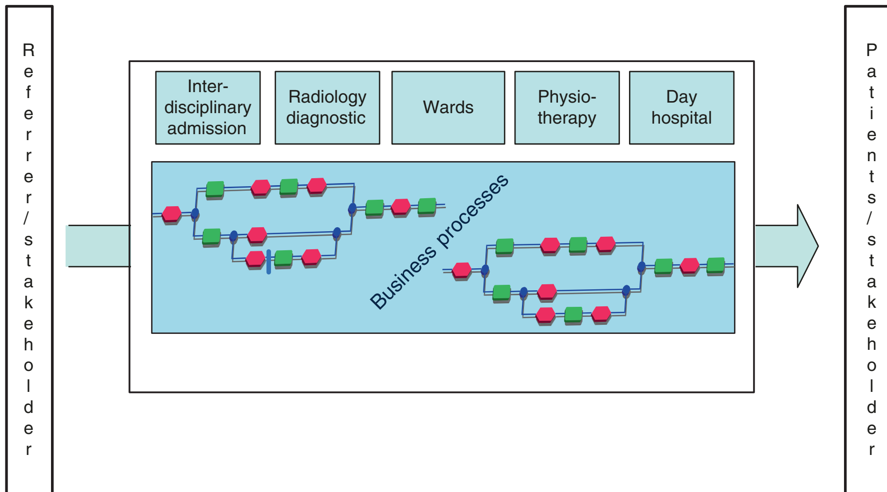

Fig. 3.5 Business processes in the hospital

Business processes vary from hospital to hospital. They should be efficient and effective. The business process should be focused, on attaining a competitive advantage for the hospital, e.g., by offering the patient and the referring doctor (practising externally) the desired service quickly and efficiently.

Figure 3.5 shows that business processes can extend over various areas within the hospital. Like the example above, they touch base not only with patients, but also with referring doctors or other external institutions.

Different types of business processes interact as follows:

- *Service processes* (or business processes in the narrow sense) produce services 'to the environment', i.e., for patients (e.g., pre-operative outpatients or day-hospital patients).
- *Support processes* support the service processes (pharmacy, bed-cleaning, procurement, and kitchen).
- *Leadership/management processes* coordinate the services, i.e., they measure the goal fulfilment and support processes, intervene if there is delay and further develop the entire system of services.

Service processes are often referred to as core processes. *Core processes* are processes with a high degree of value creation for the hospital, i.e., with a direct provision and marketing of services. The sum of all core processes in a hospital defines its competitive advantage.

Leadership/management processes serve the planning, monitoring, and evaluation of objectives, strategies and measures for the hospital.

Support services are activities necessary for the implementation of management and core processes. These processes have no, or only limited value creation for the patient. They serve to support the implementation of core processes and can partly be outsourced. They have no strategic significance for the hospital.

Analysing which processes are core processes and which are support and management processes has led to outsourcing. *Outsourcing* can be defined as the relocation of hospital processes. Reasons for outsourcing are the focus of core competencies such as:

- Service processes
- Saving or making resources available
- Using the competencies of other health care providers or
- Obtaining greater financial flexibility (Chap. 7).

3.6 How Is the Hospital Strategy Linked to Business Processes?

Figure 3.4 depicts the creation of business process strategies as being located in the area of tactical management and they are a result of strategic management. This relationship is reciprocal and can be represented as described in the next few paragraphs.

On the one hand, the hospital strategy influences the identification, scoping, targeting, weighting, and control of business processes, in addition to their integration into the organisational structure of the hospital.

On the other hand, business processes form the basis for the implementation of the hospital strategy, that is for the implementation of a competitive strategy (differentiation, focused differentiation, cost leadership, efficient consumer feedback coupled with quick responses to clients' needs; Sect. 3.8) and the development and extension of core competencies.

Accordingly, a change in the hospital strategy results in changes in the business processes. To reach the hospital's objectives, processes have to be aligned to strategies. For this purpose, they are often allocated to important business segments or business units of a hospital.

3.6.1 Evaluation of Business Processes in the Hospital

The evaluation of hospital processes serves the purpose of establishing the specific importance of the business processes. On this basis, the hospital can decide on subsequent strategic and operational issues:

- Improvement, adjustment, and renewal of business processes
- Outsourcing of business or of sub-processes
- Allocation of financial, staff, and technical resources

Different *criteria* influence the weighting of a business process, for example:

- Achieving strategic business goals
- Critical success factors

– Core competencies
– Patients' benefits and satisfaction
– Referring doctors' benefits and satisfaction
– Potential for improvement
– Effectiveness and efficiency
– Relative competitive strength

The ABC analysis, the success factor analysis and the process portfolios are among the methods to weight and prioritize processes. These methods are briefly explained below and highlighted in an example.

3.6.2 ABC Analysis

So much to do and so little time. (Cecil John Rhodes)

The ABC analysis is part of the strategic planning and alignment of a hospital. You could apply it to determine the service quality or the performance of doctors. For example, a measure for improving the rate of referrals to a hospital could be to regularly show the highest (A) and the lowest (C) rate of referring doctors. In connection with this you could also analyse who, for instance, are your main referrers, how you could satisfy them and how you can turn your lowest referrers into the highest ones. You would liaise with them and ask for recommendations for how to improve services. The ABC analysis can also be used for medication, examinations, laboratory analyses etc.

3.6.3 Process Portfolio

The process portfolio is specifically focussed on weighting business processes, for instance, to evaluate their effect regarding patient benefits and the hospital's success. A hospital's business processes could be represented as set out in Table 3.3.

Table 3.3 Business process evaluation

Business processes	Patient benefit	Hospital benefit
Strategic planning process	1	5
Innovation process	4	5
Treatment process	5	4
Controlling process	1	3
Human resources management process	2	3
Financial management process	1	5
Quality management process	3	1
Service process	4	3

'1–5' corresponds to 'low to high'

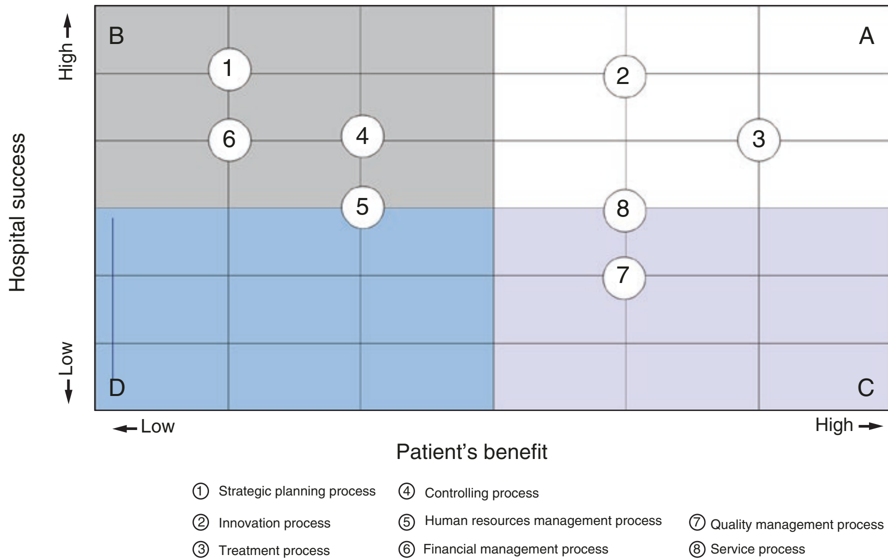

Fig. 3.6 Process portfolio

The evaluations from Table 3.3 are shown in Fig. 3.6 in a process portfolio. In column A, business processes have the highest priority as they have the strongest impact on both patient benefit and business success. Business processes in column B are necessary for the hospital's success, but do not directly contribute to increased patient benefit. These are often secondary business processes (i.e., support processes). Business processes in column C are necessary for the patient's benefit, but do not directly contribute to an increase in the hospital's success. The business processes in column D provide evidence of possible areas that could be outsourced.

If, besides the business processes, the sub-processes are also weighted, the importance of a process portfolio increases. Since the process portfolio is flexible, other criteria may also be included, e.g., improvement potential.

3.6.4 Success Factors Analysis

The success factors analysis is discussed as the third method of evaluating and weighting your processes. Initially, the critical success factors of a business unit are determined. This refers to a few features that are decisive for the success of a hospital and a business unit (e.g., a department, day clinic, health centre). According to the *Pareto Principle (80/20)* only a few factors influence the success of a business unit and a hospital. Eighty percent of the results can be ascribed to 20 % of the influences. Critical success factors are usually determined in the course of strategic planning and accordingly appear in the hospital strategy, the business objectives,

and hence in the business processes. Below, some critical success factors are listed as examples:

– Loyalty of patients and referring doctors
– Short waiting times
– Good external image and reputation
– Patient centredness
– Good interfaces with referring doctors
– High flexibility
– High degree of professional competence
– Exceptional service behaviour
– Good service agreements with cost providers
– High quality of treatment
– Innovative treatment procedures

A direct connection exists, particularly between the critical success factors of a hospital and its business processes. The success factors analysis evaluates individual business processes according to critical success factors.

The approach to success factors analysis is:

– Determining of critical success factors
– Weighting of critical success factors, based on either paired comparison or weighting from the clients' point of view, such as referring doctors and patients
– Determining the influence of the individual business processes on critical success factors, e.g., on the basis of an evaluation scale from 1 (weak) to 5 (strong)
– Determining the scoring value per influencing factor by multiplying weight and degree of influence
– Determining the weighting sum per business process by adding together all the weighting values for this factor.

The strategic importance and the rank order of business processes can be derived from such scoring.

The example of a *success factors analysis* carried out by using a process success factor matrix (Table 3.4) is shown below. In the success factors matrix process, individual success factors are weighted according to their importance for the hospital (weight SF). Then, the business processes are evaluated with regard to their contribution to individual success factors and this evaluation is multiplied by the weight of the success factor. The sum of these amounts, defined as the contribution of a business process to the various success factors, is significant to the business process for the hospital. In the example below, business processes 5 and 6 (BP 5 and BP 6) have the highest number of marks and are thus significant processes in the competitiveness of the hospital.

In a next step, the relative competitive strength compared with that of a competing hospital could be determined by using the benchmarking process. The results

Table 3.4 Process success factor matrix

Critical SF for a hospital	Weight SF	BP (degree of influence/weight)											
		BP 1		BP 2		BP 3		BP 4		BP 5		BP 6	
Services offered	5	2	10	1	5	1	5	5	25	5	25	4	20
Quality of treatment	8	1	8	5	40	2	16	1	8	3	24	5	40
Price/performance	5	3	15	5	25	2	10	4	20	3	15	5	25
Flexibility	7	4	28	4	28	5	35	3	21	3	21	4	28
Innovations	9	2	18	1	9	1	9	4	36	5	45	3	27
Service	6	1	6	1	6	5	30	2	12	3	18	2	12
Waiting times	7	3	21	5	35	4	28	2	14	3	28	5	35
Sum BP		106		148		133		136		176		187	
Ranking		6		3		5		4		2		1	

SF success factors, *BP* business process

are then represented in a process weighting portfolio. This portfolio could provide information on business processes, indicating the areas where performance should be improved either to maintain the hospital's competitive position or to improve it.

3.7 Business Models

The business models reflect the business process level (Fig. 3.2). At this level, the *hospital's strategies have to be implemented*. Apart from an analysis of business processes, a representation at various levels of refinement and the use of various perspectives, such as the perspective of procedures, data, and organisational structures, are necessary to achieve this.

The analysis of business processes and their systematic documentation in process models provides the knowledge to successfully implement changes. This becomes necessary on the basis of the business strategy. The analysis and documentation serve as a source of information and as communication medium to support process-orientated change. The reasons for business engineering can be diverse and are reflected in the goals for business process modelling.

On the one hand, business process modelling forms the basis of business engineering. On the other hand, the hospital's business processes are:

- Documented for quality management and certification according to ISO 9000
- Used for the training of staff
- Utilised for transferring business processes to other locations or as a rulebook for working instructions

In the hospital, documented business processes can serve as preparation for change management, for instance, to introduce new organisational structures, outsource hospital tasks or improve the hospital workflows. They support the preparation of the IT support of business processes (enterprise resource planning system,

workflow management, ▶ Glossary). Moreover, they serve to determine the key performance indicators of the process, to monitor process performance and to represent a basis for benchmarking among hospitals, other health care providers, and partners.

Business models include the business processes of a hospital at various levels and from different perspectives.

3.7.1 Process Maps

As mentioned previously, there are numerous business processes in a hospital. These processes are structured according to different criteria (e.g., core (service), support, and management processes, see above). If the processes in a hospital or hospital group have been documented, they can be represented according to their workflow sequences or allocated according to organisational or functional units. The business processes in a hospital are often dependent on each other. This could relate to the exchange of information or services. It is necessary to understand these dependencies so that the business processes can be monitored, managed, and improved.

Process maps are an important tool for showing dependencies and relationships among processes, the flow of processes, the analysis of processes, and the connection with external partners (e.g., suppliers, patients, referring doctors, cost carriers, banks, etc.). Process maps also help to depict the information and service exchanges between processes.

All processes within an organisation, including their interfaces with the outside world, are illustrated on a process map. Thus, a *process map gives an overview of an organisation's processes*. It will describe the structure of business processes of a hospital and the interactions of the processes. The process map can also be used when an overview of hospital workflows is to be developed and documented. The creation of a process map requires an overview of all processes within an organisation without necessarily analysing them in detail.

The diagram of the process map exemplifies the core and support processes in a hospital. It is expanded to produce further process maps for admission and treatment (Fig. 3.7).

Different tools can be used to produce process maps or to create a refined representation of specific processes.

3.7.2 Integration of Business Processes into the Hospital

The effectiveness and efficiency of business engineering strongly depend on how the business processes are integrated into the organisational structure of the hospital. Indeed, the dictum says that the *structure of an organisation should follow the business processes and in turn the business processes follow the hospital's strategy*. However, in practice, the organisational structure still dominates. In many hospitals the management hesitates to implement the necessary organisational adjustments

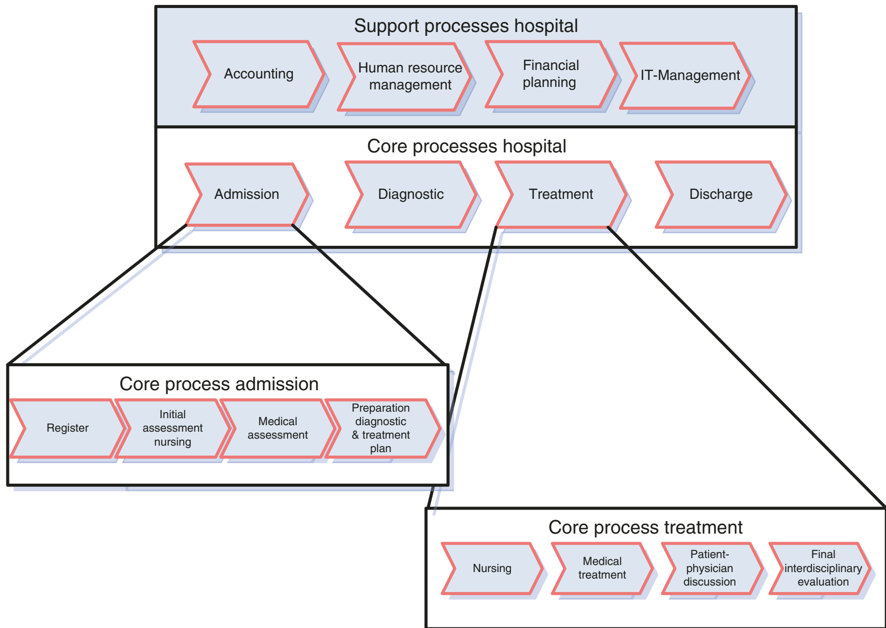

Fig. 3.7 Sample process map of the core and support processes in a hospital

that result from process re-engineering. In doing so, they miss the potential for improvement, for, these adjustments are necessary to increase efficiency and effectiveness through business engineering.

The following forms of integration of business process management may be distinguished:

– *Process-influenced organisational structure:* expansion of the classic function-orientated organisational structure by process-orientated positions
– *Multidimensional organisational structure:* creation of hybrid types of functional and process organisation
– *Pure process-based organisational structure:* replacement of functional organisation by full integration of the business processes into the organisational structure

The process-influenced organisational structure should not be the starting point for structural changes in the hospital, as it does not give the potential of business engineering the chance to develop. Furthermore, it may give the wrong impression and inhibit the learning and adjustment process. In fact, a multidimensional organisational structure is recommended to run side-by-side (business processes and classic departmental structure) for a limited amount of time so that the departmental structure can gradually be aligned based on the improvement measures of business engineering.

New organisational structures must be carefully applied to hospitals. Questions that arise in this context are: who is responsible for resolving conflicts? Who is overlooking the whole process?

Within business engineering various roles with allocated duties, competencies, responsibilities, and requirements are applied. Individuals and teams can take over these roles. Business engineering differentiates between the introductory phase and the implementation phase. In this process, the following roles have to be allocated: project manager, process advisor, process manager, people in charge of a specific business process, process controller, and process collaborator.

3.8 Project Management

> If you limit your choices only to what seems possible or reasonable, you disconnect yourself from what you truly want, and all that is left is a compromise. (Robert Fritz)

Over the last few years a veritable avalanche of projects has been rolled out across hospitals worldwide. Some hospitals even provide a list of approved and planned projects and their current status on their intranet. A great deal of resources and time are invested in individual projects and a huge amount of written papers is produced. However, in some cases the value added for the hospital is questionable and project results often end up in a drawer, completely ignored. At best, project results are occasionally reported, but do not have an effect on the overall day-to-day business.

There are many *roadblocks* in successful project management. Have you also experienced improvement processes within the organisation regarding administrative functions or procedures that later had no impact at all? After the project has been concluded and despite many meetings and paper piles of detailed reports to the hospital management, nothing has actually improved. Everything has continued the way it was, because no-one had been appointed to initiate the necessary changes. In the hospital, this would include involving the staff and getting their buy-in for necessary changes. However, this is frequently related to difficult discussions and interactions (Chaps. 6 and 9). The question remains: who is going to take on this thankless task? The project manager, who often does not deal with staff? The head of department? The consultant, who normally engages with the staff, but is not responsible for the project and perhaps does not even agree with the predicted results? The hospital management? Consequently, it is mandatory to specify before the project is initiated who is going to implement the results and how this can be done.

There are numerous *reasons* for conducting projects in hospitals. The competing hospital has started a similar project. A new member of staff is specifically interested in the subject. The hospital carries out fewer projects than other hospitals. Reasons for launching projects are easy to find. However, are these really valid reasons for running a project? It is seldom that the project focus is placed on the hospitals strategy alongside with its integration into the development of the hospital. Projects are labour-intensive and costly. Therefore predictions must be clearly specified before the

project begins. For example, what could be improved regarding hospital processes? Could the project result in more profit, greater satisfaction or better patient care?

Before the possible start of a project and before various resources are committed to it, the following question should be asked: is the project actually a project? A project must possess a defined goal, it must create value for the hospital, and it must be conducted just once in the hospital.

An example of the implementation of a project is described in this section concomitantly. It refers to the introduction of an emergency service of private practitioners into the existing emergency unit of a hospital for the department of internal medicine. The goals are defined to improving the quality of care, reducing waiting periods for patients to a minimum and improving cooperation and communication between the private practitioners and the hospital's doctors. As shown in this section, several steps are necessary to reach the objective.

A project has an objective within given circumstances (personnel, financial, technical equipment, time constraints). If projects do not succeed, mostly the goals and requirements were not clearly defined (Table 3.5).

In project management, a project is described as *SMART* if the project goals are clearly defined and the following SMART conditions are all fulfilled: it is *specific* (the project goal must be clearly defined), *measurable* (progress indicator), *assignable* (who will do it), *realistic* (the project goal must be implementable) and *time bound* (the project goal must be implementable within a scheduled period of time).

Projects have the *potential to fail* if there are too many people involved, when they run over a long period of time, when there are many interfaces with other projects and external systems, and if there is a certain risk attached to implementation. Furthermore, many problems with implementation, such as uncertainty about the time scale, cost planning, etc., only become apparent during the course of the project and usually there is competition with other projects for scarce financial

Table 3.5 Reasons for failed projects (GPM and PA Consulting Group 2008)

Causes	Percentage
Soft factors	
Lack of qualified staff	45
Dispute over respective areas of authority	45
Poor communication	40
Lack of project management experience at the management level	33
Lack of project management method	28
Lack of support from top management	22
Start of project	
Requirements and goals unclear	63
Lack of resources	54
Inadequate project planning	47
Others	
Technical requirements too high	14

and staff resources. This especially applies to hospitals. Exemption from their day-to-day duties (although this would make sense for some projects) is rarely possible. In addition, certain activities overlap and are repetitive. Finally, the high degree of specialisation of many of the staff tasks with projects makes flexible planning difficult. Even after projects have been concluded, measuring the impact on productivity and quality is time-consuming or uncertain. Caused by these influences, there is a high risk of a project failing. Table 3.5 provides an overview of the reasons for failure.

Careful project planning, continuous control of the project, and timely planning updates are important prerequisites for the *successful completion* of a project. Time and cost estimates have to be drawn up for the entire project and not only for certain activities. At the same time projects should be protected from continuous change requests. Consequently the project manager must apply stringent claim management. Requested changes are neither ignored nor automatically integrated. Rather, awareness must be created that requests for changes can lead to changed goals, new requirements or an amended project scope. Furthermore, stakeholders must be informed about possible consequences for the target figures during the project (costs/resources, time/deadlines, performance/quality; Fig. 3.8).

In classical project management, a contextual analysis is recommended. This process should include a *stakeholder analysis* (Varvasovsky and Brugha 2000) to elucidate how much support or resistance can be expected for the project. Table 3.6 shows how a simplified stakeholder analysis can be conducted.

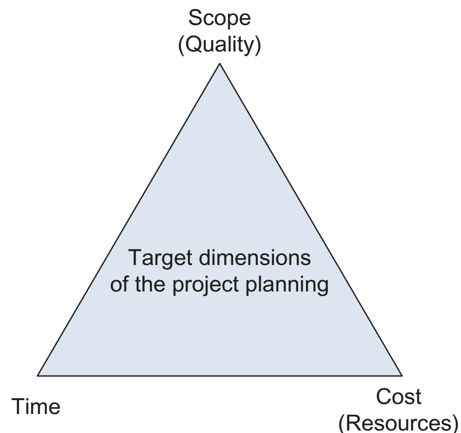

Fig. 3.8 Target figures for the project-planning triangle

Table 3.6 Analysis of important stakeholders in the case study project

Stakeholder characteristics						
	Position			*Power*		
Role player	*Degree of involvement*	*Interest in contents*	*Will he support the project or intervene negatively?*	*Which instruments of power can he bring to or against the project?*	*Where are his boundaries?*	*Evaluation influence/ power*
HoD of Medicine	High	+3	+3 support	Good relationship with CEO	Clinical manager and consultant oppose the project as it curtails their own power and resources	+2
Consultant emergency unit	High	+2	−3 No support, own power and position is threatened by project	Good relationship with clinical manager who does not support the project	Is hierarchically subordinate to consultant	+1
Representative of doctors in private practice	High	+3	+3 support (initiator)	Good relationship with HoD	No decision-making authority and influence in hospital	+2

Remarks: +3 (high level of support) to −3 (lack of support or negative intervention)
HoD head of department, *CEO* Chief Executive Officer

In our example of the implementation of an emergency unit, a stakeholder analysis should be undertaken at the start of the project. A detailed project plan should be drafted for the duration of the project. The implementation of the new admission process should be established. Figure 3.9 shows the admissions process in cooperation between hospital and doctors in private practice according to the Australasian Training Standards (ATS). Treatment modalities of ATS are shown in Table 3.7. Additionally, a precise description of the duties of the individual people involved in the project should be carried out as illustrated in Table 3.8.

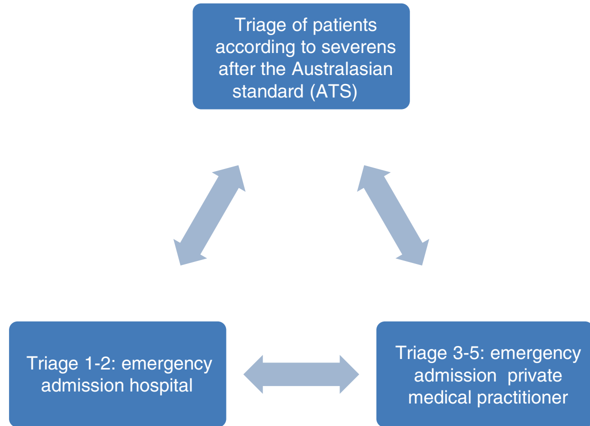

Fig. 3.9 Admissions process in cooperation between the hospital and private medical practitioner

Table 3.7 Urgency according to the Australasian Training Standards (ACEM 2005)

Triage level	Category	Urgency of treatment
1	Resuscitation	Immediately
2	Emergency	≥10 min
3	Urgent	≥30 min
4	Semi-urgent	≥60 min
5	Not urgent	≥120 min

Tools and guidelines for project management are available to enable critical situations to be visualised, to support communication with people, and to uncover problems. The planning and supervision of the project can be supported by such tools, but cannot be replaced by them. Below, a number of important issues for project management are discussed.

Project management processes are guided by two standards: the *Project Management Book of Knowledge* (*PMBOK*) by the Project Management Institute (PMI) and the *Projects in Controlled Environments 2* (*PRINCE2*) by the British Office of Government Commerce (OGC). Both standards serve to create a single language and a common understanding of project management. A number of process groups, processes, and activities help to organise the flow within projects more efficiently. Specific topics and knowledge areas ensure that expertise and best practices can be applied.

Table 3.8 Description of duties of people involved in the project (selection)

Function	Qualification	Duty	Responsibility	Area of responsibility
Project manager	Experience with projects, knows processes in the emergency unit	Detailed project and time planning	Project execution, informing persons involved	Successful conclusion of project within time frame
Nurse manager	Experience with projects and responsibility for staff	Plans the allocation of nursing care	Responsibility for budget in the area of nursing	Makes resources available by new acquisitions and redistribution

Although PMBOK is designed for the support of any kind of project, PRINCE was initially developed for the management of IT projects. The current PRINCE2:2009 standard is specifically characterised by the improved integration of other methods. Extensive literature is available on both PMBOK (PMI 2013) and on PRINCE2 (OGC 2009).

Below, project management is described in more detail. The various activities of a project are allocated to various phases as roughly outlined in Fig. 3.10.

Efficient organisation is important for the successful implementation of a project. A project possesses its own (albeit limited) personnel resources and its own project organisation (Fig. 3.11). Different duties are assigned to the people involved in the project. Within a hospital context, it is important that projects are integrated into the hospitals everyday business. Otherwise, projects are in danger of becoming rather a matter of mere window dressing. The figure illustrates an example of an project organisation including the most important project roles: steering committee, customer, team leader, and team members.

The *steering committee* monitors the implementation of the project with regard to performance, its quality, use of resources and the time frame. It accepts the project results in a responsible manner, takes firm decisions on the progress of the project, and helps to clarify significant problems and conflicts. The steering committee usually consists of people with decision-making powers, e.g., executive directors, departmental or unit managers, possibly the customer and sponsors. It is important for doctors and nursing staff to have a say in the steering committee.

The *customer* (e.g., the hospital manager) defines and evaluates the objectives as well as the results of the project. He can request project updates and information if there is a threat of time- or cost-overrun. He supports the project manager in operational matters and makes the necessary resources available. He must decide to accept or reject the project outcomes and releases the project manager at the end of the project.

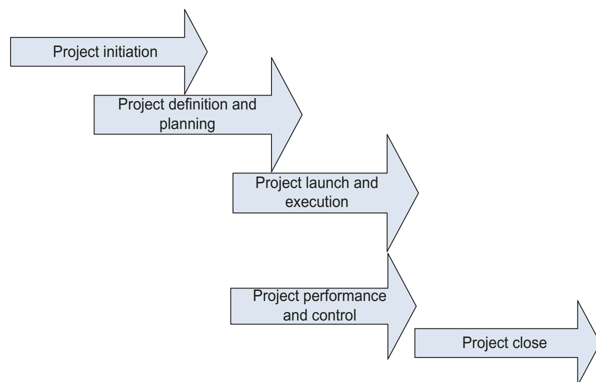

Fig. 3.10 Various phases of a project

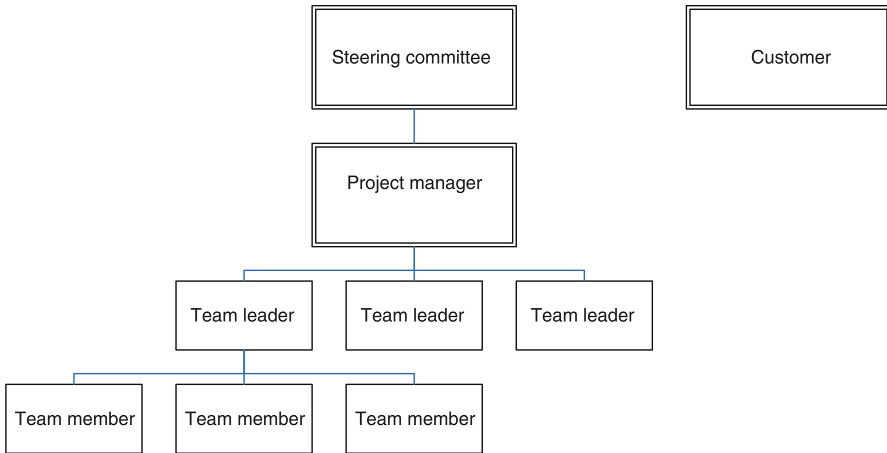

Fig. 3.11 Project organisation

The most important role is that of the *project manager*. He should be assisted by an experienced and effective team that is an integral part of the hospital and its processes. The project manager coordinates all matters with the customer. At the start he checks the feasibility of the project. He prepares the infrastructure for the team and provides the best possible working conditions. He organises and moderates project meetings and plans the project. He informs the customer of risks and deviations from the project planning. In addition, he ongoing compare actual versus targeted costs, schedules, and resources. All-in-all, he is responsible for the implementation of the project to deliver the requested results in time and within budget. The project manager must have adequate competencies and responsibilities to fulfill his tasks and meet the project's requirements. He must be informed and supported by specific departments. For successful project management, he must have the professional and managerial authority to lead his project team.

Project team members are allocated to the project preferably full-time or for a fixed period of time. They independently carry out the assigned work packages, document the results, and report back to the project manager on the progress of their work. Should professional problems arise, they work together constructively as a team. The project team should possess the relevant expertise in matters relating to the hospital. The starting phase of a project is characterised by:

– A preliminary investigation based on the project idea (usually including a feasibility study with a contextual analysis and a stakeholder analysis)
– Decision-making process for the implementation of the project
– The objectives, requirements and the project scope set up in a project charter

These activities must take place before the formal start to the project. A project can only be launched once the objectives have been fixed, and the requirements, the scope of the project, the budget and time frame have all been determined. Accordingly, the formal project start takes place only once the fully specified work has been contracted with an internal or external project team.

Planning is one of the central tasks of project management. Here, the following activities can be distinguished:

– Structuring the project. What needs to be done?
– Milestone planning. What are the significant milestones of the project?
– Planning resource requirements. How high is the workload and which resources are necessary?
– Process and time scheduling. In what sequence and when must work packages be completed?
– Cost planning. What are the costs of the different work packages?
– Plan optimization. Does the project plan comply with the customers deadlines and the availability of resources?
– Risk management planning. Have the project's risks been identified, evaluated and taken into account?

A project is a complex undertaking. Primarily, structuring serves to ease the complexity and improve transparency. The project tasks are divided into parts that can either be planned or controlled. A structured planning phase is shown in the *work break down structure (WBS)*. The WBS includes all the project's activities, but does not contain their sequencing and timing. The advantage of a completed WBS is that it highlights all activities necessary for achieving the project's deliverables. Figure 3.12 shows the WBS for the emergency unit project example.

The project team prepares the WBS as a team result. The most important item is the *complete listing* of all activities. The activities must be clearly demarcated and overlaps should be avoided. The WBS should show the work packages at the lowest level. These can be allocated to a responsible person. Furthermore, the degree of

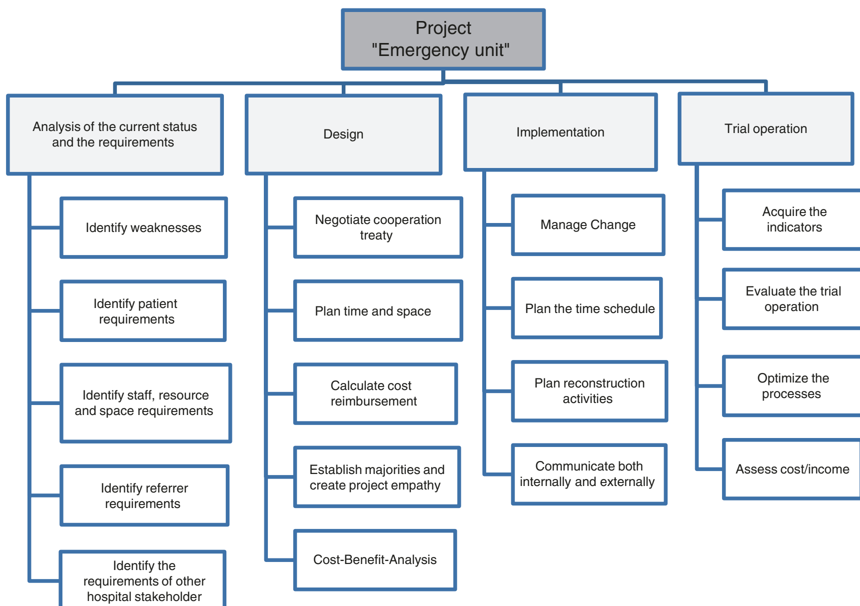

Fig. 3.12 Example of a work break-down structure for a hospital project

detail should allow reliable costing of the work packages. However, it is not the aim of the WBS to schedule the work packages.

If similar projects are frequently implemented in a hospital, the use of a *standardised WBS* is recommended. This secures the experiences in project management and provides a planning template. To check the project's progress, various time points should be fixed by which certain main processes must be completed. Typically, *milestones* are defined for development projects.

A detailed WBS is a suitable basis for *cost estimates*, e.g., what resources are needed and in what quantities. Calculating the costs is the most important and most difficult sub-item in planning the resource requirements. As human resources are the major cost driver, these are particularly difficult and important to estimate.

The planning of resource requirements is the basis for cost planning and hence for cost controlling. The resources required for completing each work package must be determined (Table 3.9). In hospital projects, the requirement for staff is usually the biggest single item. However, the cost calculation of the staff involved often does not happen, as it is taken for granted that they will participate and neglect other duties.

The costs are underestimated in almost every project. This is caused by wrong estimates but also by changes in the scope of a project. The complexity of projects means that they are vague conceptions at the start of how the objective will be reached. First estimates are thus highly uncertain. A bandwidth of accepted deviations should be defined at the outset of the project. The following points should be considered when making a *cost estimate*:

- Cost estimates for new projects are usually too low.
- Typically, staff members estimate the costs too low if they do not carry out the work themselves.
- Many staff members do not draw a clear line between cost and duration. Cost depends on the content of the work to be done; thus, it cannot be directly influenced. However, the duration can be influenced by more or less intensive work on a work package.
- There is no project management without costs. However, these costs are not often included in the planning. Exactly the same applies to the costs for quality management.
- Experienced colleagues should be reponsible for cost estimations.

In the course of planning, activities are put into the correct sequence using network planning techniques. Prerequisites are the project structure (WBS), planning

Table 3.9 Cost estimate

Work packet	Operator	Staff deployment	Cost	Duration
Define the project plan	Dr Sisulu	50%	4 MH	8 H
Specify the requirements	Dr Jacob	100%	90 MH	30 H
	Ms Sass	100%	90 MH	30 H
	Mr Hertz	100%	90 MH	30 H
Plan personnel and resources	Ms Earl	50%	4 MH	8 H
Analyse risks	Dr Martens	20%	10 MH	50 H

MH man-hours (total project effort in people hours), *H* hours (duration of the project in hours)

of milestones and of resources and the cost estimate. Furthermore, it is necessary to analyse the dependencies of the various work packages on one another. Two work packages A and B could be linked by various kinds of dependencies, e.g., B could only be started once A has been finished. The chronological progress of activities can be depicted as a bar chart. Such a diagram, also known as a *Gantt chart*, documents the various links between work packages.

Figure 3.13 shows parts of a Gantt chart from the WBS of our sample project 'Emergency Unit'. It highlights how the main activities are timed according to their duration and dependencies.

The planning up to that point still shows a number of shortfalls because the availability of staff has not been taken into account. However, in the early stages of planning this may be hard to estimate, as various projects and departments may compete for the staff.

In principle, planning can be optimised by using the three most important planning elements: people, time and costs. The main focus in optimising a project plan is generally on the required resources (staff). By using a so-called *workload diagram*, the deployment of staff members is checked. A workload diagram consists of two basic elements: the availability of people and the requirements for manpower.

People availability considers the expected availability of staff member for the project. If a staff member is on holiday or on sick leave, the value for those who will be available decreases. The *manpower requirement* results from previous planning and the timing of the schedule. Matching availability and requirement makes it evident whether the planned work can be completed in the calculated time frame. If the requirements exceed availability in a given period of time, the plan cannot be implemented and will have to be revised. Basically, there are two options.

– Availability is increased by bringing in additional staff, e.g., by working overtime or by engaging external staff. This should be carried out if there is a deadline to be met.

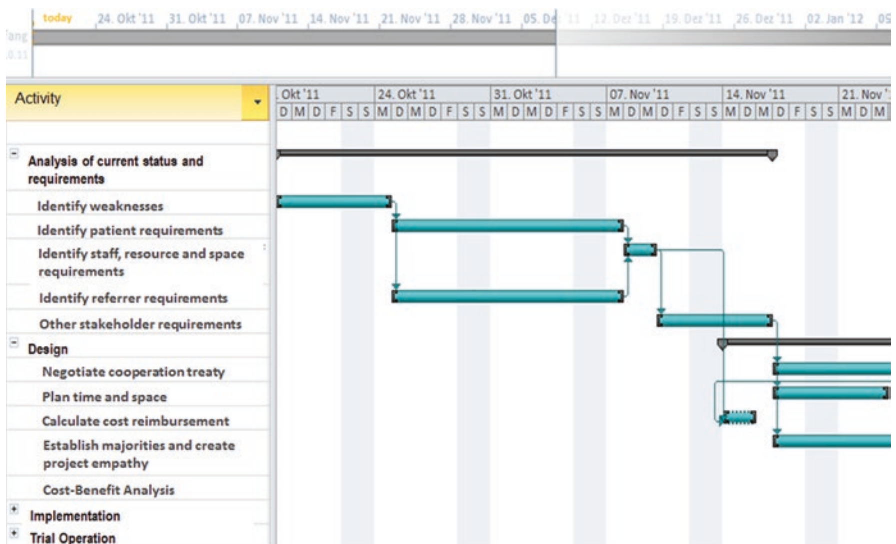

Fig. 3.13 Gantt chart

– Dates can be changed and tasks may be shifted either forwards or backwards to increase availability. If free buffer periods exist, these may be used. Thus, manpower surplus can be decreased by moving the work package forwards from the earliest to the latest position.

Manpower (staff) availability is a critical issue, especially in a hospital. Doctors and nurses have to be freed from their daily duties for effective participation in a project. Frequently, it is not evaluated whether this would be possible as the hospital's executive management often imposes projects top–down and adds them to the current workload. Thus, many projects are condemned to failure right from the start by not having adequate resources available.

Realistic project planning is necessary for the implementation and control of a well-functioning project. Project planning may be used like a map that makes it possible to discover deviations from the plan at an early stage. Planning is an important prerequisite for implementation of the project; however realistically speaking, plans are not always adhered to. The project manager needs to be actively in control if the project is to be implemented according to plan. If a deviation from the plan threatens the project, he/she has to take *measures* to respond to this.

The *comparison of the planned with the actual situation* is probably the best known and most frequently used instrument when controlling a project. This makes differences transparent and helps to estimate their effects on the further course of the project. If the comparison of planned and actual data shows a difference that makes a change of plan necessary, these updated planning dates are described as target data. This method, referred to as the *target or actual comparison*, can be applied to all control parameters (deadlines, manpower, costs).

All target or actual comparisons and trend analyses serve the single purpose of recognising variances in deadlines, performance, costs or quality *as early as possible* so as to introduce suitable counter-measures. However, such measures have side effects. For instance, if the impending delay of a deadline is met by applying counteractive measures, this is normally at the expense of performance, quality and costs.

Project completion is the official end of a project. The result of the project has been accepted by the customer. No further expenses are necessary to fulfil the project's objectives.

Another approach of embedding a project into the overall strategy for the hospital is project portfolio management, which we briefly outline in the next section.

3.9 Project Portfolio Management

Project portfolio management is pooled *project planning and management* of the projects in an organisation. It includes continuous planning, prioritisation, control and monitoring of all projects in a hospital. In this regard it is important to choose and develop the right projects according to the hospital's strategic and economic alignment. Persons directly involved in the processes must be included in the relevant projects to enhance the successful implementation.

Within the scope of strategic alignment and market development, project portfolio management can be used in conjunction with other management tools, e.g., the

Balanced Scorecard (Chap. 7). This pools activities in the hospital and effectively depicts the necessary staff. Apart from that, cross-project synergies can be utilised through project portfolio management. Particularly on the grounds of increasingly scarce resources (people, time, money etc.) prioritising and slimming down of projects (lean management) should be implemented.

The aspect of time plays an important part in running a project. This means that people or teams have to be freed up from other tasks to enable them to work on the project. Partial results can be planned in short phases, e.g., by the week or month. The project team must have the autonomy to make certain decisions and have personal responsibility. Short, direct lines of communication and reduction of hierarchic levels contribute to a project's effective implementation and success. It is important to set clear priorities and to avoid accustomed paths. An example habitually used by hospitals is a type of all-encompassing project planning worked out in the greatest detail. It is better to run several short projects one after the other than to implement many simultaneously.

The monitoring of the project portfolio must be conceptualised and responsibilities described so as to anchor the project portfolio within the hospital's organisation. It is also important to set up the operational principles amongst participating individuals and teams as well as to formulate economic performance incentives, target agreements and target compliance.

3.10 Lean Management

Lean management is applied as an approach to running organisations and hospitals through a continuous improvement process in order to advance service delivery and efficiency. In the late 1980s and early 1990s, lean management ideas developed by the Japanese car company Toyota were introduced into other international companies. A basic pillar of this concept is the avoidance of waste (*Muda*; Sect. 4.4.2). The eight forms of waste in hospitals are: overprocessing, unnecessary movements, corrections, transport, waiting, stock, overproduction, incorrect use of talent.

Furthermore, all the activities of an organisation can be divided into *value added tasks* or *non-value-added tasks*. In other words: procedures can be carried out leaner and faster when you abolish the non-value-added tasks.

Why is lean management particularly important in hospitals? During the last few decades, organisational overheads have increased sharply in hospitals and health systems worldwide. On the one hand, this is due to the legal requirements with regard to quality management, patient safety, controlling and accounting. On the other hand, according to the British sociologist Parkinson (1955), administrations tend to expand. Examples 1 and 2 illustrate Parkinson's law:

Example 1 Each task takes up exactly the time available for performing that task. In an afternoon, a senior registrar or consultant can see either two or eight patients in an outpatient clinic. With both two and eight patients he feels fulfilled by his work and can confirm to himself that he has worked to his capacity.

Example 2 A new hierarchical structure is planned to increase the number of his subordinates. The department of surgery has, apart from the consultant, three senior registrars. The consultant and the senior registrars all feel that they work to the limit of their capacity. They succeed in reaching an agreement with the executive hospital's management to convert the positions of the senior registrars to consultants and the consultant to become the medical director of the hospital. The increase in the hierarchical level should highlight and commend their extraordinary performance. In addition, the elevation to a higher level within the hierarchy is meant as an incentive to prevent them from applying for other external positions.

Conclusion: although this measure was initiated not to require additional staff, a few months later the new consultants express their urgent need to recruit appropriate deputies.

According to Womack and Jones (2003), lean management has five core principles that can be applied to hospitals. Admission, diagnostics, therapy, and discharge can be structured according to these principles and modified for hospitals. They are defined as follows (Fig. 3.14):

– *Define value:* define services from the clients' point of view (referring doctors and patients). The client receives the best service, tailored to their needs.
– *Identify the value stream:* sequence of value-creating processes to produce a service. Subdivision of processes into value-added tasks and non-value-added tasks.
– *Implement flow:* unobstructed flow of patients, laboratory analyses, examinations, etc., from one point to the next.
– *Introduce pull-principle:* the patient sets the pace. Waiting periods, also with support services, should be avoided. The pull system calls in people, services, and information precisely when they are needed.
– *Strive for perfection* by applying continuous improvement process (CIP) or Kaizen (Sect. 4.6). Conditions in health services change continuously. Standing still means a step back; bad habits are quickly re-established (Chap. 6). It is the frontline staff of a hospital who should be questioning processes on a regular basis and making suggestions for improvements, as they are directly involved.

Lean management thus tries to achieve *more* with *less* and to offer an alternative to the 'more money, more staff, more rooms' circle.

Backed up by lean management, flattened hierarchies and process-controlled decisions are becoming increasingly en vogue. However, lean management also means intensifying the work because the focus is on the work and not on the persons doing it. However, the traditional separation of a hospital into nursing, medical and

Fig. 3.14 Five-factor model of lean management for the hospital

management discourages flat hierarchies and quick decisions. Small- and medium-sized hospitals in particular place emphasis on care and economic considerations.

A representative example of a hospital that is aiming at excellent, patient-orientated medical care and consistently achieves this goal is the Mayo Clinic in Rochester, USA. Mayo has successfully implemented lean management methods. By applying these methods and structuring processes focussed on the patient, significant improvement could be seen in the rate of staff absenteeism, the number of patients treated, the time allocated for doctor–patient contact and waiting times (Tanninecz 2010).

As is often the case, a critical number of participants had to be convinced to buy in to the project and carry it forward. An example of the successful implementation of lean management in a hospital is described in the case study.

Case Study

A day hospital for children and adolescents is managed according to lean management methods. The goal is to provide the best treatment and care of patients with the lowest conceivable number of staff to obtaining a high degree of patient satisfaction. When patients are registered for admission, their information and history are entered based on a standardised questionnaire. Further medical information is ascertained from the medical records and the referring private practitioner. Only completed folders are accepted for further processing. The doctor in charge of the day hospital determines the necessary examinations (laboratory, equipment and imaging), which will be coordinated and arranged by the administrative staff. The family is contacted for an appointment and informed about the estimated length of stay in hours. One week before the final admission, the treatment plan and necessary modalities are discussed in detail by the team, which consists of nurses, administrative staff, and doctors. As all information is available it is not necessary to search for results or information. If there are unanswered questions, one person is delegated to be responsible for providing the information within the next 2 days and adding it to the database. Two days before admission, the family is reminded of the appointment by a telephone call. During the stay at the day hospital, the patient and parents are looked after by a doctor and a nurse who are familiar with the medical history and the treatment plan. After completion of all examinations, the doctor further advises the family and the patient about the results obtained and specifies future actions. The patient receives a discharge letter before leaving the day hospital. If necessary, the treating doctor phones the referring doctor to discuss the case.

Conclusion: Based on this approach, the satisfaction of the patient, the family, and referring doctor is very high. The hospital receives patients nationwide for specific treatments, even though it is only a regional hospital. Patients know that they will be treated more efficiently, more competently and faster than in any nearby hospital in their area.

3.11 Summary

Visions are seldom developed sitting at a kitchen table. The development and phrasing of a vision can be a tedious process. A clear strategy, precise definitions and execution of processes are all needed before visions are made public and can be implemented. The development of a business strategy and the strategic implementation of projects are tools for realising visions. Initially, a *SWOT* or *ABC analysis* should be conducted to analyse strengths and weaknesses and set priorities. These are important prerequisites for coordinating the strategy and the relevant processes. The entire process must be re-evaluated regularly to ascertain whether the hospital or department has achieved what it aimed at. The analyses of success factors are equally important. The project and the project portfolio management have to align with the overall business strategy and must provide benefits for patients and referring doctors through improved processes. Projects are to be implemented according to a standardised scheme. It must be clarified that they will effectively create benefits (added value) and which objectives are to be attained (*SMART*). In this context, lean management plays its part. *Lean hospital management* is conducive to making structures transparent and to successfully avoiding a negative cost loop. Processes and structures aim to become lean and efficient. Only once this concept has been successfully established *the hospital's vision* can be conveyed to the different stakeholders.

3.12 Five Reflective Questions for Practical Application

1. What is the vision for your hospital or department in 1, 2 and 5 years' time?
2. Have you conducted a SWOT analysis for your hospital or department?
3. In which area do you see a need to improve hospital processes?
4. Which projects have you implemented during the past 6 months? Which projects were successful, and which did not succeed? Outline what made them successful or why they failed.
5. Which three opportunities do you see in your area that can be structured according to lean management principles?

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4 Face Your Competitors

Goals

- Why is it necessary to do benchmarking?
- Why is it so difficult for hospitals to do the right things right?
- Which methods can improve processes?
- How can you ensure continuous improvement in your processes?
- How can Kaizen, CIP, Six Sigma, the PDCA cycle or the DMAIC cycle help you?

In this chapter we focus on process improvement. We highlight business engineering and re-engineering, and how and when they can be applied. To be successful and implement sustainable solutions you need to be familiar with Kaizen, the continuous improvement process, Six Sigma and the avoidance of Muda (waste).

Benchmarking has gained a foothold in the everyday working life of hospitals. In the benchmarking process, standards are set by comparing and analysing target values. Services, processes, adverse incidents, infection rates and patient satisfaction are compared with those of other, usually anonymised hospitals or other health care providers to analyse and improve performance parameter. For instance, the quality of neonatal care is measured among hospitals. The number of preterm infants of a particular gestational age, the rate of infections, duration of ventilation, complications, survival rates etc. are compared and the hospital is benchmarked against others.

In more recent years, the implementation of benchmarking processes for capturing quality standards has become mandatory in many specialist areas. Alternatively you can also volunteer to gain insight into quality assessment and to be present on the platform. External benchmarking is commissioned and conducted too. Which measures are evaluated or whether measures are taken is mostly decided by the hospital management, the consultant or the head of department.

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Case Study

For years, a certain hospital has participated in a country-wide survey that examines patients' satisfaction. The hospital repeatedly has low scores in the same categories. When a new consultant joins the staff and questions this, he receives various answers and explanations: the timing of the survey is badly chosen. Compared with other regions, the local community tends to give rather negative answers. Although the survey takes place country wide, the staff is not convinced of the effectiveness of the survey and the way questions are asked. Up to that point, no steps have been taken to improve matters, even though it has cost the hospital a considerable amount of money to participate in the survey.

Conclusion: Just taking part in a benchmarking process does not improve the quality of the results. You must have exact ideas about how to make use of the results.

Employees need to be informed about the underlying reasons for benchmarking analyses. If you as a department or a hospital take part in a benchmarking process, you have to be prepared to implement measures that your staff may initially see as being negative. Benchmarking has a definite impact on staff. The handling and perception of criticism and of change processes should be made familiar to staff, while these processes have then got to be lived (Chap. 6). The collected data should not be interpreted as simply serving as accolades and a mutual pat on the back: 'Actually, we could have done worse. In spite of our high workload we actually do good work.' 'Yes, you do that but you could improve the results and in turn increase the quality of care.'

Case Study

Each year, evaluation surveys are carried out by the Committee for Continuous Professional Development among the registrars in a hospital. Evaluations regarding management, management of adverse incidents, staff development, staff satisfaction, the leadership culture, etc. are conducted. In most categories the hospital scores in the lower range. The doctors in senior positions accuse the junior colleagues of depicting the hospital in an unfavourable light. The respondents are asked to revise their evaluation and put in a request renouncing the right to publish it on the internet. Internal structures and decision-making processes are not evaluated, modified or changed. At the next evaluation, only those employees whose work contracts expire before publication of the results answer the questions truthfully. The other registrars answer as positively as possible.

Conclusion: Benchmarking results should not be used to exert pressure on colleagues to answer questions more favourably due to that the results are published externally. This contradicts the idea of benchmarking and defeats the objective of using benchmarking towards continuous improvement.

4.1 Improve Your Processes Daily and Align Them to Your Benchmarking Results

Good benchmarking results will highlight the service quality and efficient processes of the hospital. Processes play a central role in hospitals, hence a focus on them will result in the standardisation of admission, discharge, and treatment management. Costs can be saved when standardized procedures are implemented, however, workflows must be analysed on a regular basis and occasionally will have to be substantially altered. *Reorganisation concepts* such as business engineering and business process re-engineering (BPR; Chap. 3) adapted from the world of business have gained a foothold in hospital management.

The change management anecdote outlined in Chap. 6 illustrates transformation and change, which is normally associated with economic success. Economic success or, in other words, the necessary competitive advantage of a hospital, is what business engineering is about.

4.2 Business Engineering

4.2.1 Reasons for Business Engineering

Benchmarking provides information on performance and other parameters, such as the rate of infection or rate of adverse incidents, compared with other hospitals. Suboptimal benchmarking results can be the reason for implementing business engineering measures. There are reasons for necessary change to obtain a competitive advantage and thus ensure the economic success of the hospital. Before going into details, we broadly describe and motivate business engineering.

Multiple changes in the local setting might have happened: for instance, there may be a hospital close by that has been taken over by a private hospital group or is expanding, or a new day hospital has opened where surgeons of different disciplines work in private practice. At the day hospital profitable operations are performed quickly and efficiently and may threaten the existence of various departments in the hospital. Problems with current procedures may occur in high-risk areas, such as admissions, discharge management, and emergency care. New legal requirements ask for the introduction of quality standards, or request a minimum number of surgeries or treatments.

Problems, such as complaints, the infection rate, and long waiting periods, are discussed in quality management. For this reason business engineering overlaps significantly with quality management. Let us look more closely at the different reasons for initiating a business engineering process (Fig. 4.1).

Changes in Business Environment

Many changes in the business environment have consequences for the hospital and often require a change in business processes. *Examples* of such changes in the business environment are:

Fig. 4.1 Reasons for business engineering

- Certain services are no longer covered by the cost carriers.
- A new hospital group employing private doctors has opened its doors. It is located in a central position with easy access, good public transport, and sufficient parking.
- Surgical interventions and complex procedures are being performed by private doctors in a newly opened day hospital.
- A private hospital group gains a high market share with profitable procedures, leaving less profitable areas such as outpatients and emergency care to the competing hospitals.
- A hospital chain opens a new day hospital in the proximity. This hospital only treats private patients who are transported from their homes by the hospital's own taxi service.

The *questions* for the hospital management are:

- What are the implications for the hospital? Which services are affected and have to be adjusted?
- What would be an appropriate plan of action?

Lack of *effectiveness* and reduced *efficiency* are two reasons for business engineering, and thus to effect changes in processes. Be clear about the difference between these two terms.

Definition
Effectiveness defines the degree to which something is successful. Effectiveness measures the output. It can also be described as *doing the right things*.

Efficiency is a subsidiary aim of effectiveness and is seen as a criterion of cost-effectiveness of resources. It compares input with output and is described as *doing the right things right*.

These definitions are coined by Peter Drucker in his book *The Effective Executive*. He distinguishes between *efficiency* (*performance*) and *effectiveness* (*efficacy*).

> The executive is, first of all, expected to get the right things done. And this is simply saying that he is expected to be effective…For manual work, we need only efficiency; that is, the ability to do things right rather than the ability to get the right things done. The manual worker can always be judged in terms of the quantity and quality of a definable and discrete output, such as a pair of shoes. (Drucker 1967, p. 1)

It becomes evident in the benchmarking process that many hospitals lack effectiveness, and have problems 'doing the right thing'. Part of this is, for instance, defining success factors, recognising core competencies or developing the right treatment options.

The hospital, its environment, and the demands have changed over the years. For instance, various hospitals are competing on the same platform, the demands of patients and referring doctors have changed, or alternative methods of treatment have been established. If the hospital did not respond adequately or not fast enough to the changed circumstances, this could influence its effectiveness because hospital vision, strategy, and objectives have not been adjusted. *Examples* of shortfalls in effectiveness are:

– Lack of a convincing and lived mission statement (e.g., the hospital is a church-owned institution; however, maximising profit is more important than ethical principles).
– Unclear strategic objectives (e.g., the hospital's executive management disparages the competing hospitals both in front of the employees and in the community. However, the hospital does not communicate its own strategies and competencies).
– Lack of knowledge of success factors and success potentials (e.g., the hospital has not conducted a market analysis on how it is perceived in the community and what the success factors are).
– Unclear market objectives (e.g., only a few members of the hospital's management know which short-, medium- and long-term market objectives the hospital is pursuing).
– Lack of knowledge of problems, needs, requirements and expectations of patients and referring doctors (e.g., hospitals and staff are working without customer orientation and continuous evaluation as well as adjustments to the clients' demands).
– Lack of process goals and treatment options (e.g., the hospital offers a whole spectrum of treatments; however, often there is little coordination with other health care professionals and offers for follow-up treatment).

As outlined, business engineering is connected to the strategic management of a hospital, which in turn, represents an important prerequisite for successful business engineering.

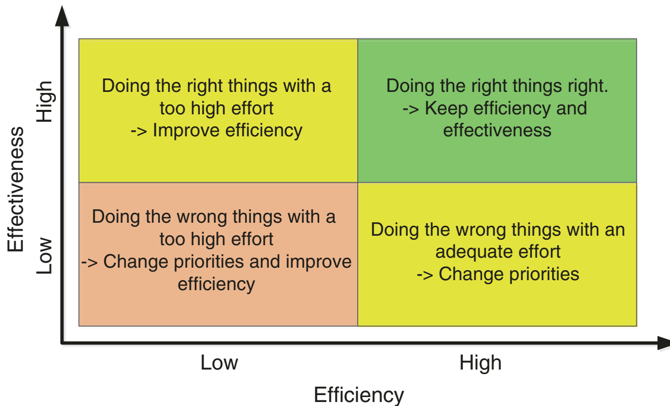

Fig. 4.2 Effectiveness and efficiency

The objective of BE consists in linking effectiveness ('doing the right thing') and efficiency ('doing things the right way'). Figure 4.2 illustrates the link between effectiveness and efficiency.

Case Study

Typically, the head of department of radiology gets the instruction 'to save 10 % this year'. That is no problem for radiology. The Picture Archiving and Communication System (PACS) support of the departments is closed down. (This is a standard procedure ensuring that pictorial, diagnostic and informational materials are distributed in the hospital.) If '10 % of costs' are to be saved, this distribution can be stopped and 10 % is saved. There is even a sustainable and positive effect for radiology, whose resources become more efficient. In the next business cycle there is the instruction to save a further 5 %. This is also no problem for radiology. Now, hard copies are no longer issued. Hard copies are films, CDs and printouts. Soft copy would be the distribution of the above-mentioned PACS. Patients no longer get films, doctors are no longer provided with diagnostics reports and everyone is forced to make their own provision for obtaining information. This causes no problems for the radiology (Salomonowitz 2009, page 1).

In the case study, Salomonowitz (2009) describes a typical standalone solution that has far-reaching consequences for the hospital. This is a question of doing the right things the right way. Although the radiology department can cope with the directives and can adjust its processes accordingly, the far-reaching impact of the change on other departments and units has not been taken into account.

Use of New Technologies

Innovation and technology play a decisive role in maintaining and increasing the hospital's competitive advantage. Specifically, technologies in the area of information and communication technology such as PACS, Orbis (▶ Glossary), the internet,

smartphones, tablets, etc. strongly influence the administrative and medical processes.

Using new technologies, various improvements have been made over the last few years: the integration of tasks has been improved, working hours and place of work have been made more flexible. This becomes particularly evident in areas where there is no need for direct patient contact. Nowadays, the authorising doctor can view and report on X-rays and other modalities at home; employees can answer e-mails on smartphones; processes can be controlled more easily; the flow of information is increased; information analyses have improved; geographical distance can more easily be overcome; data can be exchanged between the hospital and the referring doctors or between hospitals (telemedicine). A diagnosis can be made from a distance, e.g., in the case of a suspected heart attack, the electrocardiogram from the ambulance can be sent to a treatment centre. Apart from that, the collection and distribution of knowledge is accelerated. A result is that staff's skills should be equal in different hospitals (e.g., tertiary care hospital versus large regional hospital) because of the continuous learning and teaching process.

Such improvements can only lead to competitive advantage if procedures are adjusted or occasionally revised completely. Processes in companies have been radically re-organised using business process re-engineering. In the hospital context, however, this approach has been implemented in only a few private hospitals and hospital groups.

Definition
Business process re-engineering is the fundamental rethinking and radical reorganisation of the processes within a company where the status quo is called into question. BPR is often linked to significant cultural and technological changes (Hammer and Champy 1993).

Which conditions would allow for BPR in a hospital? Let us illustrate this with an example. A hospital group buys a hospital and moves later into a newly designed building. In this case, structures should be reviewed and re-organised from a process- and profit-orientated point of view. And, in this case, a radical approach such as BPR is recommended, since the current hospital will continue to function until the relocation and the hospital management has the time to train the staff in the structures and processes. We will come back to the BPR a bit later (Sect. 4.4).

Problems with the Current Processes in the Hospital
Problems with current hospital processes make revisions necessary. Frequently, the question is asked: why are processes suddenly insufficient? Processes were once introduced for good reasons and have been used successfully over the years.

One reason is the continuously evolving information and communication technology. Many processes were instituted before the introduction of certain technologies. They were often provided to compensate for a lack of information. We still partly use these old procedures, which in the meantime have been integrated into our digitalised systems. Indeed, fax, e-mail, smartphones and the internet have dramatically changed hospital procedures. But the adaptation process is still nowhere near complete, as new technologies constantly become available on the market. Many hospitals have gained a competitive edge by using new technologies quickly and effectively.

If a hospital uses a new technology such as an electronic board to reduce waiting times for patients, the competing hospital suddenly has a problem with extended waiting times. Such problems are associated with inefficient processes.

New Statutory Regulations

The government influences processes in the hospital in many areas: new regulations in consumer protection, new laws on privacy protection within the new governmental frameworks, new quality assurance measures, and the introduction of a practice fee or of an electronic medical card. Often these new regulations are linked to changes or business engineering, resulting in business engineering measures. In turn, this introduces a new mode of accounting that entails endorsing an altered treatment modality. Certain treatment options are no longer covered by insurance companies/medical aids. The hospital must then consider initiating collaboration with other treatment facilities to ensure continuity of care (day hospital, colleagues in private practice, step-down facility). This, too, entails changes in hospital procedures.

Some hospitals design their treatment portfolio in such a way that they offer mainly attractive and highly profitable treatment options and let competing hospitals handle any other treatment. Thus, from year to year, changes have to be implemented in hospitals. For example, a hospital has exceeded the treatment quota for a particular condition or surgical intervention, such as hip replacements, and is not being reimbursed for such operations. The hospital may, then, try to manage the number of annual hip operations through instituting a waiting list or patients could be handled as day-patients with integrated follow-up treatments.

New IT System

If an IT system or an electronic patient record is to be implemented successfully, it is necessary to analyse the processes beforehand. Then they should be adapted before the system is introduced. Adapted processes are the prerequisite for the success of the new system. However, IT systems often fail because other hospital's processes are inadequately considered. This causes the following problems:

– Inadequate support of processes from the new IT system (e.g., tiring and time-consuming admission procedures).
– Cementing of inefficient processes (e.g., before an appointment is made it has to be confirmed by various separate departments)
– Lack of integration with other IT systems (e.g., many interfaces and compatibility problems).

The IT systems constitute an important component, supporting the structuring and efficiency of processes. However, they do not lie within the focus of business engineering, but are simply one of many reasons for applying it. Table 4.1 illustrates an example of utilised and planned IT systems.

Table 4.1 Information technology (IT) systems in the hospital

Medical IT support	Administrative IT support	Operational IT support	Administrative IT support (planned)
Therapy and treatment	Financial accounting	Nursing care	Resource planning
Laboratory	Personnel, HR	Prescription system	Accounting, payroll
Outpatients	DRG grouper	Electronic imaging archive	Electronic procurement
Electronic patient record	Personnel administration	Intensive medicine	Electronic HR filing

HR human resources, *DRG* diagnosis-related group

4.2.2 Business Engineering: Business Process Management

Let us take a closer look at the different business engineering approaches. What does business engineering mean? What are the tasks? How is business related to concepts such as Kaizen, BPR, outsourcing and Six Sigma?

Definition
Business engineering is an integrated concept of management, optimisation, organisation and controlling of business processes or hospital processes. Business engineering in hospitals is aimed at fulfilling the needs of patients, referring doctors and other interest groups (stakeholders) such as suppliers, staff, investors, and owners. It contributes substantially to achieving the hospital's strategic and operational objectives.

The task of the executive hospital management is to create a business process culture that is stakeholder-orientated. The responsible persons should be motivated to improve the hospital's processes, establish necessary communication, and ensure trust, especially in times of change (Chap. 6).

In the optimisation process, a continuous cycle of processes is assessed regarding the improvement potential. This is the focus of business engineering. On the one hand there is the radical approach of BPR that envisages a complete renewal of the process landscape, on the other hand, evolutionary approaches such as the continuous improvement process (CIP) and Kaizen implement a step-by-step improvement of the business processes. As a further method, Six Sigma has the objective of avoiding errors in processes and therefore sets statistical quality indicators. The tasks of *business process organisation* consist in identifying business processes, structuring and modelling them as well as prioritising them with regard to the hospital's strategy. Here, the roles and responsibilities must be determined that ensure that the processes are integrated into the hospital (Chap. 3).

The tasks of business process control comprise determining the process objectives and measurement parameters and documenting the results in addition to implementing internal and external benchmarking (Chap. 7).

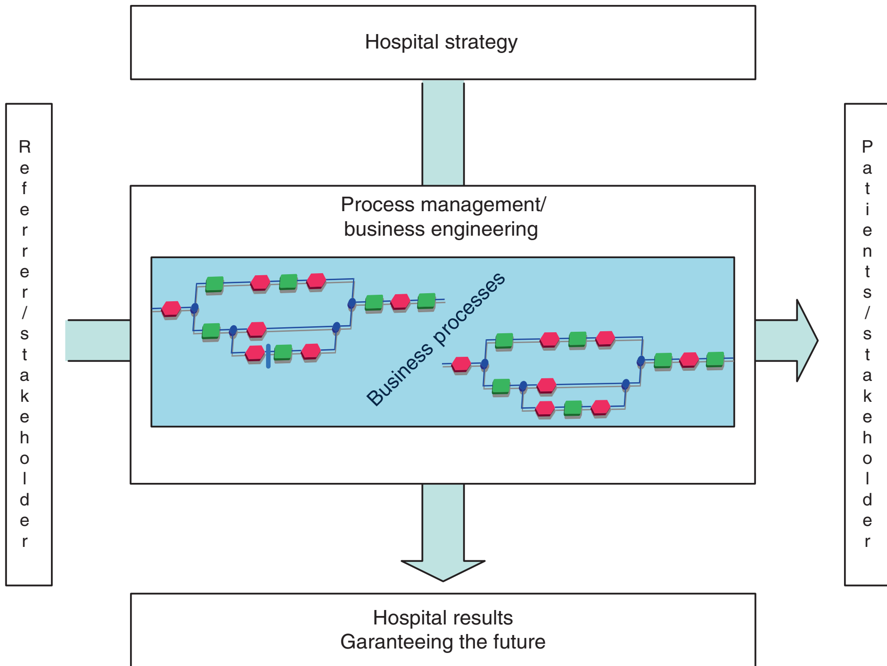

Fig. 4.3 From hospital strategy to business result

In the hospital, business engineering has two central reference points:

- The hospital's strategy, which determines which business processes are required in the hospital ('What?') and which objectives have to be implemented in the business processes ('How?'). The 'What' and the 'How' decide the alignment of the business processes.
- The demands of patients, referring doctors and the requirements of other interest groups (stakeholders).

It is the task of business engineering to fulfil clients' requirements and to structure the hospital's strategies accordingly. You should be aware that hospital processes can be geared too closely towards short-term operational goals. This lead to insufficient measures for establishing and expanding core competencies as well as success potentials. On the other hand, too much focus on the hospital's strategy can cause an imbalance between the needs of patients and referring doctors. The alignment of hospital strategies with patients and referring doctors is therefore aimed at achieving good business results and at securing the hospital's future. This situation is illustrated in Fig. 4.3.

Finally, we can describe business engineering as follows: all activities within a hospital are focused on the demands of clients (patients and referring doctors) and other interest groups (stakeholders). Hence, the structure and control of business processes can be divided into:

- *Process orientation:* the focus rests on business processes such as admission and discharge management, treatment processes, and costs.
- *Orientation towards patients and referring doctors:* structure and control of business processes are focused on the requirements of patients, referring doctors, and other stakeholders.
- *Orientation towards value creation:* the focus rests on value-creating activities as core processes.
- *Performance orientation:* the effectiveness and efficiency of the business processes are continually increased. Benchmarking processes are carried out on a regular basis, and the improvement of the processes is adjusted towards the results.
- *Staff orientation:* the staff is a crucial component of the hospital's process management. Staff members are motivated to contribute to the improvement of the hospital's processes.
- *Orientation on learning:* business engineering underpins organisational learning. You can learn from shortcomings.
- *Orientation on competencies:* the business processes serve to build and expand core competencies.

4.3 Business Process Re-engineering

In the following paragraphs we now describe the individual methods (BPR, CIP, Kaizen and Six Sigma) that can be applied to improve processes.

4.3.1 Fundamentals and Objectives

In BPR the idea is to drastically re-engineer processes. The status quo is fundamentally challenged (see definition in Sect. 4.2.1). The approach was invented by Hammer (1990) and was successfully applied in various companies in the USA in the 1990s. Hammer and Champy (1993, p. 32) define business re-engineering as follows:

> Business Process Re-Engineering is the fundamental analysis and radical redesign of business processes to achieve dramatic improvements in critical measures of performance such as costs, quality, service and speed. (Hammer and Champy 1993, p. 32).

An example of the BPR approach is mentioned in Sect. 4.2.1. Further possibilities may lie in a newly established day hospital, a new outpatient clinic, a health centre or community health care centre. If re-structuring must happen, the hospital management should take the time to consider whether a radical change in procedures and processes would increase efficiency and create value. Possible starting points for BPR are thus:

- Processes are not efficient enough (e.g., on average, how long does it take for a patient to be treated in the emergency room and admitted as an inpatient?)
- There is a lack of referral information for doctors and patients.

- Some hospital procedures differ strongly from the requirements set by the health system framework.
- Reactions to changes in the community or market-driven changes are too slow, caused by the increased complexity of hospitals.
- Expectations of patients have increased and up to now the hospital has not taken this into account sufficiently.
- Standard solutions are offered that do not meet market requirements. There is a lack of services that are specifically tailored to patients' needs and demands.
- Many services and treatments are only offered and rendered on an outpatient or day-admission basis. Several private hospitals have been established in the vicinity, resulting in an intensification of competition.
- Constant changes and adjustments are necessary. The flexibility of processes either does not exist or is inadequate.

Therefore, the *objectives* of BPR are as follows:

- Alignment of hospital processes to referring doctors and patients
- Alignment of the hospital to its core competencies
- Realising costs, quality, speed and service advantages compared with the competition, e.g., by division of different levels of care such as 'intensive/high care/low care'
- Intensive utilisation of information technology to support processes: all required patient information is available at all points and does not have to be recaptured
- Increased flexibility, e.g., higher staffing during epidemics, in the case of high or low occupancy

The BPR is often compared with the 'green meadow' method. 'If we have to rebuild our hospital from scratch on a green meadow, how would we then structure our processes?' It is aimed at newly structured business processes in the entire hospital. The driving force is the executive hospital management. Some private hospital groups implemented BPR in their hospitals, resulting in the economic success of the hospital group.

This type of optimisation characterises the radical and revolutionary method to process transformation. Everything is questioned. The basic attitude is that the existing processes are not necessary or do not function at all.

Such a radical approach is mandatory in hospitals when drastic measures such as the introduction of diagnosis-related groups (DRGs) are implemented. Hospitals have to adjust to new requirements, but are hesitant to change processes fundamentally.

4.3.2 Goals and Approaches

The approach of BPR is fundamental in its concept; it is radical in how it has to be applied in the hospital by the executive management team and it affects everyone in the hospital. BPR projects run in roughly *three phases*: stocktaking, re-design and

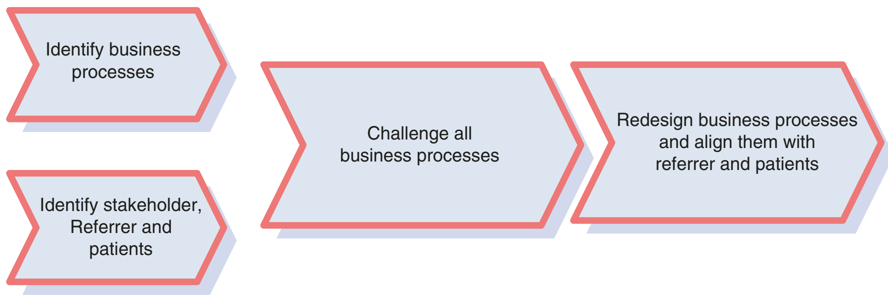

Fig. 4.4 The three phases of business process re-engineering (BPR)

implementation (Fig. 4.4). When calling processes into question, the following points must be borne in mind:

- Basic assumptions
- Division of work and procedures
- Distribution of locations and rooms
- Time schedules
- Resource allocation
- Responsibilities
- Description of functions

In this step of the procedure, the 7-Question checklist is of great help. It is applied in various areas, e.g., analysing texts, helping to define projects or work analysis. The seven questions are:

- What – needs to be done?
- Who – will do it?
- Why – is he doing it?
- When – is it done?
- Where – is it to be done?
- Why – is it not done differently?
- How – is it done?

The basic elements of BPR according to Hammer and Champy (1993) are adapted to the individual hospital as follows:

- Establishing process teams: selected staff members survey the entire process along the process chain, co-ordinate it, and take the responsibility for quality and efficiency.
- The superior is relieved of co-ordination tasks and takes over a coaching role. In this way, the performance range is increased and the hierarchy becomes flattened.
- By varying the process, patients and referring doctors are treated based on their current requirements.

The implementation of BPR elements (especially in establishing business processes) raises numerous issues, such as:

- Which core processes (e.g., patient related processes) and which support processes (supporting functions and/or processes) should be defined?
- Are core processes conceived to be as autonomous as possible, i.e., independent of supporting processes?
- How is the segmentation of core processes to be implemented? Segmentation is a central problem of BPR. It involves a decision on how well the staff is able to attune to certain client requirements. Examples of segmentation in the hospital are: seeing patients with abdominal pain in the nephrology ward instead in a centre for abdominal diseases; neonatology and obstetrics are located in different buildings within a hospital.

Below is a list according to Hammer and Champy (1993) that should be taken into account in a process redesign that has been adapted to a hospital setting:

- Do not organise processes around the tasks, but relate them to the results. The former is often applied in hospitals.
- The people who use the process results should also implement the process and be responsible for it. Example: The implementation of a multi-disciplinary outpatient department is restructured by medical and nursing staff.
- Place information processing under the real activities generating the information. Example: A letter is digitally dictated by a registrar. He electronically sends it to the consultant to be signed off. As soon as the consultant has signed it off, the system sends the letter to the referring doctor. The whole process is no longer performed via a distant office where the file would have to be opened and processed once more. In this case, distributed resources are utilised as though they are centralised. For instance, if one office is off duty, another would take up its tasks automatically.
- Set decision measures where the work is being carried out and integrate monitoring activities into the process. For instance, the consultant has signed off the order for infusions and medication. Afterwards it is sent electronically straight to the responsible pharmacist of the hospital.
- Ensure process integration, i.e., the continuity of a process through various organisational units. The interface from one organisational unit to another is referred to as organisational interfaces and presents potential weaknesses in a business process.
- Capture data only once, namely at the point at which they originate. A pronounced interface problem still exists in the medical field. Data are normally captured repeatedly and this consumes resources. Information flow gaps can develop.
- Avoid media breaks and interfaces. A media break exists if, for instance, an X-ray result is captured digitally and then is dictated or entered in letter format.

4.3.3 Problems, Opportunities and Risks

The BPR process promises significant *performance improvements* (e.g., reduction in waiting times, savings on staff), but it is also risky: up to 70 % of BPR projects are identified as failures. Whether this can be attributed to BPR or whether it is also related to the conditions under which the BPR was initiated is difficult to say. However, more than 30 % of BPR projects are successful. Despite the success rate, BPR has rarely been implemented in hospitals as the radical approach may clash with smoothly running day-to-day hospital processes. Nevertheless, BPR could be increasingly utilised if organisation, outpatients, day hospitals or entire hospitals have to be completely redesigned.

In the course of BPR various difficulties tend to occur. For instance, the introduction of new processes often takes place in one go. However, in a hospital, changes can normally only be implemented step-by-step because the care of patients must be ensured. In line with the general resistance to change, the biggest obstacles are created by the staff (Chap. 6). Unlike Kaizen, Six Sigma, and CIP, the different role players are not included in the implementation, but are rather seen as part of the problem. The result of BPR is often a different organisation with new personnel structures and new ways of working. In addition, responsibilities are shifted.

In the case of successful implementation, however, the greatest effects can also be generated. To implement a BPR successfully, the starting point is usually a crisis in the hospital or a dramatically changed environment, e.g., the so called 'burning roof' (Sect. 8.5). There are also areas that do not have direct patient contact (e.g., administration, accounts) that can greatly profit from BPR.

Apart from these difficulties, BPR has the following *disadvantages*. On the one hand, it interferes with the social balance of an organisation because of its radical and far-reaching approach and the lack of involvement of the affected employees, on the other hand, the wealth of experience gained over many years is lost. Staff is not included in the transformation process or is motivated to change processes. The hospital and surrounding culture are not sufficiently taken into account.

This is associated with the following risks. Basically, BPR is in conflict with the 'normal' day-to-day operations. For that reason, BPR is difficult to put into practice during normal ongoing hospital operations. Problems of acceptance, buy-in, and resistance occur in employees who may often feel left out. Certain frictional losses appear until the new structure has established itself. Frequent improvements are necessary. During the implementation phase, there is a high degree of instability, which can have the repeated effect of break-downs. In addition, there is no learning process for the staff. Short-term, fast improvements are introduced at the expense of long-term developments.

However, there are also *opportunities*. A modified BPR that takes hospital requirements into account should be considered. Radical change 'across the board' is still possible. Concepts and solutions can be defined relatively easily. As it can be implemented quickly, a time advantage can be gained in critical situations. Overall, processes must not only be restructured and transformed in a patient-friendly way,

but continual improvements to administrative and managerial processes are also necessary. Processes involving patients must be structured to be patient-friendly and time-effective. This is shown in the following example.

Case Study
A Department of Medicine embarks on establishing an emergency service together with colleagues in private practice. The HoD has a specific interest in integrating the emergency service of the private practitioners into the hospital processes: he wants to improve the interface between private and hospital doctors and to increase the standard of care. The CEO of the hospital also favours this innovative approach. A contract is drafted and submitted to the hospital's legal advisor and then to the hospital administration. Several months and many enquiries later, no further development is evident. The contract is forwarded from one administrative staff member to the next. It is not apparent to the main role players what exactly is happening and where the contract is located. Holidays, workshops, seminars, and other absences delay processing further. The deadline for starting the new service contract is imminent. As a contract has not been prepared yet, the tension among the private doctors, the HoD, and the CEO escalates. The head of administration is irritated by the situation because according to his view everything went according to plan, even though none of the involved parties is satisfied with the process. After a meeting between the CEO, the HoD, a representative of the private doctors and the head of administration, the pending contract is completed within a day and is approved in a meeting of the executive hospital management.

Opportunity for improvement: To avoid the failure of a potentially successfully project, the hospital administration should have focussed on the requirements of the participants (the applying department and the private doctors) and should have adapted their procedures to make the contract available in due course. This would have enabled both sides to provide reliable information. In this case, the problem arose caused by the classic three-part division of the hospital where the administration processes are disconnected from the medical processes and their requirements.

4.4 Process Improvement with Kaizen, CIP and Six Sigma

> There are three ways to learn wisdom: Firstly, by reflection. That is the noblest. Secondly, by imitation. That is the easiest. Thirdly, by experience. That is the bitterest. (Confucius)

Continuous improvement processes should be part of every hospital. They should optimise organisational processes and the safety of patients. We will now describe three approaches for continuous process improvement: Kaizen, CIP and Six Sigma. All three approaches focus on identifying weak points, problems, and errors. Their objective is to increase the effectiveness and efficiency of hospital processes. In the

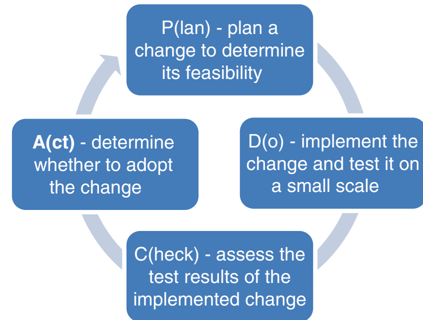

Fig. 4.5 Plan, do, check, act (PDCA) cycle

course of doing this, all three approaches work according to the plan–do–check–act (PDCA) cycle. This divides the improvement process into the following phases (Fig. 4.5):

- *Plan* includes the identification of improvement potentials (normally by the employee and/or the front-line manager), an analysis of the current situation, and the development of a new improvement concept with the involvement of the person performing the task.
- *Do*, does not indicate the introduction and implementation of the improvement, but is rather a phase of testing and practical optimisation of the improvement concept, including simple means that can be quickly implemented at a workplace.
- *Check* means that the results of the process tested in the previous phase are carefully checked and if the process is successful it is released as a standard for implementation on a broader front.
- In the *Act* phase this new standard is introduced across the hospital, formalised, and regularly checked for compliance. This phase is often very costly, as in individual cases, extensive organisational activities can arise, such as changing work schedules, the running of training courses, and the adjustment of the organisational structure and process organisation.

When this cycle is successfully implemented, the new business process is ratified as the new standard so that errors are not repeated and the learning experience is enhanced. It is referred to as the standardise–do–check–act (SDCA) cycle. Once an improvement has been implemented in the business process, further weak points are investigated and new objectives are set. This cycle never ends.

Apart from the PDCA cycle, teamwork is another pillar for Kaizen and Six Sigma (Bothe 2003) as for CIP. The following benefits are applied:

- Self-organisation and hence relief for the executive management
- Activation of strengths and compensation for individual weaknesses
- Gaining time by direct collaboration
- Strengthening of innovative collaboration
- Influencing attitudes and behaviours
- Satisfying individual needs

The PDCA cycle in process improvement is shown in the following example.

Case Study

There are frequent critical incident reports (Sect. 6.5) and ombudsman's notifications from a large, interdisciplinary outpatient and day hospital of a university hospital. Patients regularly complain of having to wait too long, continually changing contact persons, and the late arrival of letters to the referring doctors who are in charge of further treatment. In the critical incident reporting system (CIRS) notifications of 'near missed incidents' in various treatment areas, wrong applications of medication and infusions, and delayed management of emergency treatments are mentioned. The hospital manager, together with the head of nursing, calls a meeting. The topic is the 'new organisation of the interdisciplinary outpatient and day hospital'. At this meeting two groups for the areas 'CIRS' and 'Complaints' are formed that consist of representatives from the various disciplines (nursing, administration, consultant, registrar). These people serve as representatives of their peer group. Everyone else can make suggestions, which are regularly discussed with regard to feasibility and efficiency. This approach intends to ensure the buy-in of all team members. Newly structured processes and organisations are scheduled within the next 4 months. A process representative is assigned who will oversee the timely implementation of the project and support the various team members. After another 6, 9, and 12 months, patient and staff satisfaction as well as CIRS incidents are checked and monitored.

Conclusion: During the first months after implementation, a clear improvement can be observed in all three areas. Regular improvements and adaptations of existing processes are implemented by the teams 'CIRS' and 'Complaints'.

4.4.1 Continuous Improvement Process

The Continuous Improvement Process (CIP) was developed by William Edward Deming in the course of the quality improvement movement of the 1950s. The PDCA cycle developed by Walter Shewhart describes the implementation of an improvement process (see Fig. 4.3). CIP can be compared with the Japanese Kaizen approach and because of their similarity the two terms are often used synonymously (Fig. 4.4).

CIP describes an *inner attitude* of all participants and implies a constant improvement with maximum lasting impact. It relates to product, process, and service quality. CIP is implemented by a process of steady, small improvement steps in continuous teamwork. The CIP attitude of the hospital staff pervades the hospital's activities.

The executive hospital management needs to implement the results of the CIP, to authorise the CIP teams to implement their ideas, and make the necessary resources available. The absence of management support or slow-moving implementation of CIP leads to discouraged staff. If implementation is not possible in a specific case, the staff must be given a plausible explanation. A prerequisite for the implementation of a successful CIP culture is the attitude that staff ideas and teamwork are

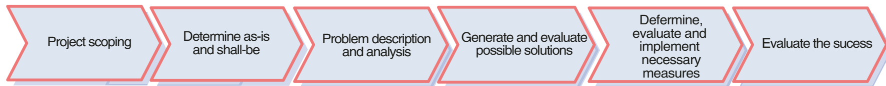

Fig. 4.6 Steps in the continuous improvement process (CIP)

explicitly sought and that the staff is given effective support and public recognition. The constructive involvement of the staff representative is also required.

The effects of CIP can be presented as follows: CIP discovers resources and synergies, optimises work processes and business processes, improves treatment processes, and the satisfaction of patients and the referring doctors. It reduces waste, saves costs, and awakens abilities, creativity, and the commitment of those involved. CIP improves teamwork and hospital culture and thus strengthens the CI (corporate identity, Chap. 2). On the other hand, it increases the pressure on the staff to perform.

In the course of CIP, staff members analyse their work area and, in groups, develop concrete suggestions for improvements. They are usually trained in teamwork and group moderation in advance. The process is orientated towards the PDCA cycle and usually follows this pattern (Fig. 4.6):

– Identify and delimit the improvement process: what can be improved?
– Describe the current and the target state using key performance data
– Describing problems: frequency per time or object unit (patient, prescription, task)
– Evaluate problems: time, money, energy, stress per time unit
– Analyse problems: causes, connections, interfaces, side effects
– Collect ideas for solutions, evaluate, and decide
– Deduce measures, costs, and returns
– Agree on measures and clarify resources: who will do what until when? Implement measures!
– Check success.

Case Study

The interns and registrars repeatedly complain that they receive poor orientation when they join the hospital. The senior registrars and the consultants point out that they did not get orientation and training either and had to gain their knowledge and experience from their own efforts. One day a new consultant is employed who sympathises with the concerns of the interns and registrars. He mediates between the various groups and emphasises that they depend on each other and have to act as a team. By applying CIP, a new training concept is designed according to the PDCA cycle, which is constantly checked and improved.

Conclusion: The staff satisfaction, quality of patient care, and use of resources clearly increases through CIP.

4.4.2 Kaizen and Muda

Kaizen (Japanese for change for the better) is a Japanese management philosophy focused on continual, systematic, and step-by-step improvement of business processes, which includes the staff. A crucial aspect is the elimination of *Muda*, i.e., any kind of waste. Waste implies that resources are used without an increase in value. Muda was first used by the car manufacturer Toyota. The seven kinds of waste are summarised in the acronym TIMWOOD (transportation, inventory, motion, waiting, overprocessing, overproduction, defects). The elimination of Muda is part of lean management (Sect. 3.9) tools. In lean management another kind of waste is added: available expertise is not used in an organisation (Womack and Jones 2003).

Muda in a hospital context occurs mainly as waste of time, personnel, and diagnostic applications. For instance, consultants' ward rounds last several hours; the executive hospital management is more occupied with long meetings than with the implementation of more efficient ways to run the hospital and using the existing resources; staff is not available due to a lack of 'meeting free' time periods; events are undertaken with the entire staff; diagnostic laboratory tests are ordered late, and the results are only available long after a patient has been discharged and are therefore not considered in the treatment process.

The Muda list of the eight kinds of waste applied to a medical context are as follows:

- Medical processes tend to create waste. Almost anything can be made 'better'. Along the lines of 'who wants to be written about in the newspapers because of neglect or a treatment error?', medical processes are arbitrarily expandable. Diseases are overdiagnosed, unnecessary, and repeated laboratory tests and diagnostic procedures are carried out. With patients becoming more empowered, they inform themselves via the internet and demand new and advanced examinations. If they do not get what they want, they approach the next practitioner ('doctor shopping').
- Patient waiting times for procedures are often too long (e.g., in emergency or radiology). Patients are lined up at the radiology department waiting to be examined?
- Complaints from patients and referring doctors result in the staff using valuable time reacting defensively.
- If staff satisfaction is low, this usually results in a considerable fluctuation of staff. Hence, new staff must be orientated.
- Distances within the hospital are too long (e.g., from the emergency unit to radiology).
- There are unnecessary steps in the treatment process.
- People in the hospital are moved unnecessarily because they have to change wards and specialists (e.g., according to the intensity of their treatment, patients have to change ward, nursing staff and the treating doctor if they need a higher

or lower degree of care), the discharge management is ineffective (e.g., discharge takes place at any time during the day or night, therefore the cleaning staff has to work nights and weekend shifts).

– The knowledge available in the hospital is not used at its full extend.

There are numerous examples of Muda in a hospital. Medical staff knows the typical kind of waste in the non-existent time management, as is entertainingly told in a hospital novel.

> Once more the ward round had been protracted and Lisa's back was sore from standing so long. After the discussion of the hospitalised patients Prof. Sanders got carried away in a heated monologue about current health reforms. Adrian Illig, registrar on the general ward, has entertained the conversation with emotive terms that Sanders used to philosophize about. To everyone's concern the ward clock stroke almost twelve when he ended the round with his obligatory nod. (Mann 2006, p. 138)

Kaizen assumes that current situation can continuously be improved. Furthermore, changes for the staff are desired. A high degree of staff satisfaction should be ensured by constant training, and internal hierarchies are to be changed in such a way that every member of staff is encouraged to participate in the change process.

Kaizen Process

The Kaizen process generally follows the PDCA cycle. Below, the relevant phases (Fig. 4.7) are briefly described and the most important goals are explained.

Phase 1: planning the process. Within the scope of planning the action, several steps are implemented by the responsible person:

– Formulate the objectives together with the staff
– Explain the steps of Kaizen at the introductory session
– Introduce the concept of kick-off meetings and training workshops
– Introduce Kaizen into the specific areas and for hospital processes
– Create an appropriate organisational structure

Phase 2: project start. In the specific areas the staff is informed about Kaizen and relevant training sessions take place emphasizing that:

– Kaizen happens directly at the place of work
– The scoping of problems is the starting point of improvements

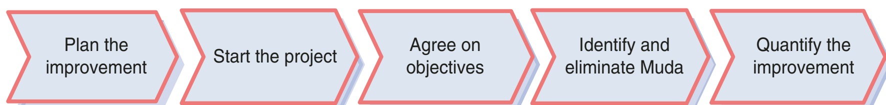

Fig. 4.7 Kaizen process

– Every error and every bit of waste may occur – but only once.
– Kaizen looks for and analyses the causes of waste and errors then removes them.

Phase 3: agreeing on objectives. After the starting phase, the Kaizen team agrees on the objectives. The Kaizen objectives are to be split into short-, medium- and long-term goals and are separated from the objectives of hospital processes as well as the hospital's objectives.

Phase 4: identify waste and remove it. This phase is the core of the Kaizen project. Errors and waste have to be discovered, for instance by applying the principle: 'Go to the source' (*Genkin-butso*), which is related to the seven-question list (see Sect. 4.3.2). The principle stipulates that in the case of undesired results or errors the 'Why' question has to be asked five times to come to a solution. However, it also means that management must get a picture of the situation (e.g., a specific treatment process) on site by going to the source and not by making decisions from a distance.

The 7-M checklist deals with the seven most important factors that must be repeatedly checked when identifying waste:

– Man/human
– Machines
– Material
– Method
– Milieu/environment
– Management
– Measurements/monitoring

Phase 5: measuring improvements. The effect of Kaizen improvements is made transparent by determining key performance indicators on a regular basis. The finance/controlling department supplies their indicators and develops them in accordance with, e.g., a balanced scorecard approach (Chap. 7).

Kaizen and Business Engineering

At the beginning of the 1990s, Kaizen was mainly used for production and logistics processes. With the introduction of business engineering, Kaizen can be utilised in all functional areas of business and in hospitals to free capacities.

Kaizen enables incorporation into the improvement process of detailed knowledge and operational staff skills. Small changes appear to be 'normal'. There is little or no, resistance to implementation caused by staff participation. Often only a few adjustments or amendments are necessary. Based on a broadly-based preparation and implementation of changes, there are no surprises.

The *risks of Kaizen* lie in the time-consuming process of finding solutions for all participants because each staff member has the right to be heard. This approach is possibly too slow if the dynamics are too high. In spite of intensive information, fairly long phases of uncertainty may occur. This can cause permanent unease. Aside from this, support from the hospital's management may decrease because other problems appear and require attention. Kaizen is a gentler version of BE and

is usually controlled and implemented by middle management. The existing processes are improved, flaws are fixed.

4.4.3 Six Sigma

Six Sigma is a statistical quality objective and at the same time a *strategy for the improvement of processes*. The core elements are the description, measuring, analysis, improvement and monitoring of business processes by statistical means. Six Sigma is aligned with the important goals of organisation's and customer's needs (Bothe 2003). The objective of Six Sigma consists in achieving the minimum deviation from a predetermined target value. Similar to other methods of optimisation, Six Sigma has its origin in a manufacturing industry: it was developed by Motorola in the 1980s as a total quality management approach (Pande et al. 2000).

The term Sigma was invented by the German mathematician Carl-Friedrich Gauss. Sigma (σ) is a mathematical term that measures how far a given process deviates from the normal distribution. The objective is to achieve a minimum deviation from the predetermined target value. This is the case with Six Sigma (6σ).

Six Sigma is thus a systematic, data-supported method of improving processes by avoiding errors, with the objective of achieving zero errors. Six Sigma is a term used in statistics to denote 'zero-error-quality': under certain basic conditions a process fulfilling Six Sigma may have only 3.4 error logs for one million possibilities.

Six Sigma is not restricted to manufacturing and is equally utilised in service processes. It can, for instance, support the change of a technical- and science-oriented hospital into a process- and client-orientated hospital (Berry et al. 2002). Six Sigma has already been implemented in optimising pre-surgery preparation in high-risk areas such as neuro-surgery. In some cases, all defined safety-related quality indicators and the economic result could clearly be improved based on process changes.

Six Sigma focuses on indicators to optimize either the requirements of patients and referring doctors or to optimize the results of treatments. Costs are reduced by prevention. Quality consciousness and process orientation are promoted.

The *disadvantages* and risks are related to increased training. It is mandatory to involve staff, professionally trained in the field of Six Sigma, who are familiar with the hospital's key performance indicators. An error analysis of the total process is essential.

Six Sigma is interconnected with the various management levels through the role players. These are:

- *Champions*: champions ensure that all the hospital's key functions are connected to Six Sigma (hospital manager/CEO).
- *Black Belt Master*: Black Belt Masters work with the Champions to coordinate project choices and training (hospital and administration manager).
- *Black Belts*: the Black Belts apply the methods and the knowledge of Six Sigma to the projects (departmental heads, senior consultants).
- *Green Belts*: the Green Belts are employees throughout the hospital who implement Six Sigma as part of their normal tasks.

The systematic, phased approach of Six Sigma is known as the *define–measure–analyse–improve–control (DMAIC) cycle*. The DMAIC cycle, which is used to improve existing processes, constitutes the core element of the Six Sigma improvement process. This is aligned to the PDCA cycle.

Phase 1: define. With regard to the success of the project, the definition phase is the first and most important phase of the DMAIC cycle. A meaningful basis for the control of the project is established. The problem and the customer should be identified, the conditions must be clarified, the roles assigned, and objective, project scope and time schedule fixed.

Phase 2: measure. The second phase serves to convey to all participants the environment in which the problem was observed. Control points for quantifying the problem have to be determined. In addition, possible reasons for the origin of the problem are collected. Bearing in mind potential causes, data gathering is subsequently planned. Data, figures, and facts provide the basis for a successful improvement project according to Six Sigma.

Phase 3: analyse. The aim of the analysis phase is to identify the causes of errors, verifying and quantifying them. This is the core of the Six Sigma improvement process. First, the general conditions and results from phases 1 and 2 are evaluated and the project is realigned. In this phase, the knowledge of the Black Belt (method specialists) for the selection of the adequate method is required, e.g., value creation analysis or the cause–effect diagram. However, project teams should avoid jumping from the 'measured' problems to the apparently obvious solutions. At this stage, the solutions are not yet the focus; however, ideas for solutions should be documented and then evaluated during the subsequent phase.

Phase 4: improve. In this phase, feasible and cost-effective solutions are selected, evaluated, and implemented. Alternatives must be prioritized and options highlighted. Elementary steps are generating ideas for solutions, selecting a solution, compiling a plan for implementing, and documenting a solution.

Phase 5: control. Finally, the identified improvements and new processes must be anchored in the everyday processes. The new process is monitored using the above-mentioned statistical methods. It is important to hand the responsibility for the process over, or back to, its owners.

4.4.4 ISO 9000 Quality Management

ISO 9000 (ff) is a set of *standards* that documents measures for quality management (QM). Accordingly, quality management includes control, organisation, and quality control. Quality management should ensure that the requirements of clients (patients/referring doctors) and other stakeholders in a hospital are being fulfilled.

Over the last several years, *ISO certifications* have been implemented in numerous hospitals, departments and private practices. This implementation has led to structures and processes having been rethought, defined and made more efficient (Fig. 4.8). Departments with well-structured processes (such as diagnostic or interventional radiology, hip replacement, eye laser surgery) are well suited for

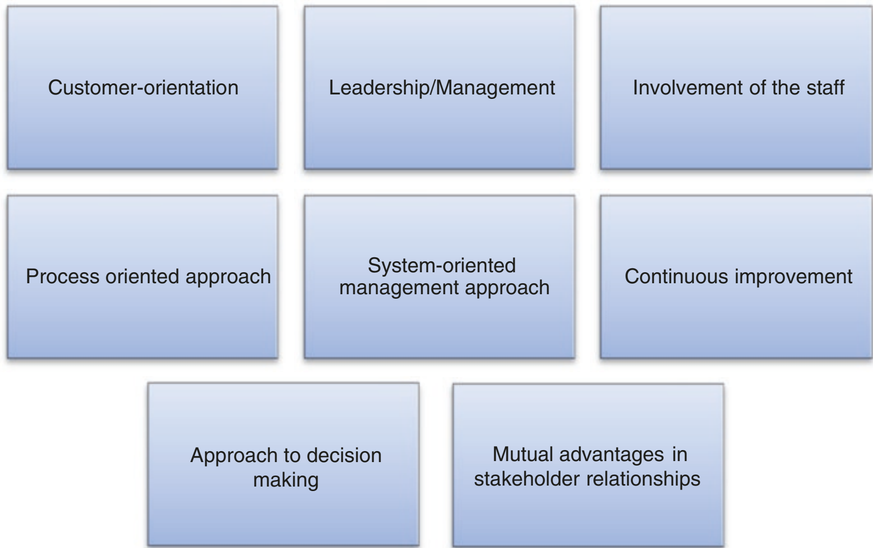

Fig. 4.8 Crucial points in International Standards Organisation (ISO) 9000 quality management (QM) certification

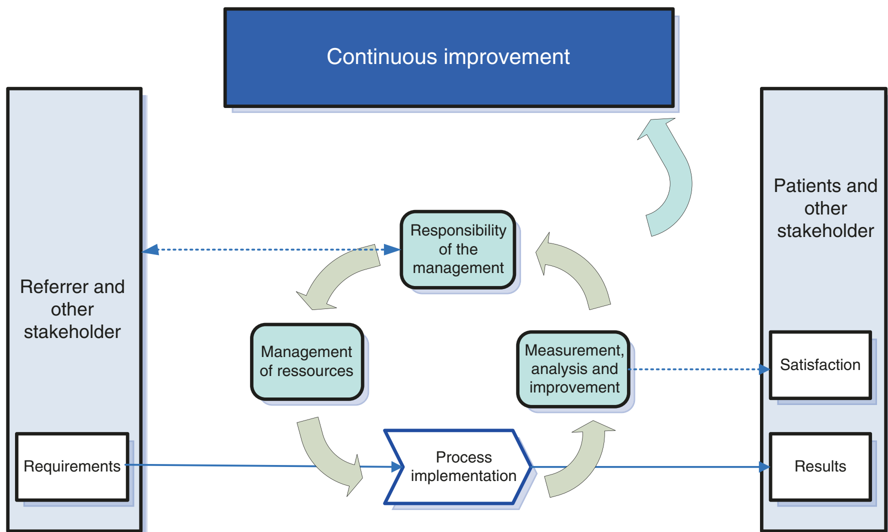

Fig. 4.9 Model of process-orientated quality management

ISO 9000 certification, and Business Engineering itself is part of the quality management framework. Quality management in itself should be structured according to the model of process-orientated quality management in ISO 9000:2000 (Fig. 4.9). But all this is wasteful expenditure if it is not lived and applied in daily practice.

Relationship to Business Engineering
A hospital or department that wants to obtain an ISO 9000 (ff) certificate has to highlight the organisational measures that have been put in place for the continuous process improvement (Fig. 4.8). The implementation of these measures and the results must be monitored and documented on a regular basis. Apart from that, the organisation has to prove how it ensures that identified errors do not recur. In this way business engineering forms an integrated part of quality management. This is also seen in the following requirements for quality management according to ISO 9000 (ff):

– Quality management distinguishes between primary and secondary processes and thus enables value-orientated control of hospital processes.
– It defines process objectives, which derive from business objectives.
– It continually measures and controls the efficiency of processes, monitors the satisfaction of referring doctors, patients and other stakeholders, and compares them with the process results.
– It utilises performance measures and assessments as a basis for a continuous cycle of improvements.
– It creates transparency of the dependencies within and between business processes.
– It ensures that the business processes function as an effective and efficient network.

Based on the close interdependence of quality management, business engineering, and the various process improvement strategies, these systems must be seen and treated as an integrated approach. For instance, CIP/Kaizen is an obligatory component in standardised quality management for all areas of a hospital.

4.4.5 Comparison of Approaches

Table 4.2 shows a direct comparison of a revolutionary (BPR), a transformational (Six Sigma), and an evolutionary approach (CIP/Kaizen).

Ideally, a combination of CIP/Kaizen with BPR should take place (Fig. 4.10). This deviates from the pure BPR philosophy. It needs professional moderation, excellent leadership, and strong become sponsors for its implementation. In addition, 'thinking in processes' should become an integrated part of the mindset of all role-players and the hospital's culture. Figure 4.10 shows an amended curve of improvement methods. One approach is seldom the only right one; usually, it is a mixture of BPR, Kaizen and CIP.

Table 4.2 Comparison of business process re-engineering (BPR), continuous improvement process (CIP) and Six Sigma

	BPR	CIP/Kaizen	Six Sigma
Degree of change	High in the short term	Longer term	Medium term
Concept of improvement	Revolutionary	Evolutionary	Transformational
Driving force in the hospital	Process team, supported by hospital management	Management team (Kaizen team); all (employees)	Projects with experts: Champion, Black Belt, Green Belt
Starting point	New structuring of processes	Existing processes	Existing processes
Design approach	Top–down	Bottom–up	Mixed
Time-frame	Limited, project work	No time limitation	No time limitation but always in defined projects
Objective	Orientation to referring doctors and patients, focus on core competencies	Removal of waste	Reduction of variation/ errors
Cost	High	Low	Medium (caused by training and special organisation)
Risk	High	Medium	Medium

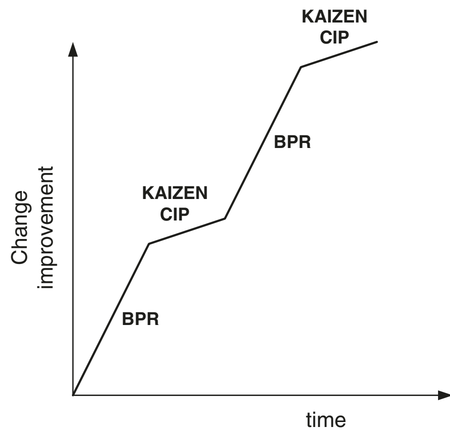

Fig. 4.10 Alternating use of CIP/Kaizen and BPR

4.5 Summary

The hospital should be designed around processes. The quality of processes has to be compared with other health care providers in benchmarking processes. To reach this goal, business process management and *business engineering* should be utilised. Business engineering is understood to be an integrated concept of management, organisation, and monitoring of processes. It seeks to fulfil the requirements that patients, referring doctors, and other stakeholders have. Business engineering contributes substantially to reaching the hospital's strategic and operational goals. In this way, business engineering forms an essential part of quality management.

Business Process Re-Engineering entails the fundamental re-thinking and the radical new structuring of business processes to achieve drastic improvements in costs, quality, service, and timeliness. This method is especially recommended for application before establishing new buildings, departments or treatment centres. However, it is necessary to analyse in advance which processes would result in value creation and which demands are being requested by referring doctors and patients.

All three approaches for continuous process improvement (*Kaizen, CIP and Six Sigma*) focus on identifying weak points, problems, and errors. The objective of these approaches is to improve processes and thereby increase the effectiveness and efficiency of hospital procedures. In the course of application, all three approaches deploy more or less the *PDCA cycle*. The *Muda list* names eight forms of waste that must be avoided with the support of Kaizen. Six-Sigma is a systematic, data-supported method of improving processes by avoiding errors. An organisation that wants to obtain a quality certificate according to *ISO 9000* (ff) has to explain which organisational measures have been put in place, so that focused continuous improvement takes place on a regular basis. The implementation of these measures and the results must be monitored and documented. Additionally, the organisation has to prove how it ensures that the identified errors do not recur. This underpins the close connection of quality management, business engineering and the various approaches amongst continuous process improvement.

4.6 Five Reflective Questions for Practical Application

1. Name three areas in your hospital/department where you participate in benchmarking processes.
2. If you compare your hospital with other hospitals, where is yours positioned according to benchmarking? In the upper, medium or lower range? Does this correspond to the 'perceived view'? Would you also evaluate yourself in this way, or do you feel the external assessment to be too positive or too negative?
3. In which areas would you consider it to implement BPR in your hospital? Give reasons for that.

4. Have you identified the success factors of your department and your hospital?
5. Which of the three methods – Kaizen, CIP or Six Sigma – could you use to optimise processes in your field?

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Improve Communication and Appreciation

5

Goals

- Why are appreciation, transparency and open communication so difficult to achieve in hospitals?
- How can you create a culture of open communication and appreciation?
- How can you ensure that the receiver understands the information ‘correctly’?
- How can you use the transactional analysis in your daily communication?

This chapter points out how to carry out personal appraisal and how to communicate in an adequate manner by choosing the right tools. You will learn more about the four ears of the addressee model, transactional analysis and how you can apply it in your everyday work. Further, we highlight the characteristics of the drama and winner triangle. The chapter ends by outlining the advantages of establishing a 180° feedback culture.

Mutual appreciation and open communication are important pillars of a success-orientated hospital strategy. Mission statements and a transparent hospital culture are not only conveyed in workshops, closed-door meetings, and discussions. They must be part and parcel of your everyday work and daily life. In a leadership position you serve as a role model. If it is known that the CEO or head of a department is short-tempered or disrespectful with others, appreciation and respect will not play an important role in the organisation.

Although a corporate culture is a binding code of conduct in many companies, this attitude still needs to be developed in many hospitals. The often patriarchal and autocratic structure, together with the three existing hospital pillars of nursing, management, and medical services, derive from historical hospital structures. To meet current demands, the approach of working ‘together’ rather than that of ‘next to each other’

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becomes mandatory. In this context a code of conduct, appreciation and open and transparent communication are important components. Although it is no longer the preferred practice to use the authoritarian-patriarchal leadership style, it continues to exist in the everyday reality of many hospitals. Many decisions are made hierarchically 'from the top' and are applied 'top-down'. This includes routine medical work, where the consultant or the head of a department decides whether and when a patient will be discharged or which therapy or procedure is applicable. This usually happens for reasons of quality assurance, since the departmental head carries the responsibility. Occasionally, however, it is used merely to demonstrate who has the power to make decisions. The *primus inter pares* (the first among equals) style of leadership requires a high degree of social competence from both sides: a senior doctor is required to regard junior colleagues as equals and the staff should understand that power-sharing must not be misunderstood as a weakness, but rather a leadership strength.

5.1 The Art of Appreciation

Mutual appreciation and respect are expressed by, for instance, good manners, greeting colleagues and patients, the structured flow of discussions and meetings, timekeeping, and active listening. People who are busy on their smartphones during meetings and making calls signal by their behaviour to those around them: 'I have more important things to attend to than listening to you.'

If an outsider would like to experience the mood, the appreciation and the working atmosphere of a particular environment, s/he should attend an internal meeting such as a ward round or the hospital's executive management meeting. Unfortunately, only very few employers offer this kind of transparency before a working relationship commences. Yet, if such opportunities are offered in advance, they can be seen as a transparent leadership tool for an applicant.

Please reflect during one of your next meetings how an outsider would sense the attitude with which staff interacts. Which improvements might be suggested? How could you yourself contribute to improving it? If a hospital wants to attract good staff or even the best available, it has to offer a good work environment and appreciation of staff. This approach might be too radical for many CEOs or heads of departments (HoDs). For far too long they have enjoyed the position of having numerous applicants enquire regularly when the next post will become available. Hospitals in which appreciation and respect are prioritised are recommended by their employees to friends and colleagues.

Case Study

The CEO urges the new HoD to give an inaugural lecture to which colleagues in private practice, consultants from other hospitals and politicians are invited. It takes several weeks to find a suitable date. Personal invitations are sent out and the event is published in the daily newspaper. Before the lecture given by the HoD commences, the CEO leaves the well-attended event after a brief introductory with the excuse that he has other obligations to fulfil.

Conclusion: Caused by the absence of the CEO, neither the HoD nor the attendees feel valued and respected. The CEO did not prioritise the task of attending the lecture; otherwise, he would have rescheduled other appointments. The opportunity to communicate with other stakeholders of the hospital, such as doctors in private practice, consulting colleagues from other hospitals, political representatives and the media, is wasted. The status of the new HoD has been downgraded by the absence of the CEO.

5.2 The Art of Communication

If I had more time, I would write a shorter letter. (Mark Twain)

Visions, strategies and their implementation needs to be communicated on a regular basis. Therefore, you must master the art of communication. Communication is the key to informing your employees and motivating them. A large number of media options are available: face-to-face conversation, telephone, e-mail, SMS, fax and social media. However, the medium chosen should be handled modestly. Particularly in delicate situations, the personal, direct contact should be favoured over a written, indirect approach. Especially for communicating unpleasant decisions personal contact should be preferred to communicating it via email. Especially in tense situations every word is weighted and misunderstandings can easily occur. These situations can be avoided if people master the art of communication.

Communication is an important tool in presenting the hospital's objectives to the staff. Both the internet and the intranet support communication as relevant information can be sent to all employees with a mouse-click. However, the staff also becomes overloaded with information. If by chance you are not working at your computer for 2 h, numerous high-priority e-mails will be waiting for you. Hence, e-mails are not often read attentively, but skimmed and occasionally deleted immediately. Wooing all employees with new information has somewhat lost its charm. Therefore, choosing the right medium for communication is becoming increasingly important. It is possible to prioritise the use of the communication media.

- Information should be put in writing, but brief (intranet, e-mail) and only if it is relevant and intended for the receiver (be careful with circulars).
- Anything personal or private should always be communicated in person (face-to-face) and not by e-mail. Otherwise the following interpretation could be made: 'He does not want to take the time to discuss the matter with me personally.'
- New strategies should be introduced to larger groups that include all hierarchical levels. It increases the credibility when the hospital management personally explains new strategies, and does not delegate this task to an external company or an administrative manager. In this way, faux-pas can be avoided.

Case Study

A hospital has purchased smartphones to replace pagers. Subsequently, in each meeting and ward round doctors and nurses are phoned or read their e-mails. Occasionally, several people are on the phone at the same time. This leads to the distraction of the whole group. Finally, the consultant decides that the use of phones is no longer allowed on ward rounds, except emergency phone calls.

Conclusion: Meetings and ward rounds run faster and more purposefully as the group is less frequently disturbed by outside influences.

5.2.1 The Four Pillars of Communication

Apart from the means of communication, the 'how to communicate' must be considered. Based on the Hamburg comprehensibility concept by Schulz von Thun (2010), the enhancement of the understanding of information can be related to four pillars:

1. Structure the sequence in a text
2. Phrase concisely
3. Phrase simply
4. Stimulate reading through the use of stylistic devices.

This sounds rather simple and straightforward. But are you able to present complex facts in a simple way? And do you really want to do it? If the content sounds rather complicated, fewer questions are asked and the respect increases. You might improve your reputation, but still have not reached the objective: to inspire the listener with regard to a new idea. The four pillars of communication should be essential for communicating with your staff. Common mistakes can be avoided. Here are some tips for a goal-orientated and successful exchange of information:

– Communication covers all events: not only the positive, but also the negative topics need to be addressed. Communication informs about processes, objectives, strategies and goals.
– There is an underlying communication concept, rules must be followed.
– Opinions and recommendations by the staff are welcomed and appreciated. In this way communication is authentic and achieves the desired result.
– The staff is familiar with the hospital's code of conduct (Sect. 5.2.2), which is available on the intranet and is lived by the executive hospital management, administration, doctors and nurses.
– Communication takes place across departments. The hospital thinking is holistic and not constricted by departmental thinking. The annual and project objectives of departments and divisions are available at any time to the staff members via the intranet.
– General information is given regularly to prevent rumours and disinterest.
– Information flow does not only occur top–down, but bottom–up as well. The executive hospital management and departmental management depend on a two-way flow of information to function efficiently.

– Staff members are personally informed of new strategies or current developments in the hospital by a member of the hospital management.
– Staff members are fully informed. If special information is required, staff can approach the hospital management or a superior.

However, how can you achieve the goal of keeping all staff equally well informed? There are always people who withdraw from receiving information because of overload or absenteeism. They will shrug their shoulders when asked and complain that they are never informed. The staff should be proactive in asking for information they may have missed. They then should to take steps to catch up. Hospital communication is not solely provided by the management and then consumed by the staff. It can only work if there are bi-directional channels.

Empathic Communication
Empathy in the hospital setting is indispensable for a successful recovery of health. Lack of empathy can affect the rate of adverse incidents. Empathy happens independently of hierarchical levels. Importantly, non-verbal and verbal communication should match each other. In addition, while the receiver must judge if the requested information was given, the sender should ask her/himself if the information asked for has been given.

Case Study
A doctor comes to the ward and enquires about a recently admitted patient. The nurse looks first at the whiteboard, and then shrugs her shoulders: 'I have only just come on duty and was off for the last 2 days. You have to ask the nurse responsible for that patient. We are only allocated the care of certain patients.'

Conclusion: The introduction of zone nursing means that nurses are responsible only for certain patients in the ward. This does not necessarily meet ergonomic work requirements. It may well be that one nurse looks after patients in rooms 1, 5, 7 and 8. This delays ward rounds and communication. The underlying idea is to concentrate competencies and responsibilities and to avoid exceeding the recommended number of patients per nurse. Although a general handover is made per shift, nurses often feel responsible only for their own patients. This attitude obstructs the overview of processes and critical patients on the ward. The doctor does not get the information he needs about the patient. The nurse does not offer any help in getting the information, but refers to her own allocated tasks.

There are many examples of codes of conduct and guidelines that have been developed for all staff members. It is important, though, that they are lived on a day-to-day basis and on all hierarchic levels.

Below we highlight an example of a successful and comprehensive code of conduct. Managers, especially function as role models in the organisation.

Example of a Comprehensive Code of Conduct

1. **Appreciation**
   – We recognise and appreciate the performance of every individual member of staff independent of their function or position.
   – We are sensitive to human and cultural differences in our hospital and see them as a source of enrichment.
   – We practice good manners and an appreciative culture of communication.
   – We are open to criticism and other opinions and express them constructively.
   – We communicate openly, seek interactions, share our knowledge, and trust one another.
2. **Responsibility**
   – We act responsibly in medical, social, and ecological matters and in an ethically correct manner.
   – We accept our individual responsibility, seek challenges, and take the initiative.
   – We are sensitive and respectful with one another and stand up for each other.
3. **Performance**
   – We recognise our goals, reach them efficiently, and allow ourselves to be measured through the results.
   – In the interests of our internal and external clients we strive for the highest quality and best service.
   – We combine our personal strengths to produce excellent team performance.
   – We are constantly working together to improve ourselves.
4. **Adaptability**
   – We have the courage to monitor ourselves and our actions, and we resolutely explore new paths.
   – We know our internal and external clients, are sensitive to developments in the market, and are one step ahead.
   – We think outside of the box and enjoy finding new solutions together.
5. **Integrity**
   – We are honest and make our actions transparent.
   – We act lawfully and in agreement with the interests and guidelines of the hospital.
   – We are reliable, keep to our arrangements, and adhere to our word.
   – We treat personal and sensitive information with confidentiality.

It is appropriate to develop the code of conduct and the culture of communication in workshops together with the staff so that these values may be lived in the day-to-day work of the hospital, independent of any hierarchies. In this area, new staff should receive separate, specific training.

5.2.2 Be Aware of the Overall Impression You Make

As soon as you have accepted an executive position you are acting on stage. Your gestures, your bearing, your activities and the way you dress together with the way you speak are composed into a message by your listeners or observers. The verbal

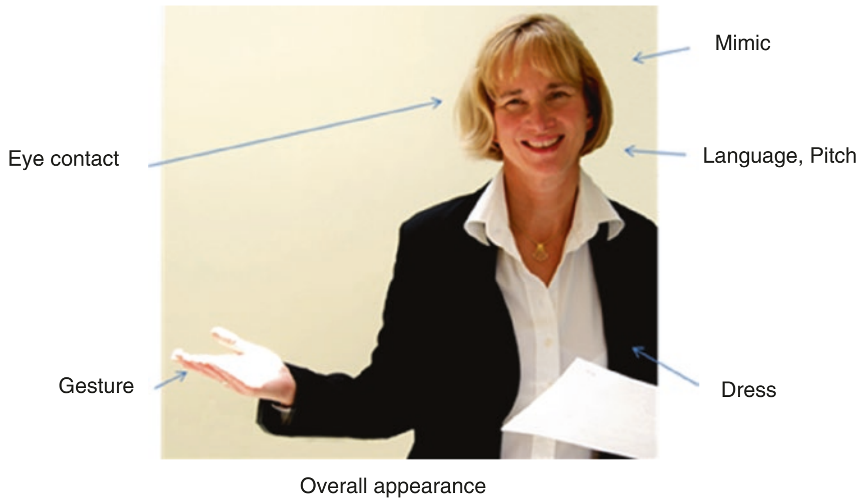

Fig. 5.1 Non-verbal communication

message is the smaller part. You should be aware of the overall impression you make and of your role (Fig. 5.1). Ensure that the communication medium you choose for sending messages (personally, by e-mail, SMS, Facebook or Twitter) is adequate. The particular attention you pay to the person with whom you are communicating, your gestures and your behaviour also are important. Someone who uses his smartphone while talking to others conveys a negative impression.

5.3 The Four 'Ears' of Communication

Messages and information are conceived and processed in four ways (Schulz von Thun 2010). Essentially, it depends on how the addressee receives the message. We as senders need to analyse how messages can be received:

– *The 'ear' for objective listening* (the matter layer). The objective content of a message is heard by the receiver and the factual issue is identified.
  Example: A senior nurse to a junior nurse: 'I have noticed that you consistently don't greet patients. The last time I noticed this it was when you met Mr. Mortimer.' Junior nurse: 'I had seen that patient here before and greeted him then.' Factual communication becomes difficult when interpersonal problems arise and are included.
– *The 'ear' for relationships* (relationship layer). Neutrally intended messages are interpreted and evaluated as if emanating from an individual. The sender expresses how he gets along with the receiver, what s/he thinks of him. The receiver can feel offended because he over-interprets a message and evaluates it negatively.
  Example: HoD, 'You should have introduced yourself at the start of your presentation.' Consultant: 'You need not tell me that. I was very well brought up and know exactly how to appear in public.'

– The *'ear' of self-disclosure* (self-revealing layer). The receiver hears the message in the light of what it says about the sender (conscious or unconscious self-disclosure by the sender).
  Example: Consultant, 'I did not see you today at the meeting when our new colleague was introduced. Why didn't you come? After all, he is employed to share your workload.' The addressee: 'It is absolutely necessary to employ someone in addition. I had so much work in outpatients that I couldn't get away in time.' The doctor analyses his superior's message with the 'ear' of self-revelation: he reinforces his superior's bad conscience in implying that up to now he had not supported him enough to see to getting someone to share his workload.
– The *'ear' of appeal* (appeal layer). The receiver hears with the 'ear' of appeal, with the idea to please everyone and fulfil unspoken expectations. According to Schulz von Thun (2010) the receiver listens with the appeal 'ear' 'practically hearing the grass grow and is continually ready to act accordingly.' The smallest signal by a sender is analysed for its appeal and interpreted accordingly.
  Example: On Monday morning, the secretary is not at work as usual, before her boss arrives. When she wants to apologise, her boss interrupts her with the remark: 'I suppose it was late last night?' Ever since, she is always at her desk one hour before the official start of her working day.

Be conscious of the four 'ears'. Be sensitive to how your message may be interpreted and how you could also be manipulated (see self-disclosure 'ear').

Be authentic and selective in your communication. Be conscious of what you feel and think and match them to what you say and do (Schulz von Thun 2010).

5.4 Childhood Experiences Influence the Present

To enable you to understand the principles of communication, we briefly explain the concepts of the transactional analysis, the ok positions and the drama triangle. What we experience during our life influences us and our communication with others. It determines how successfully we are able to realise our objectives on the level of communication. Our way of communicating is often linked to childhood experiences. As a child we wish to get the full attention of our parents. This role is adopted over and over again. Depending on one's own (childhood) experiences, those same roles are replayed or, depending on circumstances, other roles are adopted or may be changed as needed.

5.4.1 Transactional Analysis

To be able to analyse interpersonal dynamics and communication between two people you should be aware of the mechanisms of transactional analysis (TA), which originates from the American psychiatrist Eric Berne (1964).

Every one of us has three ego states from which we may speak.

- The *child state* (*C*) is the felt sense of living. Feelings and reactions from childhood are stored here. It can be split into three parts: the natural part (exuberant, playful, spontaneous), the adapted part (well-behaved, submissive) and the rebellious part (defiant, stroppy, fretful). If we allow the childhood state the necessary freedom, it is the most valuable part of our personality. It gives us strength and energy to be creative and spontaneous.
- The *parent state* (*P*) is described as the learned model of life. What parents have taught the child is stored here. Protection, help, wisdom, cautions, the requirements and prohibitions and notions of how one ought to be. The parent ego consists of two parts: the critical, judging, moralising part and the nurturing part.
- The *adult-state* (*A*) is the constructed model of living: it analyses reality with the impulses and the taught values from childhood and the adult state. The adult ego is objective, assessing, analysing and informing. It addresses the other on the same level.

All three states exist in one person, are activated according to context, and constitute the adult personality (Fig. 5.2). In communication between equals, the emphasis is on the adult state, the free child-like state, and the nurturing parent-like ego (Berne 1964).

The transactional analysis can be used to analyse which behaviour is predominant in specific situations. This enables one to interpret and assess behaviour, and to respond appropriately.

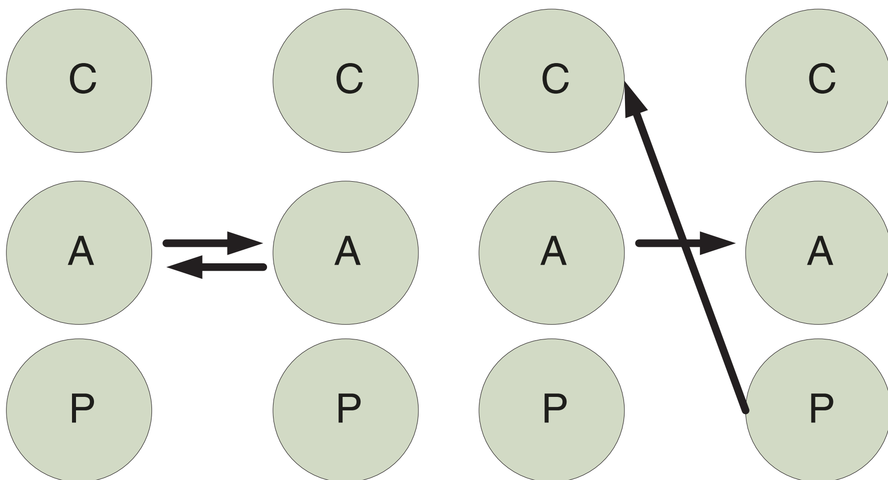

Fig. 5.2 Objective, rational communication versus overlapping communication over various levels

5.4.2 The OK Position

Relationships to other people as taught during childhood are important. During childhood one has already formed a life-long basic position with regard to the role one occupies in relation to other people. This basic position determines the trust in oneself and other people. It decides whether one:

– Sees oneself as more valuable than others (*I am ok*, *you are not ok*)
– As equally valuable (*I am ok*, *you are ok*)
– As less valuable (*I am not ok*, *you are ok*)
– Or seeing oneself and the other as of no value (*I am not ok*, *you are not ok*).

In communication, it is important to meet others on the same level. 'I am ok, you are ok' is the win–win strategy, consequently one must attribute an equivalent esteem to others. Problems arise when a negative basic position such as 'I am ok, you are not' or 'I am not ok and neither are you' or 'I am not valuable but you are', dominates (Harris 1969). In this way either the other or oneself is debased or exalted. The following example shows how the knowledge of such basic positions can define communication and the personal interaction with others.

Case Study
A consultant knows that a junior doctor grew up in a patriarchal-authoritarian home where the basic position 'I am ok, you are not ok' was the order of the day. When planning rosters and in cases of acute personnel shortages, he applies his knowledge to manipulate the junior doctor into making decisions that do not serve his personal interest, such as working on public holidays or during the festive season.

5.4.3 The Drama and the Winner Triangle

Stephen Karpman introduced the drama triangle in 1968, deriving it from Transactional Analysis. The suggestion is that we often adopt roles in expectation of some or other advantage. Roles may, in turn, be allocated. There are three roles (Fig. 5.3), which are taken as relationship patterns and may change as the situation requires.

– *Victim*: this role ('poor me') is often found in the hospital. For instance, long-term employees indicate, about their working environment: 'I am always here, sacrificing myself daily for the hospital and giving up my spare time.' Such people demand attention and sympathy, spreading the general feeling that the hospital would not function without them.
  Based on TA, the victim is in the adapted childhood state. Victims refuse to take on responsibility.

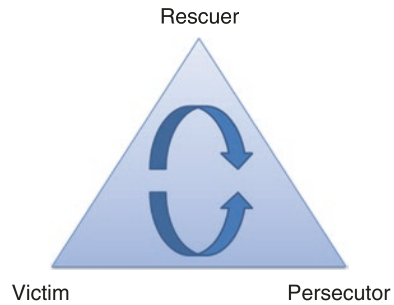

Fig. 5.3 Karpman's drama triangle

– *Rescuer*: this role ('Let me help you') is taken in emergency situations only and therefore prevents permanent solutions to problems.
  Example: In an emergency unit there are no standard operational procedures (SOPs) in existence as to how to act in specific cases (e.g., how to proceed with a request for a consultation? How is a diagnostic test processed? Who is informed when?) New employees must gather their own experience to know how to process even simple procedures. The consultant opposes suggested changes in the organisation of the emergency unit with the remark that he can be contacted at any time. ('When you don't know what to do, call me.') In this way he makes himself irreplaceable. This has a negative effect, especially when s/he is on leave or attending conferences. The holder of the rescuer role prevents improvement of the organisation and restructuring of the emergency unit to make it more efficient. According to TA, rescuers take on the role of the caring adult state. They reinforce dependencies and wants to keep people dependent on them.
– *Persecutor*: this role ('It is all your fault') is often adopted by managers and superiors to prove their dominance and control.
  Example: The CEO regularly checks after office hours if consultants are still in the hospital. If he sees someone on the way home, he asks jovially: 'Going home early today again? 'or remarks' Yesterday the lights in your office were still on, although you had already left.' In addition, he gathers information about the reputations of the various employees. He applies his knowledge, for instance, if additional staff is requested because of a staff shortage. He rejects many applications by taking advantage of his knowledge gained through his monitoring of the employees. According to TA, the persecutor takes on the role of the critical parent state.

Role-plays that take place in the drama triangle never have a positive outcome, as they prevent constructive solutions and negatively affect a sustainable working environment. In communication processes, you should always stay outside the drama triangle and be aware of the different roles that may be taken. If you notice that certain roles are being played, you should intervene. Otherwise, you will be drawn into the emotional grid and an appropriate solution is prevented. Take note of such behaviour patterns in your everyday life. You will be surprised how often they are used, especially in a hospital setting.

Remaining in the drama triangle prevents solutions; hence, it must be converted into a winner triangle. It assumes that the attitude one has towards another can change. The winner triangle according to Balling (2005) is solution-orientated. Compared with the drama triangle it proposes the following changes:

- The persecutor becomes the *confronter*. S/he, after stating an opinion, sets limits and adjusts his/her behaviour according to observations made. Signalled to the other is the message: ‘It is OK to make mistakes.’
- The rescuer becomes the *helper*. S/he asks the participant what is needed, makes clear agreements, all humans as being equal.
- The victim becomes the *needy one*. S/he asks for support, assistance, and guidance: clearly articulates what is needed and offers help in return.

When applying the winning triangle, old habits must be abandoned. Articulate clearly what behaviour you have observed and what consequences can result. Share what you expect in terms of change. In this way you can convert ‘psychological games’ into open discussions and communication.

5.5 Feedback Culture

Systematic reflection about teams developed around the group of Kurt Lewin (Sect. 6.4). Mutual disclosure, how members of the team see and are seen by others, leads to mutual feedback (Lewin 1947). Feedback has the purpose of clarifying both the one giving feedback and the one receiving it, how one’s behaviour affects the other one person and what it means for him/her. In this way your feelings and those of others become transparent, which can lead to a mutual process of change. Cooperation and communication happens more smoothly because mutual appreciation is made transparent.

Establish a culture of feedback to develop in your department and your team. Respectful feedback is a management tool. Do not be discouraged if, at first, your colleagues feel overwhelmed by the new and open communication culture. If teams are not used to feedback they will initially be surprised and will try to repel it. During feedback sessions, feelings and emotions are addressed and this can be painful. Creating a positive and empathetic feedback culture in a team is no easy task as statements on the quality of a relationship are made and become transparent.

The goal is to offer an open and empathetic atmosphere, aspiring to interact with each other and to articulate impressions and observations. This approach therefore requires discipline, respect, and openness on all sides. What should you pay particular attention to when giving feedback? Positives should be recognised; however, negatives must also be discussed without hurting the other person. Feedback should be formulated in a descriptive, appropriate, concrete, usable, well-timed and clear way.

Personal messages and opinions should be phrased as ‘I’ messages in a feedback interview: ‘I sense, I have noticed, I feel’. Concrete examples from the immediate past may be added. However, the participants should not get lost in details. Reconstruction

efforts or "finding the truth" are not intended, because often a reinterpretation of what was said takes place (Chap. 9). To make statements more meaningful, people often hide behind group opinions. Instead of saying: 'I have a problem when you assign tasks without having discussed it with me first' they often prefer to present it as a group opinion, such as 'the consultants have a problem'. In this way, they attempt to give the statement more weight by citing a larger peer group and to be less personally vulnerable. Don't let yourself be intimidated or irritated: group opinions are seldom homogeneous and a group larger than two people is seldom of one single opinion.

Eventually, the receiver has to decide whether to accept the feedback in a vote of confidence based on personal maturity. If guidelines of transparent communication are followed successfully, the team is on track to developing a positive attitude towards change (Chap. 6).

5.6 Summary

Clear *communication structures* and guidelines as well as the *lived appreciation* of individuals are key factors for a high performing hospital. The executive hospital management, together with the HoDs, serves as role models for implementing adequate communication pathways. The way in which communication takes place from the top will be lived in the hospital. The various means of communication such as conversations, telephone, and e-mail should be applied in a professional and appropriate manner. Face-to-face discussions should be given a higher priority than telephone or e-mail correspondence. Hospital staff should be aware of important interpersonal interaction theories such as the *four ears of the receiver*, *transactional analysis*, and the *drama and winner triangles*. Only if communication pathways are reliable and are used in an appropriate way, change processes can successfully take place in a hospital.

5.7 Five Reflective Questions for Practical Application

1. How would you describe the communication culture in your hospital/department (transparent, open, empathetic, etc.)? Elaborate on how, you believe, it can be improved.
2. Do you implement internal workshops for your staff in your department or hospital to foster a unified communication culture and code of conduct?
3. Can you remember conversations that were conducted within the drama triangle? How would you have been able to transform the drama triangle into a winning triangle?
4. Are you aware in your everyday work whether you receive messages with the 'ear' for objective listening, the 'ear' for relationships, the self-disclosure 'ear', or the 'ear' of appeal?
5. Do you apply feedback sessions to promote the development of your department or team? Which obstacles do you experience to implementing open communication with feedback sessions?

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6 Creating Positive Attitudes Towards Change

Goals

- Why are improvements associated with change?
- Which methods are used by change management?
- Which fellow campaigners do you need to cope with changes?
- How can you use tools such as CIRS and complaint management to make change happen?

This chapter highlights how you should engage in changing processes with health care providers. It outlines how you will be successful and how you can overcome resistance and how to support your staff in the change management process. You will become familiar with the seven phases of the change management curve. The chapter closes with a description of the critical incident reporting system (CIRS) and the advantages and disadvantages of outsourcing.

To change is difficult. Not to change is fatal. (William Pollard)

Businesses, and also hospitals, that want to align themselves with the daily challenge of the market need change processes – or, as Winston Churchill stated: 'Improvement means change'. In many cases, employees understand the reasons for change. However, during the implementation phase the change process is all too easily boycotted by some individuals. One reason is that people appreciate the environment they are accustomed to. They do not want detours or new routes because these require re-orientation and energy. Habits are deeply rooted in the evolution of mankind and the history of the organisation. People oppose change, ignore or undermine it because it runs counter to their interests and habits (Guillebeau 2010). Usually, long-lasting negative developments and counterproductive behaviour by staff are tolerated simply because nobody dares to start a change process. One rather copes

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with disadvantages than tries to initiate changes. How can you engage people in change? How can you – according to the Chinese proverb below – build a windmill?

> When the wind of change blows, some build walls and others windmills. (Chinese proverb)

It takes many windmills to carry, and carry through, change processes. An important step in a change process is identifying resistance and implementing support.

To implement change, so-called change management is required. Change management supports the change process within the framework of business engineering. It includes all planned, controlled and monitored changes in the structures and processes of socio-economic systems (Thom 1998); it also addresses questions relating to human resource management, sponsors, communication, and information. Communication is a key element within a change process.

Why is it so difficult to engage people in change processes? Even clearly unsound structures provide work and security for many people and employees. Willingness to change is distinctly different in each individual. The willingness to change often only increases when the current situation seems worse than the new one. The readiness for basic changes only arises once the inconveniences of the status quo are bigger than those of a transition (Belasco 1990). In most hospitals, this state is seldom reached unless a successful competitor opens their doors in the direct vicinity. However, by then it could be almost too late to initiate change processes.

Anecdote: Renovation for the Sparrows (Fable by G.E. Lessing)
An old church is completely renovated. In the walls, numerous sparrows have built their nests, which they now have to leave. When the church is restored to its former glory the sparrows return to find their old nests. They are surprised to find that their old nests have all been destroyed. 'What was the use of all that renovation?' they cry indignantly. 'Come, we can't live in this useless heap of stones!' The sparrows flee, scolding all the way.

Conclusion: The advantages of changes are not always evident to all concerned. This is one of the underlying reasons why people are sceptical about changes.

6.1 Change Management of Hospital Processes

> Progress is a nice word, but change is its motivator. And change has its enemies. (Robert F. Kennedy)

If you want to adapt to market demands, you have to structure your business processes accordingly. Two of the methods for achieving this are business engineering and business re-engineering (BPR). BPR applies a radical approach. Although processes can be amended and gradually improved with business engineering, BPR questions all existing processes and re-structures them completely. An imaginary new hospital is constructed from the ground up (Chap. 4).

Evolutionary business engineering can be divided into *hard* and *soft factors*. Hard factors are the strategy of the executive hospital management, business processes and the information and communication systems. Soft factors include leadership, behaviour, and power (Sect. 3.3). Specifically, soft factors determine how

change processes take place and are experienced; they are the key to engaging in change management.

The following negative example illustrates the role of power structures in process and structural changes.

Case Study

The organisational structures outlined in the organogram result in delayed hospital processes. A few years ago, the CEO changed the organisational structure. These changes consolidated and increased his power. The hospital's vision of 'patient-centred care' is not lived in everyday processes. The hospital management continually defines future strategies that are not in accordance with the real needs and requirements of the hospital. Necessary changes do not take place and the staff is increasingly dissatisfied with the hospital management's decision-making culture. Overall, this leads to unfavourable working conditions and worsens the financial output of the hospital. In contrast, patients and referring doctors are less satisfied because necessary improvements are not implemented. When the CEO is asked by the heads of various departments to restructure the current organisation to adapt them to the requirements, he refuses to do so and seeks back-up from the executive hospital board. As a result, long-term and knowledgeable hospital employees finally leave the hospital. Patient satisfaction and financial output further drop.

Conclusion: Organisational structures often serve to maintain power. Seldom are they in place to serve the patients and other important stakeholders. Implementing continuous change management is important for the strategic development of the hospital.

6.2 What Resistance Can Be Expected During Change Processes?

> Change will not come if we wait for some other person or some other time. We are the ones we have been waiting for. We are the change that we seek. (Barack Obama/Mahatma Ghandi)

Why is the implementation of change processes so difficult? You can, in fact, facilitate change processes if you shift the focus and align your hospital strategymaking orientated to processes and no longer to functions or to departments. In this case, processes and patients are better attended to. It is no longer the head of department (HoD) or CEO who is responsible for processes, but the people who implement the processes. Now, the staff controls and improves the business processes, with a role change between staff and management. The relevant control parameters are shifted from the cost centre's budget to the time, quality and cost of the business processes. As this is associated with a loss of power and includes a change of habits, resistance can develop. Resistance occurs in two ways: individual and organisational (Table 6.1).

When asked, many people cannot say precisely why they personally feel that the change process is a threat to them – nor would they admit that it is a threat. They

Table 6.1 Individual and organisational resistance

Individual resistance	Organisational resistance
The necessity for change is not understood	Existing incentive systems strengthen the existing situation (processes, power, and managerial structures)
Approach, objectives, and results of the change process are not understood	Threat to power balance of the hospital
Fear of what is new and unknown	Conflicts between groups prevent collaboration
Loss of status	Organisational structure and change process are not compatible
Threat to existing relationships (among colleagues, members of staff, superiors)	Resources bound to previous decisions and activities
Threat to existing work flows and habits	

may have an unpleasant gut feeling about what is new and different, but they cannot articulate what this feeling is.

Rooted in the historical development of hospitals and the accompanying organisational structures, innovations frequently meet with resistance. Often hospitals were not started or run as profit-earning enterprises but nowadays they have to adapt to market conditions. Many hospitals that were founded by a church or the local government offered patients whatever care and support were available. In addition, these hospitals served as non-profit organisations.

Furthermore, many hospital employees still have only obtained experience in one organisation. Some of them have been trained at the hospital and then have worked their way up in the organisation. They have had little or almost no experience in other organisational structures.

Hospital CEOs often have an economics-focused degree; some have had previous experience in hospitals or even have a medical degree. It is still not common practice that they have combined qualifications in a medical field and health economics. Occasionally, they come from businesses associated with hospitals and have gained their managerial knowledge there. The mind-set and values of hospital staff may be unknown to them.

Even if hospitals are managed more efficiently today than in the past, they are different from companies, which are run exclusively along business lines. Although similar management principles apply to both, they cannot simply be transferred wholesale and without adaption. Hospitals still must work within a health policy framework, apply ethical considerations, and be empathetic about patients' concerns. Hence, the points of view of management and the staff can be very different. In particular, this can occur in for-profit hospitals and private hospital groups. It is a fact that must be considered when change management processes are planned.

6.3 How Fit Is Your Hospital for Change Processes?

> Life consists of many closed doors. The needed skill is not to give up looking for an open one. (Author unknown)

Have you ever heard remarks like: 'We have always done it like this', when you suggest something different? How frequently do you hear comments like these?

Companies, including hospitals, where such an opinion is continuously expressed, are doomed to fail sooner or later (Belasco 1990). You can analyse how well your hospital is prepared for change by answering the following questions.

Question–Answer Catalogue for Assessing Willingness to Change
Question 1. A new consultant asks the personal assistant (PA) of the CEO to personally discuss a recent decision taken by management. What would normally happen in your hospital? Please tick your answer(s).

Possible answers:
(a) As soon as the CEO is available, he will answer the question in a face-to-face discussion.
(b) The PA asks the employee to discuss the topic with his superior.
(c) The CEO instructs his secretary to give the employee's HoD a call so that he can personally take up the matter.
(d) The employee is rescheduled by the secretary and told that he will be called back at a later stage.

Question 2. A recently employed consultant realises after a few weeks that certain admission procedures are redundant and could be improved. What would normally happen in your hospital?

Possible answers:
(a) The consultant submits an application to the executive management of the hospital and asks for certain changes.
(b) The consultant speaks with his HoD so that he can discuss the matter with the executive management.
(c) The consultant personally attends to the matter until it has improved.
(d) The consultant is told that he needs to obtain in-depth knowledge of the hospital structure before he can make suggestions.

Question 3. A neighbouring hospital in your referral area offers an integrated care concept with their day-care-hospital operations and subsequent nursing at home in the highly contested and profitable market of implants. How would your hospital react?

Possible answers:
(a) The hospital's public relation officer reports in the regional press on patients' satisfaction at being treated under the existing system.
(b) The hospital management instructs a consulting company to examine the issue.
(c) A multidisciplinary working group is formed that consists of members of the department of orthopaedics. The group is asked to submit a detailed proposal within 30 days.
(d) The executive hospital management refers to its own good financial results and lets the neighbouring hospital gather their experience in the matter.

Question 4. Over the last year, the number of births in the obstetrics unit is clearly decreasing. However, the neighbouring hospital shows an increase in births every year. How would your hospital handle this situation?

Possible answers:

(a) The long-serving consultant is dismissed after two warnings if he cannot show improved figures within a given time.
(b) The executive hospital management forms a working group to examine this problem.
(c) The labour ward is upgraded as it is assumed to be the cause of the problem.
(d) The consultant of the unit is given the mandate and autonomy necessary to propose and implement a new concept within three months.

Be honest and assess which answer relates most closely to your hospital. Then add together the marks of the answers.

– Question 1: 2/0/0/0
– Question 2: 1/0/2/0
– Question 3: 0/0/2/0
– Question 4: 0/1/0/2

The total indicates your hospital's willingness to change:

– 0–2 marks: you have a great deal of work ahead to make your hospital fit and open to change processes.
– 3–5 marks: your hospital is moderately able to change, but needs a boost. There are lots of red carpets around.
– 6–8 marks: in your hospital change processes can be implemented successfully. Carry on and demonstrate the changed practices through your actions.

6.4 How Can You Encourage Willingness to Change?

It is not the strongest who survives but the one that is able best to adapt. (Carly Fiorina)

Now we will move on to the questions: how do you encourage willingness to change and which obstacles have to be overcome? Many people are overwhelmed by the oft-repeated 'we have always done it like this'. Change processes are like clearing a thicket. If you neglect the task for a couple of days, it grows back again and the earlier efforts are hardly visible.

The following guiding principles can encourage the willingness to change (Belasco 1990):

– Convey a sense of urgency.
– Sketch a clear picture of tomorrow.
– Develop a new path.
– Display the new values in the way you yourself act.

John Kotter and Holger Rathgeber's penguins anecdote offers a good illustration of the various steps of change management (Kotter and Rathgeber 2006).

The example below highlights how half-hearted implementation of these principles can, however, lead to failure of the change process.

Case Study

The CEO of a large regional academic teaching hospital conveys to his staff the possibility of the hospital being taken over by a private hospital group that is already in the neighbouring town. To highlight the urgency of the matter, he cancels bonuses for additional duties such as the teaching allowance for students who are being trained for entering the nearby university. He defends these steps to his staff by reasoning that the additional money is urgently needed for the cash-flow of the hospital. A further step is staff reduction. The remaining staff willingly accepts the additional workload of their colleagues whose fixed-term employment contracts are not renewed. Over time, cost saving becomes the dominant motto of the hospital; individual and outstanding performance are appreciated less and less ('everyone is replaceable'). The executive hospital management celebrates its financial successes and increasingly takes on external speaking and representative engagements. Some of the staff members can no longer identify themselves with the hospital's strategy and move to competing hospitals where they are offered better development potential.

Conclusion: In this case, the executive management creates a sense of urgency ('your job is in danger'), but neglects behavioural changes that go beyond saving costs. Furthermore, no new values or new hospital strategies have been implemented to address questions such as: how can we set ourselves apart professionally from competing hospitals? What are our competitive advantages? No examples of implementing new goals have been shown. Some staff members felt alienated from their initial job description and no longer identify themselves with the hospitals strategy. Furthermore, the staff have become rather sceptical as to whether the executive hospital management is capable of developing a suitable strategy that will ensure the hospital's viability in the long run.

Further difficulties in the successful implementation of changes will be illustrated by a few examples:

Lack of Commitment or Impatience of the Initiator: The project's initiator has instructed the senior outpatient nurse to conduct a patient survey to determine their satisfaction with the outpatient department. Based on the results, she is asked to complete an action plan. When they meet again after two weeks, the initiator cannot understand why the outpatient staff have not been informed about the project and the first results are not yet available (e.g., questionnaire, time frame etc.).

Resistance to Change: Too Little Understanding of the People Concerned: The staff of an outpatient department is asked to record the waiting times in both the medical and nursing areas and reduce these by 20 %. However, the nurses and doctors working in this area are convinced that they are already working close to capacity and cannot work any faster to shorten waiting times.

Lack of Qualified Staff: The nurse in the outpatient department is responsible for the project 'Outpatients' waiting times'. But she does not have the necessary professional competence to judge the performance and quality of the doctor on duty.

Lack of Communication Between the Initiating and Participating Groups: There was no meeting time that was convenient for the relevant role-players such as nurses and doctors to have the opportunity to discuss with the project leader the project's objectives and timeframe. Subsequently, either the support of the participating staff was lacking or the person responsible for the project was missing.

Lack of Consideration of the Hospital's Culture: The nursing staff of a hospital that is run by one of the churches receive more appreciation than do the nursing staff in a government hospital. An initiative to optimise treatments of private patients in the church-run hospital initiated by an HoD threatens to fail because the nursing staff were not consulted beforehand. As the nursing staff were not included in the project from the beginning, they feel offended and are now blocking the process.

Lack of Sponsors: Due to the poor flow of information, only a few staff members know what the project's objectives are; as a result, the project is not supported by the staff.

Lack of Willingness to Change: Most members of staff have been working in the hospital for a long time and by now constitute a well-attuned team. As changes have rarely been initiated over time they are often ignored or undermined.

One often forgets that change requires perseverance. There is also the instance in this case of neglecting to inform the involved staff adequately about content, timeframe, and personal job security.

Change processes do not only imply changes affecting departments or the entire hospital. They can also include small projects, such as the way to do ward rounds or reduce the waiting time in the Emergency Unit. In change processes, the interests of the various stakeholders must be understood (Chap. 3) and analysed, while the staff involved must be engaged and should participate. Soft skills and social competence are required to achieve the set goals (Chap. 10).

Change processes run through *various phases*. According to Kurt Lewin (1947) the phases are 'unfreeze', 'move' and 'freeze'. As shown in Fig. 6.1, the existing processes and structures must be *unfrozen* to allow the entry of change processes. Then the enterprise has to be *moved*: new values will develop, but insecurity also arises. The path becomes rough and seems uncertain; the vale of tears is traversed. Remarks such as 'Everything was better in the past' are heard on a regular basis. In

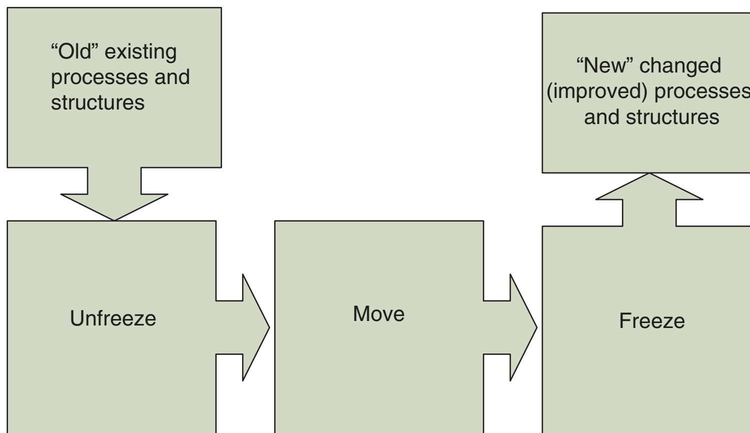

Fig. 6.1 Change processes according to Lewin (1947)

the *freeze* phase, the process has been completed and new behaviours, values, and norms are anchored and, most importantly, lived by everyone.

The team should familiarize themselves with the change curve so that feelings and experiences are recognised as among the normal reactions to a change process.

In contrast, change saboteurs use these phases to emotionally influence the change process. Troublemakers can exploit people's basic needs (e.g., for the safety of the work place) to deliberately unsettle them while simultaneously strengthening their own power and influence.

In implementing change in a hospital culture, it is necessary to ensure that being open to changes is experienced as an opportunity. Furthermore, understanding and anticipation are needed rather than mere reactions to events. The executive hospital management should be able to accept criticism and should avoid listening only to the people who agree with them. If they allow only their existing opinions to be confirmed, this will entrench stagnation and result in a step backwards. On all levels, permanent, personal, and organisational learning should be regarded as self-evidently essential. Further, teamwork must be lived. A CEO, a head of department (HoD) or medical director should retain the ability to listen actively and to change their point of view (Chap. 10). This is shown in the following negative example.

Case Study

The hospital management invites consultants and HoDs to attend a workshop. Various topics are discussed in the different groups. The CEO of the hospital is a member of one of the groups. Only when he has voiced his opinion do the others take part in the discussion and they support him.

Conclusion: This hospital will develop only along lines that the CEO envisages. A free expression of opinions is neither appreciated nor asked for by the executive hospital management.

Apart from the above-mentioned guiding principles formulated by Belasco (1990) and Kotter and Rathgeber (2006), we wish to show in the following section how successful change management can be implemented by using a systematic approach.

6.5 The Seven Phases of the Change Curve

It often takes more courage to change one's opinion than to stick to it. (Friedrich Hebbel)

To facilitate change processes in your hospital, you have to educate your staff about the different phases of the change curve. The defence mechanism is a normal part of it. Structural changes proceed according to a uniform scheme. In a change process everybody should be aware of the current and future phases. Figure 6.2 shows the perceptions of, and the reactions to the different stages of structural changes.

– *Phase 1 – all in agreement:* the interior perception conforms to the exterior. Attitudes are aligned with the information received from the outside world.
– *Phase 2 – shock and disbelief:* a sudden change occurs. We are informed that we must change. At first, we deny this message. Dismay prevails. It is the task of the change leader to listen to your concerns with empathy.

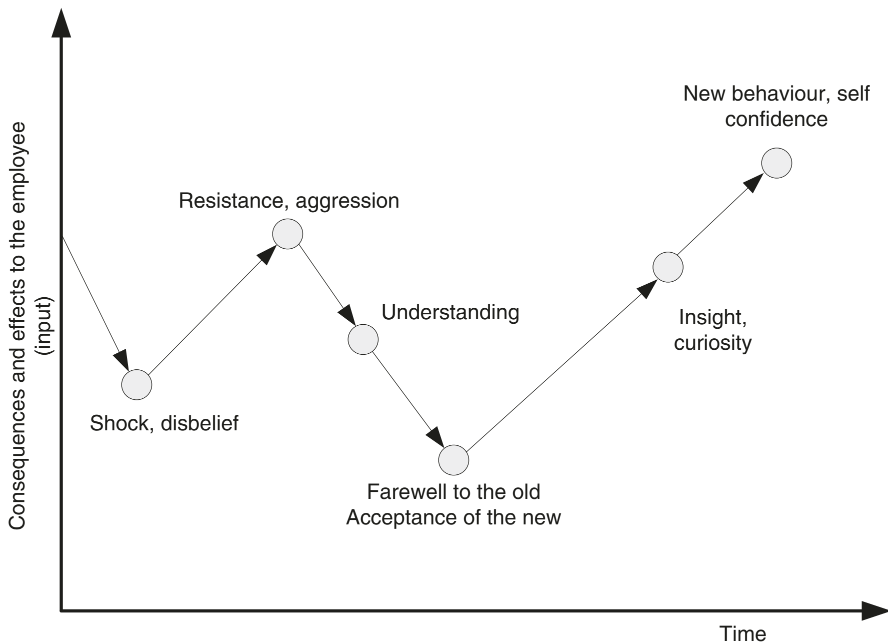

Fig. 6.2 Change curve, staff perceptions of changes

– *Phase 3 – resistance and aggression:* the familiar attitude is defended by the team. The team still denies that change is unavoidable. It is the task of the change leader to consistently communicate in order to raise awareness of the new realities.
– *Phase 4 – understanding:* individuals try hard to pretend that change does not exist. In spite of that, the team begins to understand that change has to happen and to feel the effects.
– *Phase 5 – farewell to the old and acceptance of the new:* there is closure with the old and a dignified parting from it. Discussions come to a close.
– *Phase 6 – insight and curiosity:* a change in attitudes, beliefs and values takes place. The road is clear for new behaviours and skills. The task of the change leader is to permit mistakes and discuss them in an atmosphere of empathy. The new becomes routine. Assurance sets in.
– *Phase 7 – new behaviour and self-confidence:* the new goal can be visualised both inside and outside. The task of the change leader is to praise teamwork and plot successes.

6.6 The Seven Steps of Successful Change Management

The change process can be divided into seven steps:

– Assessment of the sponsor
– Analysing the hospital culture
– Planning the programme
– Planning the implementation
– Communicating the programme
– Installation of the programme management
– Monitoring the process

Apart from management, changes also demand leadership. The part played by *management* is to plan and pursue management objectives. Among them are: monitoring whether measures are being carried out; communication within the hospital and with the separate departments and staff; managing operational and human resources. As a leader you establish a vision and a strategy for a long-term direction. You motivate and inspire your staff and define a hospital culture. You reinforce this by actively living it.

6.6.1 Assessment of the Sponsor

In a change process, you need fellow campaigners who will support your project, vision, hospital culture, etc. and carry it further. They can be divided into the following groups:

– *Sponsors:* persons or group of persons with the power to reorganise (usually executive hospital management, HoDs).

- *Agents:* person or group of persons who are responsible for the implementation of change (e.g., senior doctors, consultants, managers).
- *Affected persons:* persons who have to change (e.g., doctors, nursing staff, administrative staff)
- *Advocates:* persons or groups who want the change, but don't have power (e.g., doctors, nursing staff and administrative staff).
- *Camp followers:* persons who are affected without being particularly convinced and play subordinate roles.
- *Blockers:* persons who work against change.

The best sponsors want the change themselves and at the same time feel themselves to be both agents and affected persons. This is illustrated in the following case:

Case Study

The CEO of a hospital wants to implement the concept of patient centered care. He is not a medical doctor himself and is not familiar with hospital processes. However, he tries to put himself in the role of patients and considers how patient centred care could be implemented in the hospital. Spontaneously and without advance notification he attends daily activities in various units (ward rounds, discussions, outpatients, admissions, discharges) as he wants to get a realistic, uncontrived impression ('management by walk-in'). One evening he attends the trauma unit to experience how the hospital functions from the patients' point of view.

Success is dependent on good and reliable sponsors. The sponsor is the key factor for successful changes. If the CEO wants to change the hospital culture without actively supporting change processes, the project is not going to succeed.

If the hospital board wants to implement changes, they should support the CEO and the executive management team in developing the necessary skills and management tools. If the CEO remains resistant to change, the hospital board should consider replacing him. Effective change management from the top cannot be delegated or ignored.

A successful sponsor has to have various tools at hand: for instance, the resources and formal power to enable acting autonomously. Furthermore, s/he must be empowered to influence the persons involved and the organisation. Integrity, the ability to develop vision, foresight and consistency in actions are important characteristics. A sponsor is critical to the successful launch of a change management process. Agents cannot take over the role of sponsors, as they have to implement the change.

The following case study highlights the importance of consistent action in a change management process.

Case Study

For several years, the HoD and the hospital management pursue the plan to rebuild the hospital in another location to improve access and patient flow. It has already invested a lot of time and money in the planning. However, after the building plan has been officially submitted, the CEO withdraws the project. He then disseminates the goal of building a new outpatients treatment centre because this is faster to set up and would relieve certain hospital and treatment processes.

Conclusion: To initiate projects such as the urgent construction of a new hospital and then to pursue, instead, the development of an outpatient treatment centre wastes resources, and confuses the staff and other stakeholders. If urgent business reasons make such a change in strategy necessary, this must be communicated appropriately: these reasons should be made transparent and understandable to the staff and all other stakeholders.

6.6.2 Installing Programme Management

Change management must be planned and coordinated with measures and tools. The organisation and planning process is known as *programme management*, the activities accompanying it, as *change management*.

Among the objectives and tasks of programme management is the overarching planning of the change management. It also includes planning of points-of-decision-making as well as feedback control on existing processes. Key activities are setting up interfaces to BE projects or other projects, the methods and tools of change management and ensuring information flow. An early warning system for problems should be installed so that they do not accumulate. A professional press officer to facilitate communication plays an important part. As an interface, he should be familiar with the hospital, the public, and other role-players.

The person responsible for change management is primarily a communicator. He must keep his eye on the entire change process. The style of change management is important. A *democratic-cooperative leadership style* has good chances for success (Chap. 10). This approach is based on the appreciation of employees, as is signalled by including their knowledge and abilities. Drafts of decisions need to be developed and presented, from which the superior may choose.

The necessary steps of programme management could be outlined as follows:

- Mobilising for the programme: 'We cannot continue as we are.'
- Workshop I, 'situational analysis': 'We realise that we have to take the new path.'
- Workshop II, 'solution concept': 'We know where we are heading.'
- Workshop III, 'planning the implementation': 'We know how we are going to get there.'

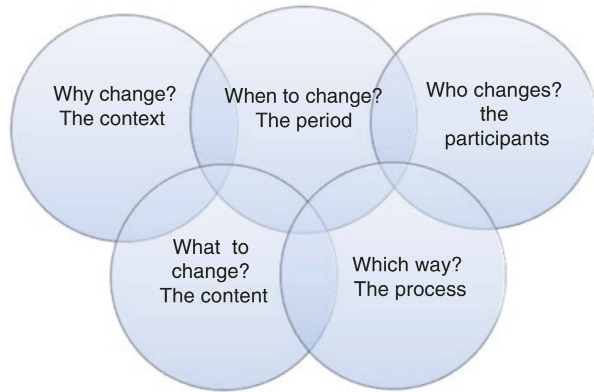

Fig. 6.3 Five W questions

It is important to explain the various steps to staff members ahead of time and inform them in various workshops.

6.6.3 Communicating the Programme

> The best way to obtain information is to give information. (Machiavelli)

Communication is the decisive instrument for successful change. In the following example, we show how communication could be implemented during a change management programme.

As shown in the above example, the progress of change management is to be communicated by the 'W' questions: what, when, who, and which way? (Fig. 6.3).

Case Study
The executive hospital management is planning a new surgical outpatient building. On several occasions the CEO invites all staff to attend short in-house presentations with opportunities for questions and answers. He personally outlines the most important milestones and calls for active participation by way of contributing creative ideas. He explains to the staff why this project is so important for the hospital, informs them who is involved and which departments will profit from it. He sketches the different phases of the new building as well as addressing the departments and administrative areas that are affected by it.

Conclusion: All levels of staff feel well informed and included in the process. By being able to make suggestions that are considered and taken up, the executive hospital management, too, gets their buy-in.

In communicating information about the programme or project, the following process can be applied. The reasons and the current status of the programme are repeatedly and briefly communicated. Apart from that, the programme and the various steps including the various reasons and goals are presented on the intranet. The press officer who aligns the communication holds a key position in this process.

Furthermore, the time frame and the changes to it are reported. Explanations are given as to who is affected and involved, when the change is being implemented and what the effects will be.

Every opportunity for feedback should be used, e.g., in a questionnaire for 'Workshop I – situational analysis', a question could be: 'In your opinion, what are the advantages to pursuing the new goals?' A four block matrix with a time dimension could be provided-short-term/long-term and an importance dimension-direct/indirect.

The staff's reactions to the different phases within the change process should be discussed and considered. They could be used to modify strategies and ensure the necessary support.

6.6.4 Analysing the Hospital Culture

During change management, training and workshops will become necessary to overcome resistance to change (Krueger 1994). In the first place, the hospital's culture should be analysed to identify and understand possible opposition to the change process.

Analysing the hospital's culture to assess willingness to change, various methods in organisational and cultural analysis can be applied. Among them are the map of power assessment of executives, the support-influence matrix, and the web of cultural analysis.

In a map of power assessment, executives are analysed and grouped according to their roles. The hierarchy within the hospital can be marked with '+' or '−'. This will give you an overview of who is supporting or opposing the change, who are the involved employees and who has been identified as a sponsor, blocker or advocate (Fig. 6.4).

In the framework of the *support–influence matrix* the employees are grouped according to their willingness to support change as well as according to their influence. This can be done by grading them into the dimensions of 'influence: low/high' and 'support: low/high' (Table 6.2).

Before you start far-reaching change processes, you should realistically assess and analyse how change processes have been handled in the past. What were the characteristics of earlier projects? Which problems arose? How were they handled? Did the projects result in new structures, organisational changes, and processes which are being lived in the daily work? Which groups have been successful in this? How high were the costs of the previous project?

A comprehensive *organisational and cultural analysis (web of cultural analysis)* can be drawn up by applying the following twelve parameters. This will help you to determine ahead of time what resistance you could possibly encounter and in which areas problems can be expected (Pfeffer 2010).

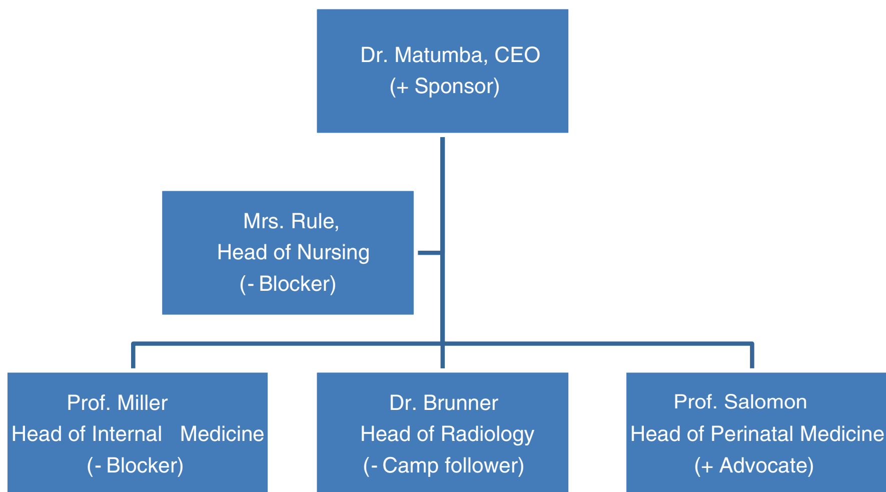

Fig. 6.4 Example of a map of an assessment of executives

Table 6.2 Support and influence of the employees involved

Support	Influence high	Influence low
High	**Sponsors:**	**Advocates:**
	Prof Dowling (HoD)	Dr Johnson (Senior Registrar)
	Dr Steyn (Consultant)	Sr Jeffrey (Nurse)
	Mrs Bosson (Nurse Manager)	
Low	**Blockers:**	**Camp followers:**
	Prof Blockman (Deputy HoD)	Dr Gilbert (Consultant)
	Dr Picker (Consultant)	Sr Abrahams (Senior Nurse)
	Sr Spikes (Senior Nurse)	
	Dr Beth	

HoD Head of Department

1. *Drive for improvement.* How intense is the individual drive for improvement within the team? Is the team striving for excellence or do most of them just try to get through the day? How many improvements have been made in the hospital during the last twelve months that were successfully implemented and have advanced the operational work?
2. *Willingness to collaborate.* How developed is this attitude in your team/department/hospital? Do the team members work well together? Does the team work with other specialists and departments or do they prefer to work among themselves?
3. *Need for cooperation.* Does the team feel a need to work together with others?

4. *Need for continuity.* Is there a wish to leave everything the way it is – in accord with the old saying: ‘a new broom sweeps clean, but the old one knows all the corners.’
5. *Dependence on others.* Is the team autonomous, authorised to make decisions, or are they dependent on others? Is there an alpha dog in the team?
6. *Aversion to risk.* Does the group accept risks or are they averse to risks? Is the team prepared to head into a new direction and experience new things?
7. *Oppositional stance.* How much opposition should you expect from individuals or from the team?
8. *Orientation to power.* On the executive level, is the main focus on staying/retaining power?
9. *Internal competition.* How much internal competition exists, and how much is allowed?
10. *Perfectionism.* Is there a desire for perfectionism that prevents innovation or can people tolerate degrees of imperfection enabling them to move on?
11. *Results-focused thinking.* Does results-focused thinking dominate? This is the key to successful change processes.
12. *Team dynamics.* How dynamic are the individual members and the team as a whole?

The criteria measuring the culture of learning, willingness to change and aggression can help you to estimate the risk for the change process:

– *Culture of learning* (willingness to learn new ways of acting): criteria 1, 2, 11 and 12
– *Willingness to change*: criteria 3, 4, 5 and 6
– *Aggression* (intention to block or harm the change process): criteria 7, 8, 9 and 10.

The following example illustrates an operational process in change management. This will lead us to the next step in programme planning.

Case Study

The executive hospital management, the HoD for orthopaedics, and the HoD for the trauma unit have decided to establish a surgical day hospital. This will include aftercare in collaboration with private orthopaedic specialists and surgeons working in the outpatients department. The day hospital will be housed in a new hospital wing. The colleagues in private practice will jointly work together with their hospital colleagues in both surgery and outpatients. The objective is to offer patients better treatment options and improved aftercare services. Furthermore, the treatment costs for the hospital have to be reduced, as the number of negotiated procedures exceeds the limit and are therefore not reimbursed by the health care insurances.

The following steps are necessary. The environment (i.e., the hospital staff, colleagues in private practice, purchases and patients) must be aligned to the goal of 'new integrative care in outpatient surgery with optimised aftercare treatment'. To achieve this, an interdisciplinary project group comprised of members of various stake holders is formed to outline a vision and create awareness of the goal.

The current attitudes of those concerned are analysed to identify barriers, find sponsors and to include opponents and blockers. At the same time, the relevant information must be disseminated. In addition, training is offered to highlight the necessity for changes as well as to inform about further developments and the envisaged goals. It is also helpful to share experiences of other hospitals with similar projects. After the buy-in from the role players, an attitude in favour of change must be established. Those concerned should be actively involved in the project, and play a part in it. The various steps have to be recorded. Ensuring continued support is an important task, as the process continues.

6.6.5 Programme Planning

> If you want to build a ship, don't drum up people to collect wood and don't assign them tasks and work, but rather teach them to long for the vast and endless ocean… (Antoine de Saint Exupéry)

Two aspects of programme planning are the design of the concept and the implementation of the change process. The strategy needs to be separated from the planning ('initiate the change, i.e., build participation and convince people to get involved') and the implementation ('manage the change, i.e., in each phase, implement each stage quickly and manage the risks'). Programme planning comprises the set goals within a certain time frame and the way to proceed further, depending on what has been achieved.

There are various approaches to leading the change process. Improvements that can be made in the short term must be implemented immediately because your colleagues and the management need to see results. Then even notorious blockers will look unreasonable as time goes on.

No major change can be achieved in one go. Intermediate stages – plateaus – are necessary. They can be structured according to different principles, but the hospital must be able to function at each plateau. Each level has its guiding principle and is balanced in itself.

In health systems, i.e., hospitals, day clinics, private practices, the visualised objective must be analysed repeatedly and if necessary, be adapted as continuous changes and modifications take place. The transformation programme of change should benefit from a combination of 'push' and 'pull' factors: *Push* should be

understood as stimulus given by management and *pull* as the participation and buy-in from colleagues. 'Learning by doing' transforms affected persons into advocates. This can become a 'pull' factor, i.e., those concerned will pull others along.

The lessons learnt from the change processes will create innovative work structures. 'Making mistakes' must be permitted as long as there is the willingness to correct them and learn from them. The willingness to take on risks (responsibility) promotes development. Resistance to change management and innovation processes is normal, partly predictable, and measurable if you take the time to analyse it (Chap. 5).

6.6.6 Planning the Implementation

To implement change successfully, there are various approaches, as described above. Start with projects that have a short- to medium-term time line and a high probability of success. For this, select the most suitable colleagues in the hospital as initiators. In the implementation phase, the snowball principle, building on the push and pull factors, has been proven to be effective. Furthermore, changes are not only initiated top–down, but also, since the staff is included, bottom–up. For each hierarchical level the mind-set of its occupants must be considered, moved and changed.

It is necessary to analyse how staff members react relative to the relevance and speed of the particular change process. The four-field matrix with the dimensions speed (high/low) and participation (high/low) can be used to make the analysis. The readings are to be interpreted as follows:

- *Low speed, low participation:* lack of interest, resignation (apathy). At every regular meeting you have to point out the importance of taking part, even if no significant progress has been made since the last meeting. The targeted innovation process shows a high risk of failure.
- *High speed, low participation:* restlessness, uncertainty, opposition. Since the last meeting, the project has advanced without those involved having participated actively. They feel that they are not being adequately consulted and involved.
- *Low speed, high participation:* frustration, implausibility. The staff members participate actively in the change process and contribute actively. However, the progress is very slow. As time goes on, they are frustrated and no longer convinced that enough support is being given by the sponsor.
- *High speed, high participation:* motivation, creative thinking. This is the ideal situation. The group is prepared for the flight of the flamingo (Chap. 8).

As outlined, you as the project sponsor need to find the appropriate speed that will ensure the high involvement of your team. Depending on that speed, you will have to set goals and deadlines and adjust them.

6.6.7 Monitoring the Process

The entire change programme must be continuously monitored and controlled. Progress across all stages of the transformation requires much patience. The agents and sponsors must be prepared to encounter resistance on all levels. If resistance is not taken seriously, success will be endangered. Even if the change process is broadly accepted, this does not automatically imply satisfaction of all the staff involved. People who resist the change should be given the opportunity to articulate their doubts. However, blockers need to know from the beginning that they are expected to actively support the change.

The web of cultural analysis (Sect. 6.8) shows the chance for a successful change. During the change process this must be continually updated to assess how far the change has been embraced by the involved staff.

Even if the change process slows down, there are ways and means of getting the process into gear again. It calls for a change of strategy.

Example Change of Strategy

Change of strategy: a man was standing outside a building with a sign that read: *I am blind, please help*. A 'creative publicist' was walking by him and stopped to observe. He saw that the blind man had only a few coins in his hat. He dropped in a few more coins and, without asking for permission, took the sign, turned it around and wrote another announcement. He placed the sign by the blind man's feet and left. That afternoon the creative publicist returned to where the blind man sat and noticed that his hat was full of bills and coins. The blind man recognised his footsteps and asked if it was he who had re-written his sign; he wanted to know what he had written on it. The publicist responded: 'Nothing that was not true, I just wrote your sign out a little differently.' He smiled and went on his way. The new sign read: *Today is the first day of spring and I cannot see it*. (unknown author)

The following options for a change of strategy exist: more time can be assigned to staying on a level, especially if it is on the first plateau; goals can be modified; the 'pain' of the present situation can be increased (e.g., 'The new consultant will only be employed once the innovation process of restructuring the department has been implemented.'). In addition, instruction, training, and coaching can be intensified.

6.7 Which Strategy Can Be Applied When?

Depending on the requirements, changes can be introduced at various stages. Collaborating, advising, instructing and active decision-making are options and should be applied in a specific situation specific manner (Table 6.3). The strategy depends on the degree to which your colleagues support the various steps and how urgently changes need to be implemented.

Change processes include small changes, step-by-step application, modular transformation, or the reorganisation or restructuring of an entire department or hospital.

Table 6.3 Conditions for various change strategies

	Step-by-step	Transforming
Collaborative/advising	*Participative*: Only small changes are necessary in the hospital/department. The groups support the change	*Charismatic transformation*: The hospital/department needs changes urgently. There is little time to ensure general participation. Important role-players in the hospital support the intended changes
Direct/mandatory	*Forced change*: For the hospital/department smaller and bigger changes are necessary and there is enough time available in order to do so. Although interest groups are resistant to change	*Directive transformation*: The need to change is urgent. There is neither the time nor the support for radical changes. The changes are necessary so that the hospital/department recovers and quality of treatment improves

Modified according to Dunphy and Stace (1990)

6.8 CIRS

The *Critical Incident Reporting System (CIRS)* is a system for controlling processes and initiating changes (Fig. 6.5). How does CIRS work and how is it evaluated? CIRS reports originated in the field of air traffic control. For decades, a systematic data analysis of incidents (accidents/events) and near miss incidents (‘almost’ accidents) have been carried out and officially published. This process has significantly increased flight safety worldwide because mistakes were made transparent to the wider community who could all learn from it. In hospitals an internet platform in which data can be entered anonymously would be ideal. Job details (medical services/nursing/administration/security/others) should be entered. Anonymity must be granted, related to other departments and to the hospital management. The designated CIRS person of the department/hospital evaluates the data regularly. The different topics are summarised and subdivided into various subgroups; the topics are discussed at least once a month together with the HoD/consultant and the head of nursing. In turn, the executive CIRS team regularly presents the findings and measures passed on to their peer groups (medical services/nursing). Problems and measures taken of the departments/hospital should be documented in the intranet to advise new or absent staff. The nominated CIRS person of a department/hospital will forward the relevant reports to the head of CIRS in the hospital who then collates the anonymised report for the executive hospital management. An open, trusting and transparent atmosphere in the hospital promotes participation in CIRS. This enables risks and problems to be communicated to higher levels, since it is imperative that hospital management and risk manager be informed about current problems.

Whereas the nursing staff tend to use CIRS on a regular basis, doctors are more hesitant. The higher the hierarchical level, the greater the hesitation to provide critical information. A contributing factor is the traditional concept of the medical

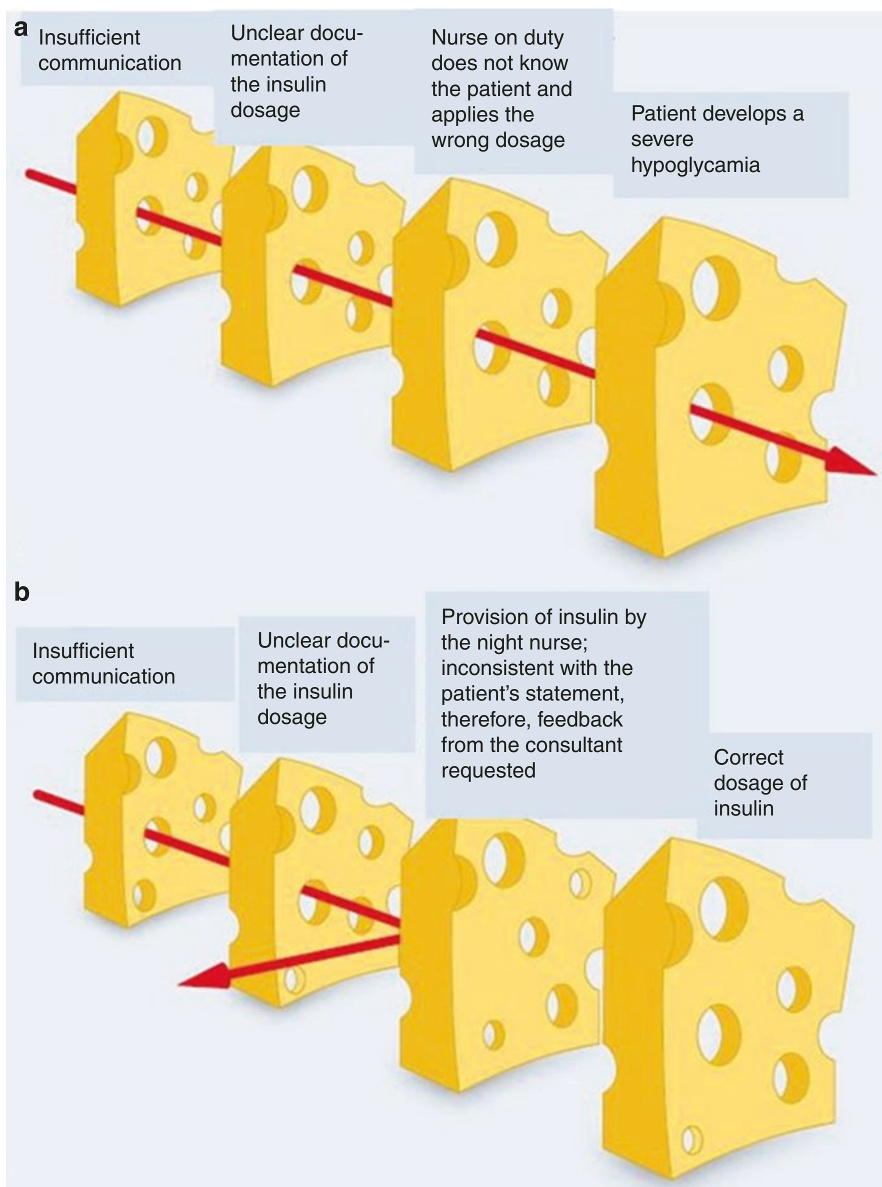

Fig. 6.5 Swiss cheese model. (**a**) Depicts when no back-up and checking system is in place, causing incidents. (**b**) Shows the incidents avoided because there are back-up and double-checking systems in place

expert: 'Who will admit to making mistakes if he is supposed to know everything related to his expertise and managerial level? What are the consequences for me, as a doctor? What must I expect if I admit to having made a mistake?' Within the hospital a mind shift has to take place: the staff must recognise that criticism is

something that can be used in a positive way. And that it drives the hospital forward if it is treated constructively and is a part of the work environment. Doctors often voice support for CIRS as a good and efficient tool to external stakeholders. The internal reporting from clinicians tells a different story.

Medicine is still perceived as a zero error zone. Unfortunately this perception does not mirror the everyday reality of hospitals. The following anecdote illustrates this:

Anecdote

"Let us take Mrs Moore as an example. She is the wife of the multi-millionaire Moore, the creator of Moore's Law. Once she was admitted to John Hopkins Hospital. Around midnight a night nurse makes her ward round: 'Mrs. Moore, your injection!' Mrs. Moore asks: 'Which injection?' The nurse: 'I have to give you your injection.' 'I am not supposed to get injections.' 'Here is my instruction; you are to have an injection.' 'I don't want to get an injection.' 'Oh well', says the nurse, 'I'll call the doctor. He has documented it clearly but if you insist. After all it is after midnight, he won't be pleased, but I'll ask him.' Mrs Moore finally gave in: 'No, we don't want to disturb him. Give me the injection.' The injection was insulin. It was not intended for Mrs Moore. The lady in the bed next to her was asleep. Mrs Moore fell into a coma, but luckily survived.

Mr Moore, a wise man, did not sue the hospital but instead implemented a quality management improvement programme known now as the 'Moore Foundation of Nursing'. His view was: whose fault is it? Is it the behaviour of the nurse that deserves criticism? The doctor for his wrong documentation, and that he was not to be woken up? The nursing manager? The consultant on call? The HoD? The pharmacist who put Mrs Moore's name on the medication? The Chief Operating Officer (COO) who is responsible for the medical departments? The CEO? The head of the holding? The vice-president of the Medical Association? The Minister of Health?

The biggest problem factors exist in the variability, the irregularity of processes, broken processes and the uncertainty of processes. We experience them in our everyday life and accordingly also in the hospital" (Salomonowitz 2009).

However, CIRS is also used as a tool to express 'gripes' and current tensions. Consequently, CIRS reports separate incidents 'without injury to patients' (medication swopped, wrong infusion mixed before administration to the patient, mother's milk exchanged etc.), from those incidents that result in injury to patients and those arising from interpersonal problems. Transparent reporting is required for the patient's benefit. Even if the patient has not been injured, s/he must be informed if a breach of rules has occurred. If patients or relatives were to be informed via another source, trust in the hospital would be damaged forever.

6.9 Change Management by Outsourcing

This chapter discussses outsourcing of processes as an alternative form of change management. In outsourcing, work or business processes of a hospital are given totally or partially to external service providers. These services present a special

form of external procurement of services that have previously been handled in-house. The duration and the subject of the service are fixed by contract. This differentiates outsourcing from other forms of collaboration. The most often used departments for outsourcing are laundry, IT, security, outpatients and, where an emergency an external medical centre is attached to the hospital, laboratory, radiology, and, pathology or there could be strategic hospital development through external consultants.

Hospitals can improve their image by outsourcing processes. If the catering and canteens are serviced by an outstanding caterer, this could also attract non-patients to use it, particularly in small towns.

Outsourcing includes in-house or external allocation:

- In *internal outsourcing,* a partial area of the hospital or the hospital group is assigned to another provider in the same group (e.g., hip replacements will be carried out by casualty surgeons instead of orthopaedic surgeons; neonatology and birth medicine will be transferred to another hospital within the hospital chain; the hospital establishes another hospital, such as an outpatient health centre, to optimise after care and shorten the duration of services; a service is subcontracted in-house (e.g., all hospitals/departments of the entire group are charged by the in-house cleaning firm for cleaning according to the floor area).
- *External outsourcing* takes place when services are given to external regional or global companies (typically: cleaning, laboratory, radiology, pathology). Over the last few years, outsourcing of services has become strategically important in hospitals due to cost constraints (Sect. 3.7). For successful outsourcing, modern service and logistics concepts must be applied. Some hospitals send all their hospital laundry to a neighbouring country for washing, although this approach is not in accordance with green hospital goals (www.greenhospitals.net). An alternative could be to join a group of hospitals and have the laundry done at the same place. The hospital is then less vulnerable to bottlenecks caused by events such as strikes, the onset of winter, and epidemics. A collective arrangement also reduces the carbon footprint of each hospital and so contributes to protecting the environment (Sect. 7.8).

There are a number of reasons for outsourcing:

- The hospital is able to concentrate on its actual core competencies (service processes) and it is therefore optimally adjusted and focussed on market requirements.
- There is a lack of qualified staff or technical knowledge in the hospital.
- Efficiencies improve, by, for instance, the external company collecting laboratory samples directly from the wards.
- Caused by the reduction of costs, the hospital is financially more flexible and can react faster to changes.

However, there are also difficulties and challenges involved with outsourcing. The cost-effectiveness can sometimes not be correctly calculated in advance. With

regard to pricing and price increase, the hospital is more dependent on an outside company. The quality of the outsourced processes can only be influenced indirectly (e.g., if the IT maintenance and support of the entire hospital was outsourced and the obtained support remains below standard). Furthermore, the specific expertise of the hospital is not protected if services are given to third parties.

Further problems of outsourcing include quality requirements, interruptions in the communication structure and shortage of resources (lack of linen at the outbreak of an epidemic, missing devices, lack of surgical tools, etc.).

Experience has shown that occasionally extensive effort is needed for communicating and coordinating matters between the outsourcing entity and the contractor. The secondary costs arising are usually not calculated by the hospital because they are compensated for the existing staff. This is illustrated in the following case study:

Case Study
A COO has decided to outsource the emergency department including radiological modalities, as the low reimbursement rate per case does not cover the incurred costs. To provide these services, the emergency department has been outsourced and subcontracted to another location. Over the next months, the hospital staff (porters, nurses, support staff and doctors) are engaged in answering logistic and external inquiries without being able to charge for this service.

Conclusion: The hospital management cannot understand the reason why staff still has to work overtime even though the emergency processes have been outsourced.

If a hospital is looking at possibilities to outsource, the long-terms risks must be carefully considered and calculated. Returning to the previous situation is almost impossible or only at very high costs.

6.10 Summary

Change management includes all planned, controlled, and monitored changes in structures, processes, and the hospital's culture. A hospital run by a church would presumably possess a different culture from a public hospital or a private hospital group. The methods of change management are *business engineering, BPR, Kaizen and CIP* (Chap. 4). An integrated change management approach combines human resource management and communication of change. Change management includes the entire time frame of the change process. It can be divided into *seven steps*: from assessing the sponsor to monitoring the process. Sponsors, agents, affected persons, and advocates are typical roles adopted in effecting the change process. Possible causes of failure are organisational or personal opposition. These need to be

considered in advance and relevant countermeasures must be taken accordingly. Outsourcing is another method of change management. The strategic advantages and risks must be carefully analysed beforehand.

6.11 Five Reflective Questions for Practical Application

1. How open-minded is your department/hospital towards change? Would you describe it as low, medium or high?
2. Which changes have you implemented during the last twelve months? What type of opposition did you encounter? What form of resistance led to failure?
3. Can you define who the sponsors, agents, affected persons, and advocates are for a current project in your department/division or hospital?
4. Have you established CIRS in your department/hospital? Describe three positive results in your hospital processes. If none, give reasons.
5. How is CIRS being received? Which forms of resistance do you encounter in its implementation and its daily use?

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7 Develop and Communicate Your Strategy

Goals

- Which performance indicators can you apply to analyse and develop the various departments and the hospital further?
- Why do financial performance indicators have only limited relevance?
- What can you expect from the Balanced Scorecard?
- Why must the Balanced Scorecard cycle be continuously repeated?

This chapter guides you in developing goals from your vision statement. It outlines in detail the Balanced Scorecard (BSC), the different perspectives and the approach to applying it. Problems that may occur are described. Measures of communication are briefly explained.

"Your most unhappy customers are your greatest source of learning." (Bill Gates)

Diagnosis-related groups (*DRGs*) were developed in the 1980s by a collaboration between the Yale School of Management and the School of Public Health. Hospital cases are classified into groups based on International Classification of Diseases (ICDIO) coding and co-morbidities. This method replaces cost-based reimbursement. Important parameters are the *case mix index*, which highlights the complexity of cases, the underlying *base rate* for cases, the *maximum duration of stay* for each DRG and the *readmission rate*. In the UK called Healthcare Resource Groups (HRGs).

Diagnosis-related groups enhance the transparency of the financial situation of health care providers. Hospitals have now to publish the number of services, treatments, modalities, hospital-acquired infections, surgical interventions, bed occupancy rate etc. in their annual reports. Frequently, special emphasis is put on the presentation: well-designed glossy brochures picture caring hospital staff treating

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satisfied patients. A genuine comparison and benchmarking of hospitals, as is propagated and aimed at, is still seldom possible.

However, the hospital's most important performance indicators are known only to a few insiders in the executive management team. The director of finance holds the money and the power associated with these resources. Only a few staff members in the hospital have a sound economic business knowledge, although everybody – including interns, registrars and nurses – is being asked to work economically. How this can be achieved was not taught during their training. Whether the year has been a good or a bad one will mostly be outlined in the annual New Year's speech given by the CEO. The new year is always rated as difficult, partly because of the annual budget negotiations with the various health insurance funds and with the local and national government as well as health care purchasers.

The knowledge of the financial indicators and the allocation of funds is frequently abused in power struggles between different departments. If more people in the hospital possessed sound economic knowledge, they could use this expertise to demand higher transparency and pursue common goals to drive the hospital forwards in a bottom-up approach.

7.1 From Vision to Objectives

The *Balanced Scorecard (BSC)* offers a good path for developing sustainable future strategies beyond the key performance indicators. In addition, the BSC furnishes all staff with valid decision criteria. It was developed in the US for businesses during the 1990s by Robert Kaplan and David Norton (Kaplan and Norton 1996). Their studies investigated what a performance measurement system should be like in the future. One of the major underlying questions was whether monetary indicators are sufficient or whether non-monetary indicators are just as important for the long-term operation of an enterprise such as a hospital. They said that only one instrument (for instance, financial data) was not adequate for controlling an enterprise. Consequently, they developed the BSC and suggested using three other types of indicators, apart from the financial ones (financial perspective):

- Indicators related to the clients (patients/referring specialists): *client perspective*
- Indicators related to the processes: *internal business process perspective*
- Indicators related to learning and growth: *learning and growth perspective*

7.2 Four BSC Perspectives

However, Kaplan and Norton (1996) do not see these four perspectives as fixed parameters appropriate to every kind of enterprise, but instead, as a template for developing one's own BSC. First used in a classic business environment, BSCs are now gaining importance in hospital settings (Stewart and Bestor 2000; Zelman et al. 2003). The outline below no longer refers to the business environment generally but to hospitals specifically. Norton and Kaplan applied the client's perspective to businesses. We now subdivide a hospital's clients into referring doctors and patients,

Fig. 7.1 From mission via strategy and balanced scorecard (BSC) to the objectives (Pyramid)

thus forming two sub-groupings of the client's perspective, being the referring doctors' and the patients' perspectives.

The BSC is a method that increases the probability of a planned strategy reaching implementation: it starts from a mission statement, derives objectives from strategies, and substantiates these objectives by means of measured values, goals and actions. This refining and substantiating of objectives can be represented as a pyramid, as shown in Fig. 7.1, which depicts how the hospital's strategy can be converted into concrete activities on the individual level. Every department and every staff member will know how they can contribute to the company's success. The goals of BSC usually relate to performance indicators, and for these key data indicators specific goals are defined, in particular what precisely has to be achieved (Banker et al. 2004).

In business management, performance indicators can be used to evaluate companies and hospitals. They also play an important role in the BSC, serving as the basis for decisions (problem recognition and presentation in addition to the acquisition of relevant information), for monitoring (target versus actual performance comparison), for documentation or coordination (behaviour control) of important facts and interdependencies within the hospital. Performance indicators can be subdivided into categories, some of which are shown in Fig. 7.2.

In controlling and monitoring processes within a hospital, traditionally the focus rests on financial key data, such as profitability or liquidity. In health systems that apply DRGs the *case mix index* and the *base rate* are important financial indicators. Financial key indicators give an indication of the financial success of a hospital, but for the following reasons they are insufficient for its strategic orientation.

Financial performance indicators often refer to the past. This diminishes their helpfulness when positioning a hospital appropriately for the future. It is not possible to derive a reliable prognosis of the performance for the next year from the turnover and profit of the previous year. Therefore, financial performance indicators can give only limited help regarding a good or a less favourable development of a hospital.

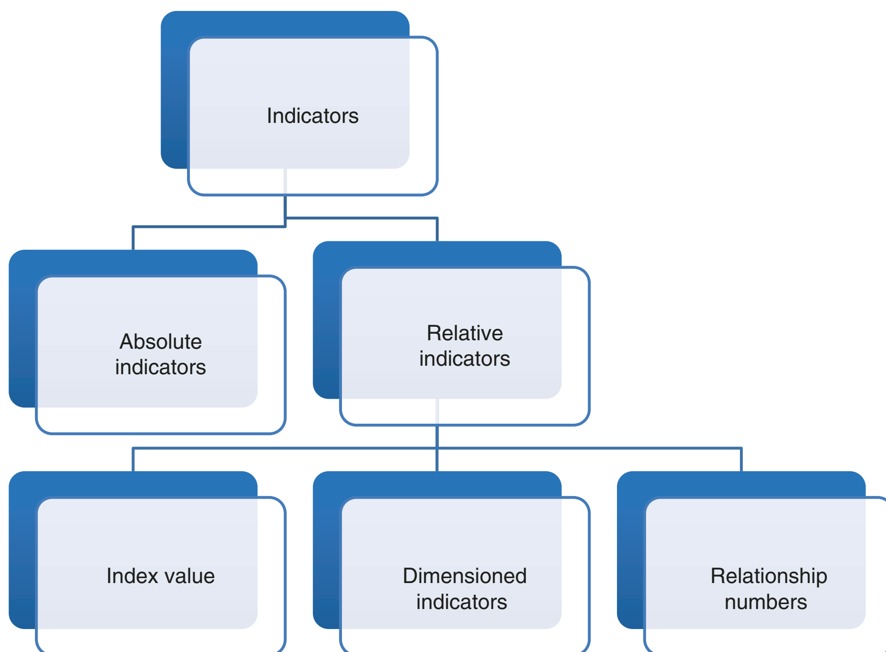

Fig. 7.2 Classification of performance indicators

Performance indicators can be used to measure business processes and improve them. They include information on technical and business management matters as well as on processes, stakeholders, shareholders, staff or clients (patients, referring doctors; Fig. 7.3).

The vision and strategy of the hospital or a hospital group form the key factor to measure the performance indicators. They provide the management executives with a comprehensive overview of the performance and effectiveness of the hospital and its business processes. BSC is based on the assumption that a one-dimensional description and control of a hospital is not realistic. With the help of the BSC, other crucial parameters of a hospital can be illustrated and the information necessary for controlling the hospital can be made available. Thus, the BSC facilitates a holistic management and key data system, which, in addition to the financial perspective, includes non-monetary performance indicators. Based on the BCS concrete actions can be taken and monitored to align the performance of the staff with the hospital's vision and goals. In a BSC, key data with a different chronological reference are needed, such as early (performance drivers) as well as late indicators (result key data):

Leading (early) indicators give an impression of the course the hospital is taking. They can facilitate the development of the hospital and indicate whether the objectives will be achieved. They are therefore called performance drivers. A good example of a performance driver is the number of recourse claims and complaints. Admittedly, they do not mirror treatment results but they give an indication of the

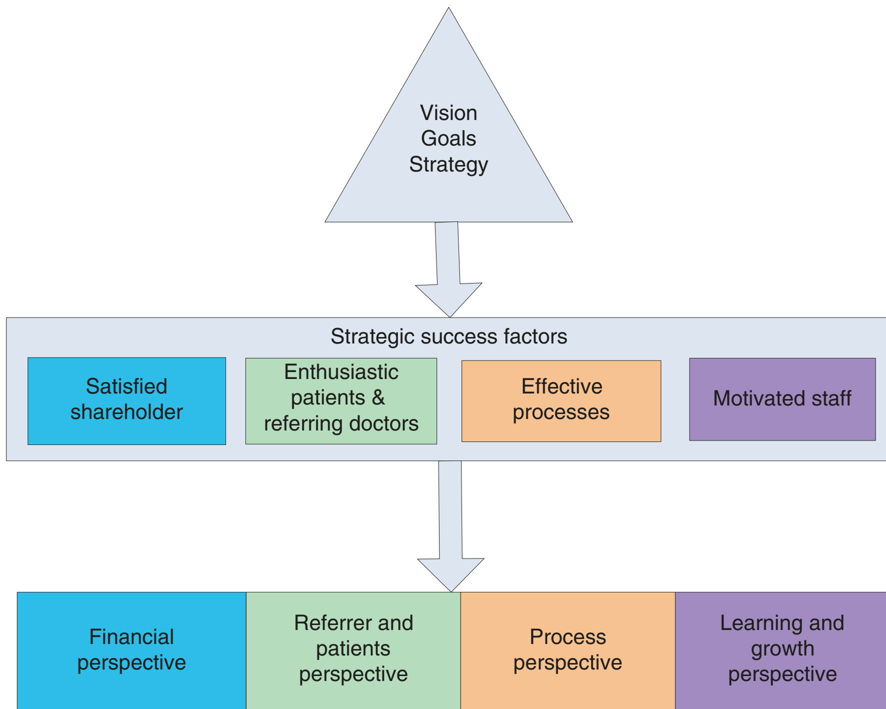

Fig. 7.3 Cross-linkage of individual perspectives to vision and strategy

quality of service deliveries in the hospital. A change of this performance driver is going to affect the hospital's results (lagging indicators) in the foreseeable future.

Lagging (late) indicators show whether the hospital has reached its objectives. A typical example of such an indicator is the number of patients treated. This number indicates whether a hospital has reached its goals. This key indicator does not, however, provide insight into any future development of the hospital. In some health systems the number of cases are budgeted and hence limited. Hospitals are then unable to thrive economically by increasing the number of cases, since additional cases will not be reimbursed. The prescribed aspects of the national health system framework affect hospitals and influence their economic and strategic alignment.

Combination of leading and lagging indicators Both kinds of indicators are only valuable when they are looked at together. It is the combination of performance indicators relating to the past and to the future that makes the BSC most useful:

- Lagging indicators on their own only indicate which objectives the hospital wants to achieve in the long run (turnover). They do not indicate how these objectives will be accomplished (lowering of error rate).
- Leading indicators on the other hand, enable only short-term, operative improvements (lowering of complaint rate; recourse claims). However, one cannot see whether, and how, the financial results have been changed by these performance drivers.

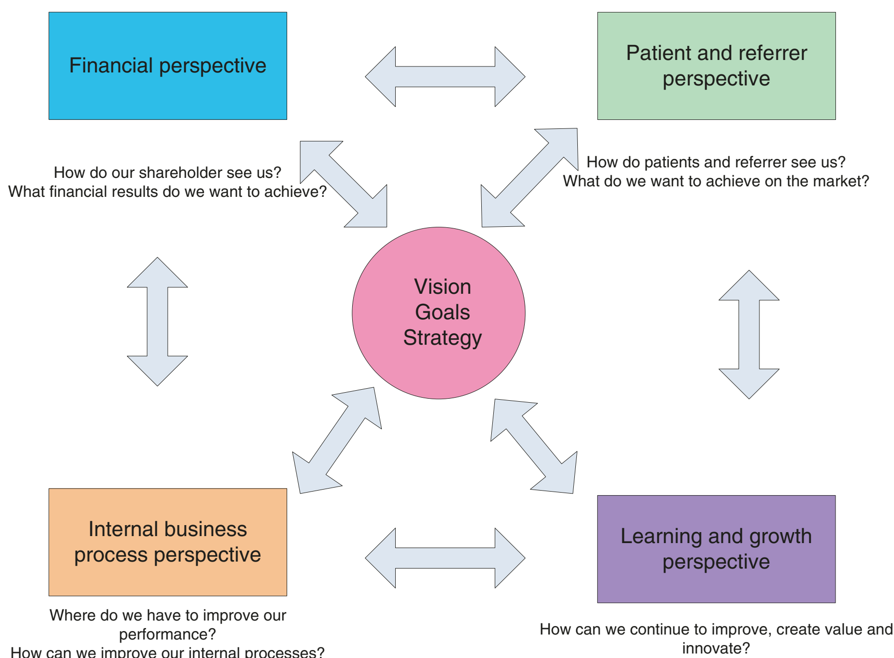

Fig. 7.4 Standard perspectives of BSC

Accordingly, leading and lagging indicators are defined for each of the four perspectives. This makes it possible for the hospital to be guided in such a way that its strategic objectives for all four perspectives may be reached in a balanced way (Fig. 7.4).

- The *Financial perspective* serves as an orientation for the other perspectives. It includes information about a hospital's financial position and performance. For this purpose, the key data of efficiency (e.g., process costs) and effectiveness (e.g., savings) can be utilised.
- The *Patients' and referring doctor's perspective* provides information about the services by which current and future patients and referring doctors can be attracted to the hospital. A possible key figure for this would be the patient's satisfaction rate.
- The *Internal business process perspective* describes the most important characteristics of the business processes and assesses them according to costs, time, and quality. The focus is less on the improvement of existing hospital processes, but rather on the identification of potential client requirements, such as referring doctors and patients. Process perspectives include key data such as patient waiting times, average length of stay, case mix index, etc.
- The *Learning and growth perspective* defines the necessary infrastructure to enable growth and improvement of the hospital's competitive position. In these areas only 'soft' performance indicators are utilised (e.g., staff qualifications in the field of managerial and economic processes.)

7.3 The Role of the Cause-and-Effect Chain in BSC

The BSC helps to visualise hospital performance indicators for the staff. Thus strategic objectives become evident for the people involved. The strategies are anchored in every-day operations and the budget and, if necessary, are adjusted to the changing environment. In this way, the visions and the derived strategic objectives are measurable.

It is not so much a matter of grading the performance of the past but also of monitoring the variables that strongly influence the performance of your hospital in the future. Therefore you should use the BSC as a tool for implementing strategic objectives.

Through the cause-and-effect-chain, the hospital's strategy is linked to the clients' perspective (patient and referring doctors' perspective). This is connected to the hospital's processes and in turn to indicators on the learning and growth perspective. The challenge lies in choosing fewer but at the same time relevant performance indicators which influence each other in the various perspectives. For instance, a client performance indicator should be selected in such a way that its achievement has a positive effect on the associated financial indicator.

The development of a BSC is at least as valuable as the resulting objectives, performance indicators and their measures. In developing the BSC, you and your staff gain deeper insight into the future alignment between key indicators and performance. It results in a stronger identification with the hospital's objectives. Consequently, the motivation of the staff increases to play a part in a hospital's business processes and contribute to them (Fig. 7.5).

The introduction of BSC forces management and staff to reflect on the hospital's vision and strategy and, where applicable, revise it. The BSC links a hospitals' past with its future. The communication at traditionally difficult interfaces, for instance between the hospital management and the medical staff or between accounting, procurement and operational business, can be distinctly improved by the common 'language' of the BSC.

The BSC serves as a leadership tool for aligning the organisation to the strategic goals in the various perspectives (finance, patient and referring doctors, processes, learning and growth). Unlike guiding principles and other fuzzy formulations, the BSC tries to make the goals tangible and implementable by deriving measures from it.

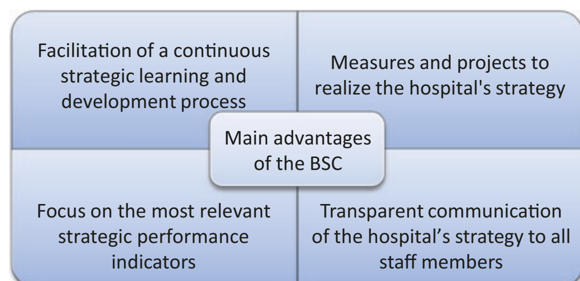

Fig. 7.5 Advantages of BSC

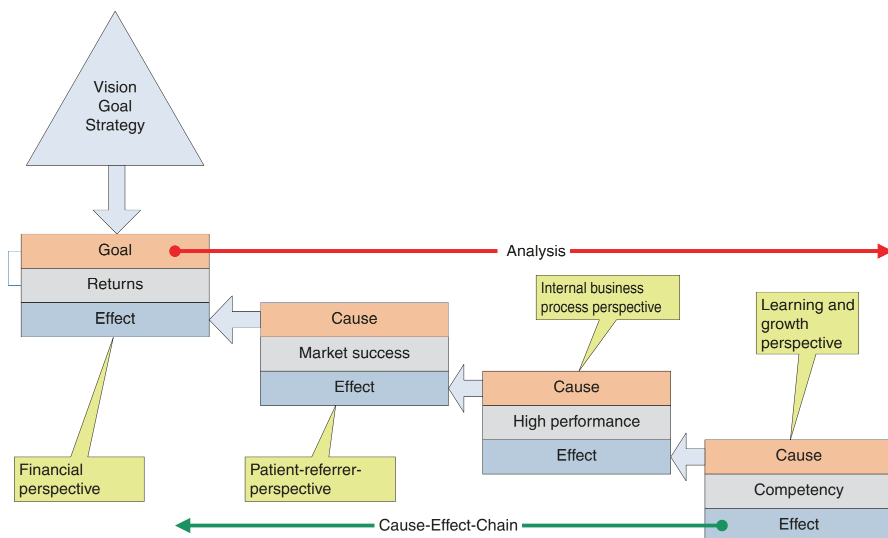

Fig. 7.6 Functioning of the cause–effect chain

The above-mentioned perspectives are interlinked by a logical cause–effect chain that is described as a cause–effect diagram. Not all links are set out here, only the strategically intended cause–effect ones (Fig. 7.6), i.e., connections that are important for the hospital's goals and strategies.

The core element of the BSC is the establishing of this complex web of reciprocal relationships. The participants often have very different perceptions about cause and effect. However, intensive and open communication between the hospital's various stakeholders can bring about the necessary process of reaching consensus.

By thinking in terms of perspectives and the various links, you can highlight the essential interdependencies in one system to support the implementation of your strategy. While you document the cause-effect chain on three or four pages, your strategy is described entirely. Therefore, the cause–effect chain is also called a strategy map. Every change in one of the BSC performance indicators has thus an effect on other indicators. This underlines how the entire hospital is reflected in the BSC. Although individual perspectives are balanced among themselves, the financial perspective plays a kind of leadership role. In the long run, the other perspectives must eventually improve the hospital's financial situation.

The connection between key performance indicators and the cause–effect chain (strategy map) is depicted in Fig. 7.7 (modified according to Kaplan and Norton 1996).

Within the BSC, the following points for the cause–effect chain must always be kept in mind:

– When interlinking all key data, this often results in a kind of spider's web. Within this net, no performance indicator can change without having an effect on the others.

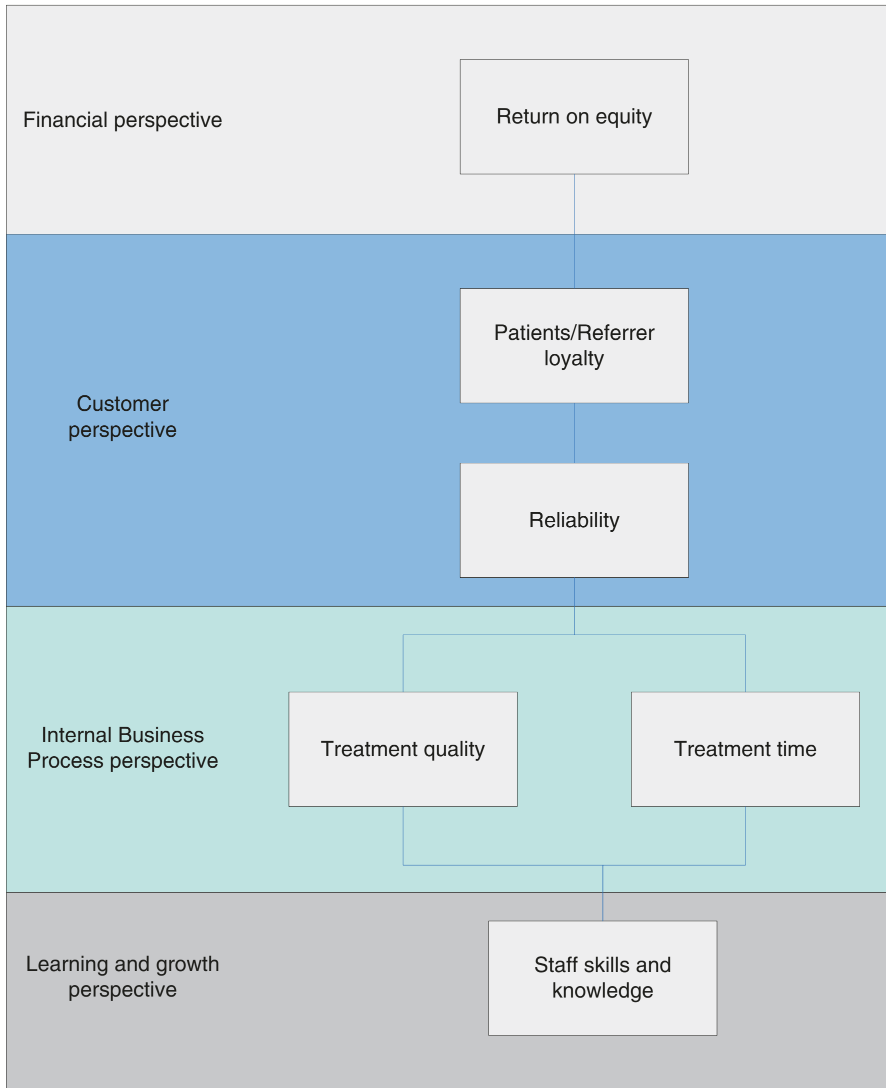

Fig. 7.7 Example of a cause–effect chain (strategy map) with the different perspectives

– The cause–effect chain connects the entire hospital with its objectives. In this way you achieve a more in-depth discussion of the performance indicators within the hospital.
– The hospital's strategy is expanded to the entire hospital because every individual directly influences the results of the BSC.
– The hospital can better utilise their change potentials through the cause-effect chain. You can explain the effects of single changes for the entire hospital.

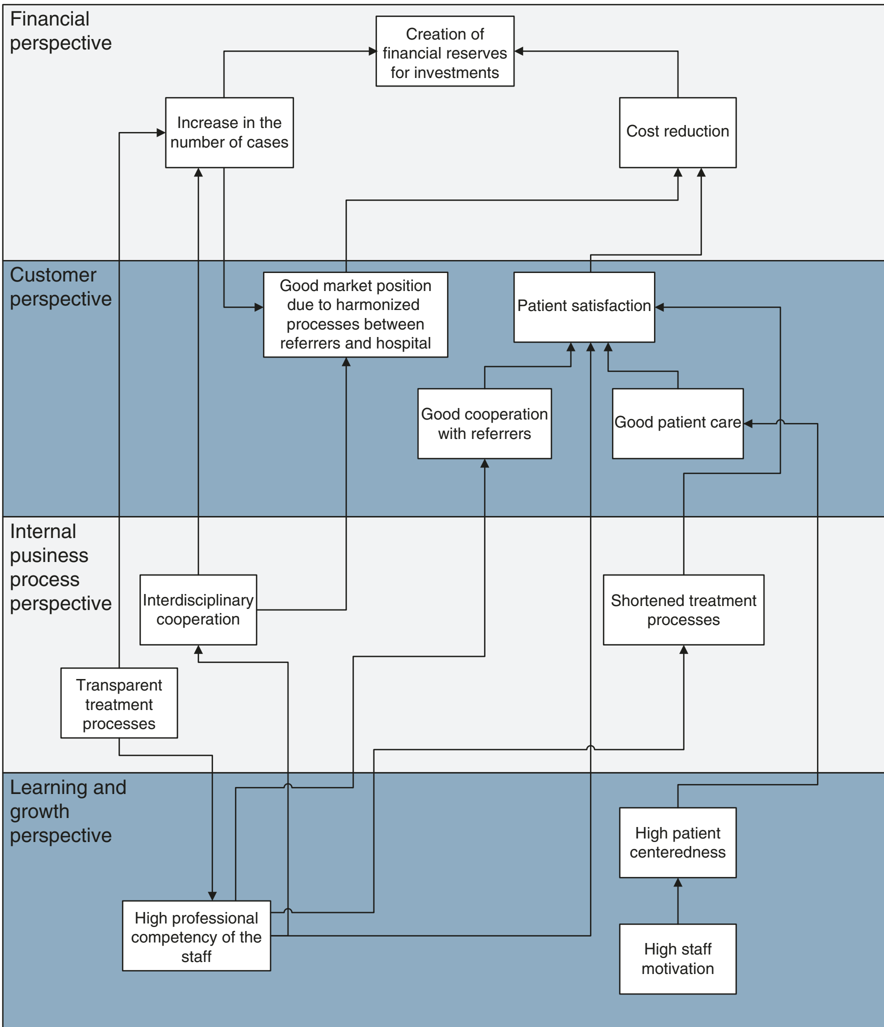

Fig. 7.8 Strategy map interconnecting the various perspectives

A further example of the implementation of a strategy into a cause–effect chain is shown in Fig. 7.8.

Case Study
The BSC has been utilised in various hospitals and departments. An example is Duke's Children's Hospital in Durham (North Carolina, USA) (Kaplan 2001). This hospital introduced the BSC to react to a number of changes in the environment, such as

– The average length of stay is too high and above the national average.
– The hospital is uncertain about their service provision.
– There are no goals to which management, doctors and nursing staff agreed on.
– Communication and cooperation with private paediatricians is inadequate and unsatisfactory.
– The hospital's position on the market is threatened by competing medical facilities.

Despite all these difficulties the hospital pursues the vision of becoming a 'centre of excellence'. Patients, parents and referring doctors should be offered the best possible, empathic treatment with outstanding communication. The following goals are set: patients should experience a high degree of satisfaction, a high rate of recommendations, excellent information and the best admission and discharge management. The referring doctors should be provided with a high degree of communication and have consistent contact persons in the hospital.

These goals were reached by applying the BSC. Within the first years, the average length of stay decreases and a higher case-mix is achieved as intended. In addition, loyalty and satisfaction increases in both patients and staff.

7.4 Implementing the BSC

> Budgeting: a method of being annoyed before, rather than after spending the money. (Voltaire)

The introduction of the BSC is not a process that is concluded after one run-through cycle. The implementation is a continuous cycle that is repeated again and again. This approach transforms the BSC into a strategic operational framework for the hospital. Each strategic decision falls within the course of the BSC. As an integrated and comprehensive management approach, the BSC provides a continuous cycle with the following phases (Fig. 7.9):

– *Development of a strategy*: setting up the hospital's vision and strategy; formulating the BSC based on an analysis of the environment and hospitals potentials.
– *Communicating the strategy and initiating the objectives*: communicating the vision and mission statement and connecting the objectives with individual performance parameters in specific areas, departments and teams by applying BSC key performance indicators.
– *Setting up and implementing plans*: integration of BSC key performance indicators into regular controlling (reporting, budgeting and forecasting).
– *Strategic feedback, learning, adapting*: regular revision of the BSC, and monitoring the BSC key performance indicators with regard to their relevance to success.

Fig. 7.9 BSC cycle

To summarise the above, a hospital that employs a BSC will first have to be certain about its vision and strategy. Then the vision and strategy are transformed into the hospital's objectives and circulated within the hospital. The objectives must then be implemented. In the planning phase, this needs to be separated from budgeting. It should rather meet the strategic planning and alignment of the hospital with the objectives. The strategic feedback, results and new knowledge closes the BSC cycle and leads to the review of vision and strategy (Fig. 7.9). Currently, a frequent limiting factor is that the strategy is based on the budget instead on the vision of the hospital.

The BSC links the development of a hospital strategy with its implementation. At the same time, the objectives are specified and monitored by the performance indicators. In this way deviations from the specified goals by non-adherence to key data will become evident at an early stage.

We will now discuss in possible goals for the four perspectives of the BSC, such as key performance indicators, the target values and possible measures. Accordingly, each perspective should provide information (Fig. 7.10) on:

Objectives (strategies): in general, long-term economic success and medical–strategic alignment will secure the survival and the development of the hospital.

Key performance indicators (*dimensions*): after the objectives have been set up, you have to deduct indicators that permit measuring the degree of success in reaching a goal in each area.

Target parameters (*values*): in the context of implementing the objectives, you have to specify concrete target values for each of the measures taken. These targets should relate to the actual values.

Measures (*initiatives*): you specify your initiatives to achieve the objectives.

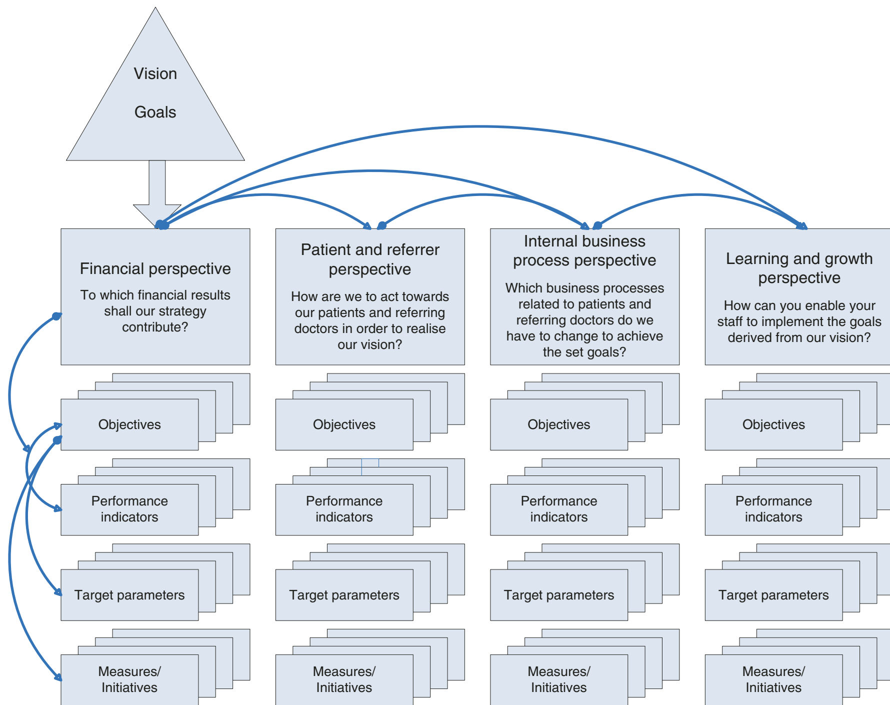

Fig. 7.10 The different perspectives of the BSC

7.5 The Financial Perspective

In the BSC approach, the following questions cover financial perspective: How do we as a private or non-profit hospital have to visualise our success? How can we demonstrate the financial success of our vision? In the development of the BSC, the following specific steps must be implemented:

– Define financial objectives
– Determine key performance indicators (leading and lagging indicators)
– Specify target parameters/values for the key performance indicators
– Introduce measures and initiatives (including responsibility and time frame)
– Organise feedback (continuous development of the strategic goals; Fig. 7.11)

7.5.1 Objectives of Financial Perspective

Although the different perspectives of the BSC are of equal importance, financial success is the primary goal of every enterprise, including a hospital. Even a public

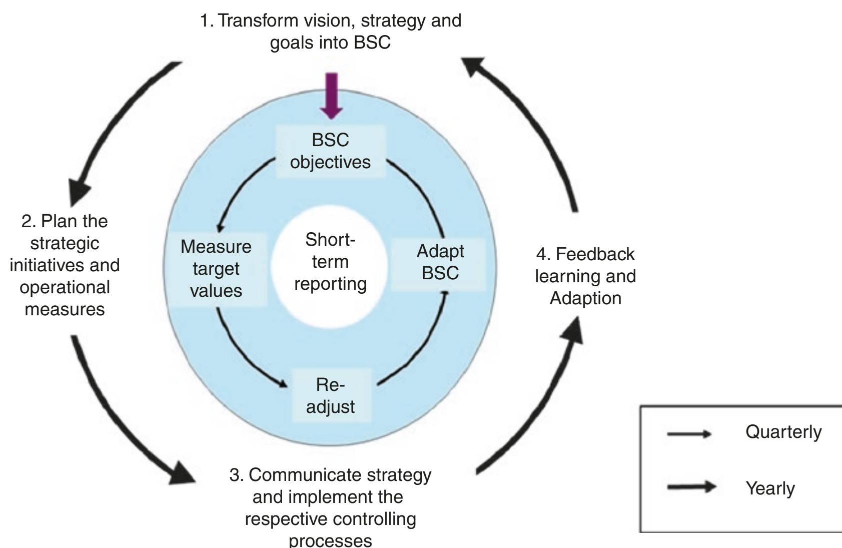

Fig. 7.11 Control processes of the BSC (Modified according to Kaplan and Norton (1996))

or non-profit hospital has to work economically so that future capital investments can be made to ensure the continued development of the hospital according to the demands of the market. The key indicators of the other perspectives are interlinked and therefor influence improves the financial performance of a hospital or a hospital group.

By introducing the BSC, or in the course of strategic planning, part of the profits can be sacrificed for the sake of promoting certain things. However, it is expected that eventually these will contribute to an increase in profits. Examples are: members of staff are trained so that the knowledge they have gained will later be used for improving the business results, or a hospital department that is not profitable is supported and promoted by other departments to increase future performance.

7.5.2 Key Performance Indicators of the Financial Perspective

Most hospitals usually have a large number of key indicators for the financial perspective. Therefore, the right ones must be chosen for the BSC. In contrast to key indicators of the other perspectives, the key indicators of the financial perspective are well known to the hospital management and the finance department. The financial triangle (Fig. 7.12) depicts the key indicators and objectives of the financial perspective of a BSC. The following objectives could form the basis of the financial perspective in the hospital:

- Growth of profitability and mix of earning sources, i.e.,
  - Extension of services to reach new patients and new medical fields
  - Change to services with higher value creation
- Decreasing costs and increasing productivity, i.e., by reduction of the direct and indirect costs of services
- Utilisation of assets and investment strategies
  - Better utilisation of the hospital's resources, e.g., subletting of unused training facilities to third parties during weekends, evenings, and holidays
  - Reduction of current assets

Possible key indicators for profit growth and various earning sources. With regard to the above-mentioned objectives, the following key indicators are relevant for the growth of a hospital:

- Proportion of revenues from new services
- Turnover in new treatment areas
- Enlargement of the target market share
- Profitability of patient groups or treatments
- Turnover regarding new patients and referrer

Possible key indicators for decreasing costs and improved productivity Potential key indicators for reducing costs and/or increasing productivity in a hospital are:

- Costs of the hospital compared with competitor (benchmarking): costs per case
- Reducing costs: comparing costs in various departments
- Increased productivity: profit per department/patient/referring doctor

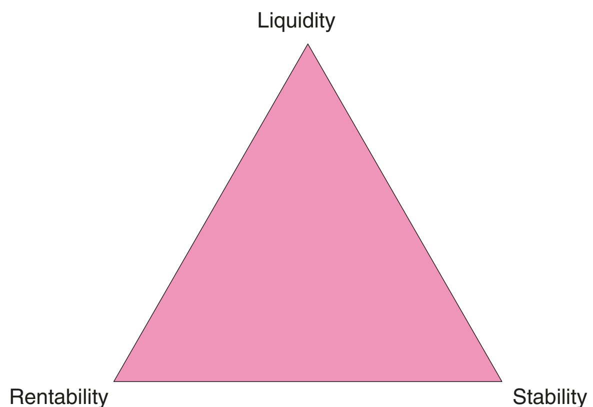

Fig. 7.12 Key indicators of the financial perspective

Table 7.1 Examples of the implementation of goals from the financial perspective

Objectives	Key performance indicators	Target parameters	Measures/initiatives
Competitive cost structure	Reduction of costs	Annual reduction by 10 %	Outsourcing or privatisation of certain services (outpatients, laboratory, radiology, pharmacy)
Reduction of tied capital	Increase in utilisation periods of facilities	Additional 2 years	General overhaul, shorter maintenance intervals

Possible key indicators for utilisation of assets and/or investment strategies. The alternatives for key indicators for the utilisation of assets and/or *investment strategies, are:*

- Shareholder value
- Cash flow
- Growth of turnover
- Increased service life of devices
- Utilisation of assets depending on turnover (investment rate, investments in research and development)

The implementation of goals in objectives, key indicators, target values and measures could, for example, look as described in Table 7.1.

7.6 Patient and Referrer Perspective

From the patients' and referring doctors' perspective, the following questions cover the BSC approach: how do we act towards our patients and referring doctors to realise our vision? In the development of the BSC, the following specific steps must be implemented:

- Develop objectives for the different target groups
- Define key indicators (early and lagging indicators)
- Specify target parameters/values for the key performance indicators
- Introduce measures and initiatives (including responsibility and time frame)
- Organise feedback (continuous development of the strategic goals)

7.6.1 Objectives of Referring Doctors' and Patients' Perspective

For the layout the referring doctors' and patients' perspective, the following considerations must be made:

- The hospital must satisfy the requirements of referring doctors and patients.

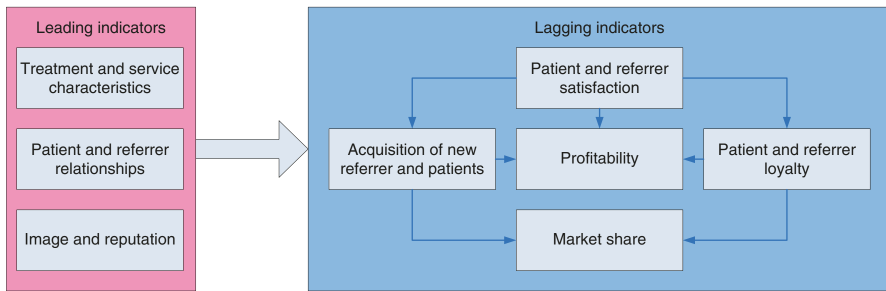

Fig. 7.13 Leading and lagging indicators of the referring doctors' and patients' perspective

– The hospital must determine the focus in which medical fields it wants to be competitive.
– The hospital must clarify in which way it offers the services to the patients and the referring doctors.

7.6.2 Key Performance Indicators of Referring Doctors' and Patients' Perspective

Lagging indicators are already commonly used in many hospitals. In their basic form, they are unique for all hospitals but still have to be adjusted to the specific requirements. Many of these lagging indicators can be turned into early indicators by changing the angle from which they are viewed: Patient loyalty and patient satisfaction can quickly turn into early indicators in case of forward-looking treatments and therapies (e.g., laser operations, minimal invasive techniques, interventional endoscopy, day-hospital treatments and outpatient surgeries). Figure 7.13 illustrates early and lagging indicators as well as the different interrelations.

Leading Indicators of Patients' and Referring Doctors' Perspective They enable observations about future treatments and are valuable indicators for the future market.

Leading Indicator – Satisfaction of Patients and Referring Doctors The satisfaction of referring doctors and patients is an important factor for a hospital. Satisfied patients will return to the hospital for other medical conditions. They are a credit to the hospital and will tell others of their positive experiences (multipliers). The following examples of key indicators for patient satisfaction can be established by questionnaires:

– Survey results of general patient satisfaction
– Recommendation rate
– Number of positive feedbacks from patients' and referring doctors'

Leading Indicator – Patients' and Referring Doctors' Loyalty The loyalty indicator provides information on how well the hospital looks after the patients and referring doctors. Many hospitals only concentrate on new patients. Existing relationships are not fostered and referring doctors and patients might turn to other competing health care providers such as hospitals, day hospitals and colleagues in private practice. It is often forgotten that it is more cost-effective, and thus more profitable, to foster a customer base than to acquire new customers. The following example illustrates that loyalty indicators for referring doctors and patient are comparatively easy to ascertain in-house:

– Share of turnover of 'long-standing' referring doctors and 'long-standing' patients
– Growth of 'long-standing' referring doctors and 'long-standing' patients
– Allocation and referral frequency

Leading Indicator – Treatment and Service Characteristics The quality of medical treatments and services a hospital offers in the following three areas is important for referring doctors and patients:

– Personal and individual attention
– Quality of care
– Waiting and treatment time

The following key indicators can – if used correctly – give an early indication of whether the hospital is on the right track in fulfilling its clients' requirements:

– Accessibility and availability
– Proportion of re-admissions for the same diagnosis
– Complaint rate - rate of adverse incidents
– Medical services and additional health services

Leading Indicator – Image and Reputation An early indicator for the patients' and referring doctors' perspective is given by the public image of a hospital. Patients will more easily choose a hospital with an excellent reputation. Monopolists have an advantage; however, this can quickly disappear once there are competitors on the market. The press and public relations office can significantly contribute to an improvement of a hospital's image. Some indicators are

– Growth of advertising budgets of the press office
– Number of positive comments/reviews in the media
– Number of articles in the press
– Number of visitors at hospital events (regular and new visitors)

Leading Indicator – Relationships with Patients and Referring Doctors Relationships with patients and referring doctors influence the success of a hospital to a large extent. If a hospital cannot build up positive relationships with the referring

doctors and patients, it will lose them sooner or later. The important points in this context relate to:

– Accessibility of the hospital
– Time to address enquiries, complaints and appointments
– Number of complaints
– Patient satisfaction

Examples for key indicators are:

– Friendliness and customer service awareness of the staff. Surveys among patients and referring doctors are helpful to provide the relevant data.
– Waiting times for admission, at the patient administration, until a telephone call is picked up, requests for appointments are dealt with, etc.

Lagging Indicators from the Referrers' and Patients' Perspective

Lagging indicator – acquisition of new clients. The acquisition of new clients such as patients and referring doctors is important for a sound financial performance. The following key figures for new acquisitions can be ascertained internally:

– Proportion of new patients within the total number of patients
– Growth rate for new patients and referring doctors
– Ratio of newly referring doctors to the number of potential new referring doctors who were contacted

Lagging indicator – profitability. A hospital needs to measure its profitability on a regular basis. In order to recognize if the relationships with other stakeholders are valued, the various contracts with the service providers must be analysed. Occasionally, there might be strategic reasons to exempt an individual service provider from making profit but this should be the exception. As a rule, contracts should make profit. The following key indicators can be utilised:

– Profitability per patient/patient group
– Contribution margin per patient/patient group

Lagging indicator – market share. The market share is also important because it can measure its success with the desired target group. The following target figures can be utilised:

– Market share in a specific market (e.g., regional)
– Market share in a specific target group (e.g., youth, families, senior citizens, old age homes)

Within a specific target group, key indicators measure the share within the total number of patients ('account share' or 'share in the number of referred patients').

Table 7.2 Examples of goals from the perspective of the patients and referrers

Objectives	Key performance indicators	Target parameters	Measures/initiatives
Development of a higher price segment for private patients treated in wards offering 'comfort class'	Number of new private patients in the 'comfort class' wards	Annual increase of 10 %	Marketing campaign
			Sponsoring
Most patient-friendly hospital in the region	Customer satisfaction index	Annual increase of 5 %	Regular feedback from test persons
			Continuous service training for staff

– Example: The total share of a target group covered by one referring doctor (e.g., share of patients suffering from diabetes mellitus and co-morbidities such as hypertension and neuropathy).

The implementation of goals, i.e., the parameters of objectives as key indicators, target values and initiatives could for example be described as in Table 7.2.

7.7 Internal Business Process Perspective

When you apply the BSC to the process perspective, you should ask the following questions: which business processes related to patients and referring doctors do we need to change and how must we change them to achieve the set goals? By developing the BSC, the following specific steps must be implemented:

– Defining the objectives for innovation, treatment processes and patient services
– Determine key indicators (early and lagging indicators)
– Specify target parameters/values for the key performance indicators
– Introduce measures and initiatives (including responsibility and time frame)
– Organise feedback to continuously develop the strategic goals

When you apply the BSC in hospital processes, avoid to put the emphasis on a certain part of the process. Rather, the total process should be analysed from the strategic point of view to identify those processes that are critical for achieving the objectives for patients, referring doctor and shareholder. This step is in line with *business engineering*. For example, the entire process can be subdivided into four different aspects for the relevant key indicators.

– *Innovation* describes the identification of the market and the requirements of patients' and referring doctors' in addition to new services to be offered.
– *Treatment* describes the therapy and treatment offers.
– *Service* includes all services intended for patients. This comprises the service for in-patient and outpatient treatments. In addition can serve to secure patient

satisfaction, e.g., talks of health professionals on certain diseases, diet and fitness for cardiac and stroke patients.
– *Internal and external communication:* communication is a process that can continuously be improved because weaknesses need to be detected and removed and new technology needs to be considered and applied.

In the process perspective you cannot differentiate between *leading and lagging indicators* as the relevant business processes are sequences that are passed through continuously (cycle).

Example: The key indicator 'post-operative care patients' actually appears to be a typical lagging indicator as it provides information on whether patients are satisfied with the services in the hospital. If one uses them to indicate new patient requirements, it turns into a leading indicator.

7.7.1 Innovation

> The best way to predict the future is to create it. (Alan Key)

This process cannot be delegated to colleagues, the departments or the head of the innovation hub. Rather, every staff member, irrespective of his level in the hierarchy, must become actively involved in the hospital's innovation processes to solve problems, e.g.,

– Identification of patients' requirements
– Creation of appropriate services to fulfil the patients' and referring doctors' requirements.

Possible key indicators for the innovation process are:

– Number of newly identified patients' and referring doctors' requirements
– Degree of implementation of identified patients' and referring doctors' requirements
– Project success rate – how many ideas are successfully implemented?
– Time to market (time until practical implementation of the innovation)

7.7.2 Treatment and Service Processes

In all hospital services and treatment processes, each step from procurement to treatment, discharge, and accounts has to be structured in such a way that the services fulfil the patients' requirements in the following respects:

– Quality
– Costs
– Time

Then key indicators can be utilised for the processes:

- Time until appointment
- Number of appointments kept
- Number of complaints and recourse claims

7.7.3 Service for Patients and Referring Doctors

In order to obtain satisfied referring doctors and patients who are to recommend your hospital to other patients, it is necessary to provide support for the patients after the discharge. Some key indicators illustrate how capable these patient services are:

- Number of patients treated after being discharged in collaboration between the hospital and private practitioners
- Lead time to reply and settle queries and complaints
- Waiting times
- Billing and collection times regarding private patients and service providers

One of the most important strategic objectives is a continuously high standard of treatments and services. All patients should be cared for and treated courteously, not only those who know the executive hospital management or the HoD or who complain about their concerns: if patients are successful in bypassing staff, they will increasingly talk to the hospital's management first without having the matter discussed with the people in charge. Consequently, the executive hospital management should redirect decisions and complaints to those responsible for dealing with them: this will ensure that management do not face a loss of competence and, at the same time, they are empowering their co-workers.

7.7.4 Internal and External Communication

A hospital's internal and external communication must be seen as a business process that plays a key role in the hospital.

Internal communication is vital for the BSC, i.e., the dissemination of strategic goals throughout the hospital. This can be measured by the following key indicators:

- *Internal dissemination of news in the hospital's bulletin*: Are staff member interested in the contents? How many staff members read the paper regularly? Which content is read? Are the matters related to the interests of the staff or is the content published by and for the hospital management?
- *Number of staff contributors to the hospital paper.* Is the paper intended to enhance internal communication? Are the concerns of the staff taken up in the

bulletin? Or is it instead seen as a prescribed and persuasive medium working on behalf of the hospital management? Blogs could also present an innovative way of communication enabling staff to express internally, in the hospital, their opinions on projects and strategies; it is also a method that avoids matters being broadcasted outside the hospital, via social media.

External communication, important for defining the hospital's image and reputation, usually comprises three areas:

- Public relations
- Advertising
- Hospital events

They can be evaluated using the following performance indicators:

- Number of positive reviews/articles in external media such as the daily newspapers or television
- Number of participants in hospital events (number of regular and new visitors)
- Number of participants attending 'open days'

7.8 Learning and Growth Perspective

This perspective, which is frequently regarded as the staff perspective, is aimed at transforming the hospital into an organisation with a culture of learning and growth. To achieve the goals of organisational growth and development, the necessary infrastructure must be set up.

7.8.1 Objectives of Learning and Growth Perspective

The objective is to empower staff so that tasks will be carried out as best as possible. In addition, relevant information technologies must be available to provide the organisation with the necessary information. How can you enable your staff to implement the objectives derived from this vision?

7.8.2 Key Performance Indicators of the Learning and Growth Perspective

For the performance indicators of this perspective, it is particularly important to define how the results can be determined. It might be difficult to express these objectives in key indicators and related target values. However, if this task is taken up by a mixed team from all involved departments, it could lead to an overarching awareness of the organisational culture in the hospital (Fig. 7.14).

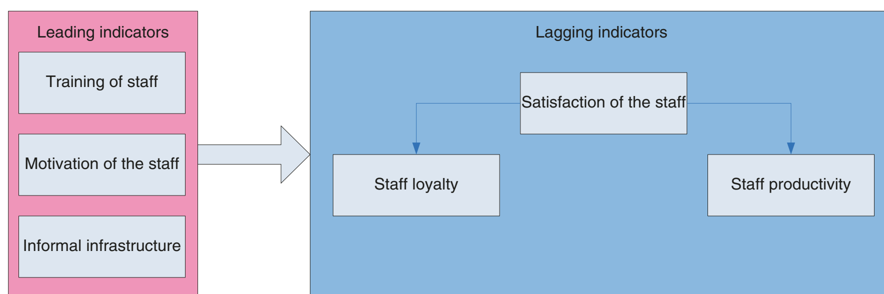

Fig. 7.14 Early and lagging indicators for the learning and growth perspective

Lagging Indicator – Staff Satisfaction
Satisfied staff is the requirement of a well-functioning hospital. Satisfied colleagues perform better than unsatisfied. The following factors influence positively staff satisfaction (Sect. 10.6):

- Responsibility assigned to the employees
- Performance appraisal
- Pleasant and trusting work environment
- Reliability in the hospital and the different departments
- Open and trusting working relationship with one another

The following examples of key indicators can be used for measuring staff satisfaction:

- Average sick leave
- Willingness to work (unpaid) overtime
- Number of applicants by whom the hospital was recommended by staff members
- Willingness to take on tasks that are beyond normal work routine (e.g., participation in student teaching and supervision).

Lagging Indicator – Staff Loyalty A high degree of staff loyalty can contribute to the success of a hospital for various reasons:

- The training of new employees is costly and does not render a 'return on investment' if the employee is going to leave the hospital after a short time.
- Every employee gains knowledge and experience while working at the hospital, which will be lost when they leave the hospital.

The following key indicators can be used for determining staff satisfaction:

- Average affiliation with the hospital in years
- Resignation rate
- Number of absentees and days absent

However, there is a potential risk when the long term affiliation of employees is put in the centre of hospital strategy. In spite of long affiliation with one organisation, employees should be able to repeatedly face new and changing tasks. A regular influx of new staff from other health care providers must be the goal to maintain the competitiveness of a hospital and the enthusiasm for innovation. Vacant positions should be promoted in an official process and filled preferably with external candidates.

Lagging Indicator – Staff Productivity The productivity of staff members depends on their job satisfaction: on whether their abilities match their present position and whether their work is appreciated. The following key indicators can be applied:

- Number of patients
- Rate of regress claims, complaints and ‘critical incidence reporting system’ reports. (Caution: the reports may decrease if staff feel that their reports do not add value. They will then save themselves the effort of posting a report.)
- Additional qualifications that serve the completion of a task
- Number of consultants and HoDs cooperating with other health care providers, such as hospitals, doctors in private practice, day hospitals, treatment centres

Leading Indicators of the Learning and Growth Perspective

Leading indicator – staff training. The training level of staff is a typical early indicator. If the expertise of staff increases, they must be given the opportunity to apply their new knowledge. It is necessary to plan training courses: these should be varied, for instance, compulsory specialised courses, and to evaluate if that serve mainly the general interest of the staff or are in the interest of the hospital. For a hospital that wants to further position itself in the market it is vital to continually improve the qualifications of its employees. Key indicators for staff training, such as the total number of training events can hardly be linked to tangible success in the short term. Only in the long run will newly gained knowledge contribute to a hospital’s success.

Leading indicator – staff motivation. Besides being satisfied with their current work task, employees must identify themselves with the hospital’s goals and strategy to further improve results. The following measures could be applied for staff motivation:

- Centre (e.g., innovation hub) that allows staff to contribute to the hospital development
- Possibility for teamwork
- Hospital management that attends to the needs and demands of the staff

Possible performance indicator could be:

- Suggestions for improvement per employee
- Payment of incentives for improvement suggestions and implementations
- Number of suggestions submitted by a team
- Implementation of improvements (e.g., measured via paid incentives)

Table 7.3 Examples of the implementation of goals from the learning and growth perspective

Objectives	Key performance indicators	Target parameters	Measures/initiatives
Increased staff competency	Number of training units per staff member	3 per staff member	Continuous qualification; targeted training programmes
Increased rate of innovations	New service and treatment offers	25 %	Improved website and communication with private doctors via social media
Increased staff motivation	Rate of resignations	3 %	Mentoring programme, incentives

Informal infrastructure: using information technologies such as the internet, intranet or the hospital's in-house software solutions is indispensable. But how is it possible to ascertain whether these technologies are, in fact, being used? Key performance indicators for the usage of these technologies could be the following:

– Percentage of software solutions and apps used
– Accessibility of available data or evaluations
– Number of IT usage hours by management and employees

Availability of medical/management reports. The implementation of goals, i.e., objectives, key indicators, target values, and measures, could be described as depicted in Table 7.3.

7.9 Case Report on the Application of the BSC

Rochester Heights (RH) is a large regional general hospital. Like many hospitals in the neighbourhood, RH is facing the following problems:

– Proximity of several competitors
– Low bed occupancy rate
– Low financial revenue
– Unmotivated staff, shortage of skills
– Duration of stay too long

To tackle these issues, RH develops the following mission: 'Personalised patient centred care providing a high satisfaction level'.

Rochester Heights follows the vision 'what we want to achieve in future': 'We want to raise the rate of private patients to 30 %.'

Consequently RH promotes the following strategies:

– High degree of patient satisfaction
– Highest degree of patient centredness in the market
– Short waiting periods before admission
– Vision: In 3 years we are the major regional provider serving private patient.

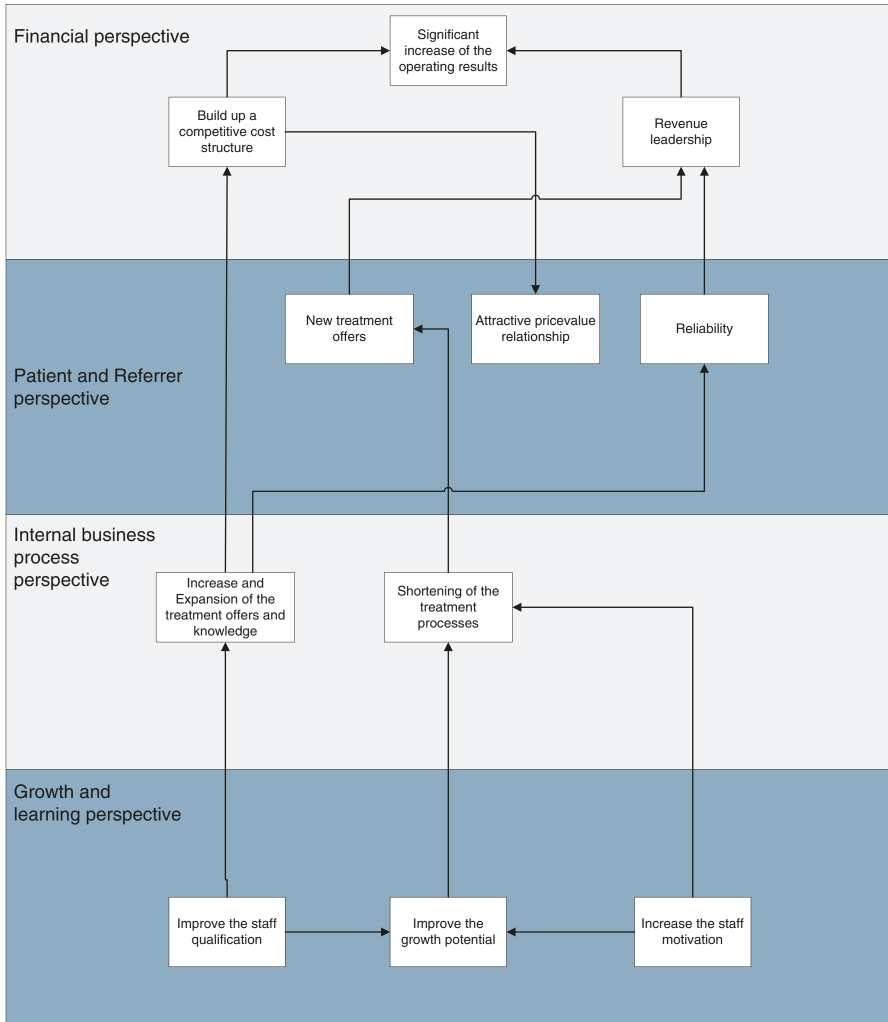

Fig. 7.15 Strategy map of Rochester Heights

In several workshops the executive management developed a strategy map (cause–effect chain; Fig. 7.15).

Based on these results RH decides to outsource the treatment services for private patients as an independent hospital branch and calls it 'Health Center of Excellence Rochester Heights'.

The executive hospital management looks for an investor in the market and approached the neighbouring headquarters of the car company Mobi-De. The vision and implementation for a Health Centre of Excellence are presented there: the staff of Mobi-De will receive improved medical care. The hospital management promises fast treatment processes, individualised care, enhanced recovery time through combined medical services, and optimized support by cooperating with colleagues

Table 7.4 Sample case: Rochester Heights

	Objectives	Key performance indicators	Target parameter	Measures/initiatives
Financial perspective	Increased profits	Turnover of patients	Annual increase of 15 %	Financial cooperation with Mobi-De
Perspective of patient and referring doctors	High reliability	Satisfaction index	Annual increase of 20 %	Use of software and marketing programmes
	Waiting time	Online tools	Granting requested appointments increased by 15 %	Interfaces and online tools
Internal business process perspective	New services	Time first to market	100 days	Marketing by hospital management. Improved implementation
	Number of private patients	Turnover of private patients	30 %	Marketing measures
Learning and growth perspective	Staff competence	Number of training units per staff member	3 per staff member	Continuous qualification process. Targeted training programmes
	Service competence	Greater client satisfaction, lower rate of complaints	25 %	Targeted training of staff
	Staff motivation	Reduced absenteeism and resignation rate	3 %	Mentoring programme

in private practise. Financial support and the profit share are agreed upon. As a long time result, the hospital increases the number of private patients and could achieve the set goals. The goals, key indicators, and measures are displayed in Table 7.4.

Through staff training and scheduled implementation of the new vision and business goals, the Center of Excellence RH is able to establish itself in collaboration with its stake- and shareholders in a niche market as well as to provide improved service provisions. By creating new income resources, the financial revenue improves so that future-orientated capital investments can be made throughout the year. As a result, not only the private hospital, but also RH gains a better financial revenue.

7.10 Problems in the Development and Implementation of BSC

We want to briefly address various problems in the development and implementation of the BSC. The BSC carries the risk of implementing wrong or unrealistic goals. However, even ‘bad’ strategies can be managed professionally.

Furthermore, a BSC can be overloaded with too many objectives that are too complex. If the BSC is developed too superficially, a one-sided focus on key indicators, particularly on lagging performance indicators, can result. When this happens the intention of the BSC to align actions to strategic goals and the sustainable future development of potentials is lost. If you attend mainly to key indicators, an unbalanced 'optimisation' of key indicators can take place – especially if remuneration or incentives are linked to the fulfilment of key indicators. Therefore, the individual targets must be balanced, to avoid undesirable effects.

If a hospital strategy is implemented by applying the BSC, it is necessary to monitor compliance with the relevant key indicator to ensure long-term acceptance. However, you cannot always hold people accountable for every deviation that occurs. Particularly, in cases of external interventions such as the implementation of top-down saving measures in the health system, the reason for departing from the plan cannot be placed with the person responsible for key indicators. Thus, it is a fundamental principle that 'responsible for' and 'not responsible for' deviations from the plan are clearly separated. The best chance of achieving this is to explore risks related to a specific target figure when the BSC is being developed. Precisely these risks should clearly describe a 'not responsible for' deviation from a planned and expected value. By using this approach, strategic management and risk management are integrated and the efficiency and logical consistency of both systems can increase.

7.11 Summary

The control and definition of *key performance indicators* are an important part of, but should not be the major focus of, business decisions made by a hospital's management. Key performance indicators play a central part in the hospital's concept. If the focus rests only on financial key indicators, the bigger picture gets lost. The balanced scorecard is a holistic management approach that provides a key indicator system of non financial and financial perspectives for the monitoring process. It serves to ensure the consistent alignment of actions, processes, and measures within a team/organisation (hospital, departments, project groups, etc.) to a common goal. In contrast to the classical key data systems, the BSC also focuses the attention on non-financial indicators via the assumed interrelationship of the cause–effect links. By means of the BSC, the different perspectives are analysed and help to establish competitive advantages for a hospital so that the various key indicators and measures can be aligned to it. Apart from the classic financial key indicators, the BSC includes referring doctors, patients, treatment processes, and staff. Relevant key indicators must be defined for each of them. Consequently, the hospital can be developed in such a way that the strategic objectives for all *four perspectives* may be reached in a balanced manner. Unlike guiding principles and other fuzzy formulations, the BSC enables that measurable goals can be implemented.

7.12 Five Reflective Questions for Practical Application

1. What is the strategy of your hospital or department? Outline your 1-, 2-, 5-year plans.
2. Why do you regard the BSC as useful/not useful for your hospital or department?
3. Which areas can you envision implementing a BSC?
4. Can you apply the pyramid depicted in Fig. 7.1 to your hospital or department?
5. What resources and which people would you need to realise your mission?

References and Further Reading

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8 Find the Best Staff and Develop Their Skills

Goals

– Which fundamental changes have taken place in hospitals over the last decade?
– Why structured staff development is important for hospitals?
– What are the typical features of characters you can find in hospital?
– What is the ideal composition of a team? What would be the ideal fit for a team composition?

This chapter gives you guidance on how to achieve a highly competitive team. It depicts how to engage in continuous staff development and highlights key characteristics of clinicians and managers. An outline of leadership is given in addition to characteristics of team bonding and how to achieve it.

8.1 The Future Starts Yesterday

Learn from yesterday, live for today, hope for tomorrow. (Albert Einstein)

Thirty years ago there were sufficient nurses and doctors available on the market. Apart from a few leadership positions, regional hospitals mainly recruited local staff. Most of the employees would already have known the hospital for many years, and had possibly been born there. They and their families had some good and sometimes not so good encounters with the hospital. The hospital was part of the local community and people went there whenever they needed hospital treatment. At that time, the hospital had no website on the Internet and quality assessments of hospitals or doctors did not yet exist. Economic aspects played a minor part because most hospitals were financially supported by the community, province or church. Deficits

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were mostly balanced by the public sector. If a family member had to stay longer in hospital because there was no-one at home who could care for them, the ward doctor would extend the stay. If the referring doctor wanted to have a patient observed in hospital because he could not classify the disease, this was often not a problem. The regional hospital dealt with routine cases; complicated cases were referred to a tertiary centre for further diagnosis and treatment.

This was before financial measures such as diagnosis-related groups (DRGs) were implemented. Now, there are treatment splits if patients have to be transferred to another hospital, fees are reduced if patients have to be readmitted within a certain time period. For every disease, there is a maximum length of stay and fixed treatment costs. Hospital treatments are seen as unnecessary referrals if the patient could have been treated more cheaply in an outpatient department or primary/secondary health care facility. In such a case, hospitals are not reimbursed for the treatment they provide. For a sustainable financial situation, hospitals should treat a broader variety of cases and be able to look after complex cases as well to achieve a high case mix index. Treatments and diseases have become more complex and patient co-morbidities have increased. Often, capacity limitations prevent the transfer of patients to another centre. Referring doctors prefer to have their patients treated at the place of residence rather than in a distant hospital that the referring doctor and family members are not familiar with. Many complicated cases that were transferred to other centres in the past are now dealt with in the regional or local hospital. Referrals are handled differently depending on the country; national competence centres might exist only in some metropolitan areas, and patients need a referral from a primary or secondary centre ('gate keeper') to be treated there ('primary, secondary, tertiary care').

Improved treatment results and increased life expectancy have consequences: life expectancy after cancer treatment has improved, although admittedly the long-term side effects of radio- and chemotherapy have increased; babies can survive from the 24th week of pregnancy, although often with severe long-term effects; angiograms, bypass surgery and joint replacements are routinely done in many hospitals. This highlights the fact that the demands on doctors and nursing staff have increased considerably. A hospital needs well-trained and highly motivated staff to deal with the new demands and the market-orientated service delivery (Coomber and Barnball 2007).

All these improvements necessitate equipment, expertise and staffing. In hospitals, personnel costs account for at least 60 % of the budget. If a hospital wants to save money, the quickest way to do this is to reduce the staff. And yet staff remains the most important basis for a competent, patient-orientated and economically run hospital.

On a first impression, patients will be impressed by contemporary standards in the health care facility. A hospital can always impress with these. But given time to observe more deeply, patients will notice that there are more important matters than an impressive entrance hall and comfortable one-bed wards. Service delivery relies on people. Empathetic and patient-orientated staff is crucial, even if some executive hospital managers still like to reiterate that everyone is replaceable and that one person is as good as another. How a successor works is a different matter and will only be evident after some time. This is illustrated in the following case example.

Case Study

The new HoD restructures the neurological department and within 3 years it develops strategically well. The occupancy and revenue figures improve significantly over time. Through a high standard of treatment and service delivery more referring doctors and patients are attracted by his department. The various insurance companies could have been convinced to increase their reimbursements for service delivery and the overall budget allocation. When the consultant approaches executive management requesting an increase in the staff in proportion to the increased services, they deny this request. An external consulting company that the CEO approaches states that no additional staff is needed. The HoD is told that further expansion of services is not necessary. A few months later the HoD hands in his resignation as he has received another, more rewarding job offer. His successor is a previous senior registrar of the hospital who became a consultant in another hospital. Three years later only a small part of the previous range of treatments remains. The referring doctors now increasingly use other competing hospitals so that the number of treatments and the revenue figures have significantly declined.

8.2 Successful Hospitals Through Continuous Staff Development

> Train people well enough so that they can leave, treat them well enough so that they don't want to. (Richard Branson)

In contrast to medium-sized and large companies, staff development in hospitals has, in the past, played only a minor role. However, concepts such as appreciation or staff planning have gained in importance over the last few years. Initially, this took place in nursing care, and was caused by the health care crisis, which led to more attractive working and development conditions being created for nursing staff (Willis-Shattuck et al. 2008). Furthermore, nurses are often part of the hospital's executive management board and have a say in the decision making process. In many hospitals nurses are offered various hospital-related development programmes that are financially supported.

Many doctors leave the daily hospital routine for new areas or foreign countries. One of the underlying reasons are the changes in the job description that overload them with bureaucracy. In addition, life priorities have changed. Compared with the past, the life focus is no longer solely on "being a doctor" rather, family and leisure activities take precedence (known as a Generation X characteristic). This is frequently equated with the so-called 'feminisation' of medicine, although the concept of 'family-friendly work environment' ('combining family and professional tasks') would describe the trend better. There are increasingly more mothers working full-time and fathers who stay at home to look after the children. Fathers also work less

so as to have more time for their families. This is a trend that has to be taken into account together with the current emphasis on 'work–life balance'.

Increasingly, there are fewer medical specialists available for direct patient care. Hence, the competition among hospitals for well-trained and experienced doctors that started some time ago. When choosing a position, doctors want to know what professional and social development opportunities are available (working atmosphere, work load and duties, roster, leadership quality of HoD and executive hospital management). Employers who are quick to dismiss staff are increasingly avoided. Hospitals in unattractive or rural locations have to be especially committed and should offer applicants development opportunities with good social integration (i.e., nursery schools or child care facilities, search for employment for the spouse or life partner, housing, etc.), regular feed-back discussions (Sect. 5.11), accessibility and empathy of superiors (Chap. 10), review meetings and options for further development that are discussed regularly with superiors. Such opportunities should be part of the standardised development and support programme of a well-run hospital.

The hospital management should also be prepared to reflect on itself and conduct surveys on a regular basis as to how the staff sees their job. This would help to evaluate the potential for improvement and development (Willis-Shattuck et al. 2008). You will be surprised at the quality of the innovative ideas that staff members can produce when their opinion is consulted. Consequently, ideas must be followed up. Interns, registrars and nurses often come up with practical suggestions, which then ought to be implemented if you do not want to stop this flow of ideas in the future.

As far back as 1949, Ferdinand Drucker, a famous US economist of European origin and pioneer of modern management science, said:

> Any institution has to be organised so as to bring out the talent and capabilities within the organisation; to encourage men to take initiative, give them a chance to show what they can do, and a scope within which to grow. (Ferdinand Drucker)

8.3 How Do You Experience Your Working Environment?

It is a well known fact that motivated and committed staff thrive in an open-minded, appreciative working environment. Hospitals conduct regular staff surveys, but it is rare that a hospital is so transparent that these results are published in detail, for instance on the intranet. Surveys are seldom used to initiate specific changes and as a result valuable potential is wasted.

Engage in a brief survey on how the current working environment, in your department is experienced. Don't be afraid of the results! Take it as advice that will enable you to analyse how to implement potential changes. A further step could be to work out suggestions for change and then implement them. In this way, you can assess which further steps are necessary for effecting changes.

You could use the brief questionnaire shown in Table 8.1. This provides a reason to focus on special areas more intensively. Use it as orientation for recognising problem areas.

Table 8.1 Brief questionnaire on the working atmosphere

	Correct	Neutral	Does not apply
General questions about the working atmosphere			
Staff enjoys working in our hospital/department			
Each staff member has a say in the hospital processes and his suggestions are heard, considered and, if possible, implemented			
Questions about colleagues			
The working atmosphere appreciates each staff member			
If someone experiences problems, there are colleagues around prepared to help			
We work in superficial politeness			
Everyone can openly state his opinion without having to be afraid of negative consequences			
Questions regarding supervisors			
The mood in the hospital/department is independent of the mood of the superior			
Good work is appreciated by my superior, the HoD, the CEO			
Our superiors respond to our concerns, problems and complaints			
The superiors know how to create an environment in which everyone can reach their true potential			
Questions regarding the hospital/organisation			
Tasks are allocated according to the abilities and potential of staff			
In our organisation the different departments work together in an open and transparent way			
The units/departments concerned adhere to the agreements			
We often have to do additional work and work overtime			
Questions regarding communication and having a say			
We are informed about important matters in our department/hospital			
The hospital management considers staff ideas and suggestions on a regular basis			
The information we get is often contradictory			

8.4 Which Staff Fits Your Hospital?

When analysing staffing, it has been observed that frequently staff members are not positioned according to their abilities and talents. In staff planning, the ability of employees should get the highest priority. However, it may happen that a candidate is suitable for a position, but his working style differs to other team members. When he challenges existing processes to improve them, he must be supported by

executive management. Simply having worked at the hospital for many years cannot be the crucial deciding factor for the next career step. New employees should be selected in accordance with the hospital's objectives; although they might clash in the case of long-standing employees, who resist change and refuse to act in line with the new strategic goal of the hospital. The supervisor has the responsibility of analysing in advance which objectives are being pursued and of supporting the staff according to their abilities and plans. When career advancement is discussed at the regular evaluation session, the employees need to be adequately prepared if they are meant to take on a new role, rather than being put into their new position with the encouraging words: 'You'll manage', and a pat on the back.

In summary, the three following issues must be analysed in advance:

– What are the long-term goals for the department/hospital? Are we aiming to continue with minor changes or are we aiming at a major change in direction?
– Which types of employees and which head would be best suited?
– Which leadership qualities do we need if we want to change and restructure the department/hospital? What support will the new consultant or head of department receive from the executive hospital management, or other superiors?
– How can we best reach our goals?

There are various approaches to recruiting personnel. An external human resources consultant may be employed. Based on his/her expertise, the hospital would then rely on his/her making the right decisions. Often, the consultant will make decisions according to the requirements the hospital has formulated, even although he/she does not possess all the relevant details. Assessment sessions would be organised for executive positions.

Another approach to recruiting staff is to apply a detailed job description that includes evaluating and ranking criteria based on the job's requirements. The applicants are evaluated according to their submitted documents and a personal interview. These results are transferred to a spider's web (Fig. 8.1). The diagram depicts a job profile for a post: the candidate's attributes are marked in the solid line with the ideal required profile traced by the dotted line. In the given example, the applicant has a high degree of patient-orientation, professional expertise, social competence and networking capability as well as good networking abilities. In the areas of leadership and organisational competence he/she is less qualified. The spider's web highlights the gap between the job profile and the applicant's qualifications. Very seldom is complete conformity reached. Initially the priorities of the department and hospital must be identified. Furthermore, the composition of the selection committee has to be determined. It may be appropriate for the person who has the responsibility to make the final decision. In most cases, this would be the hierarchical superior. Selection committees must be a well-balanced and neutral, but this should not obscure the fact that agreements and block decisions can happen during the selection process. Be aware that bias will always be present in the process.

As the institution's requirements and those of personal development change, measures for further personnel development should be carried out periodically.

A hospital needs staff with diverse character traits. Characters can be divided into the following main groups:

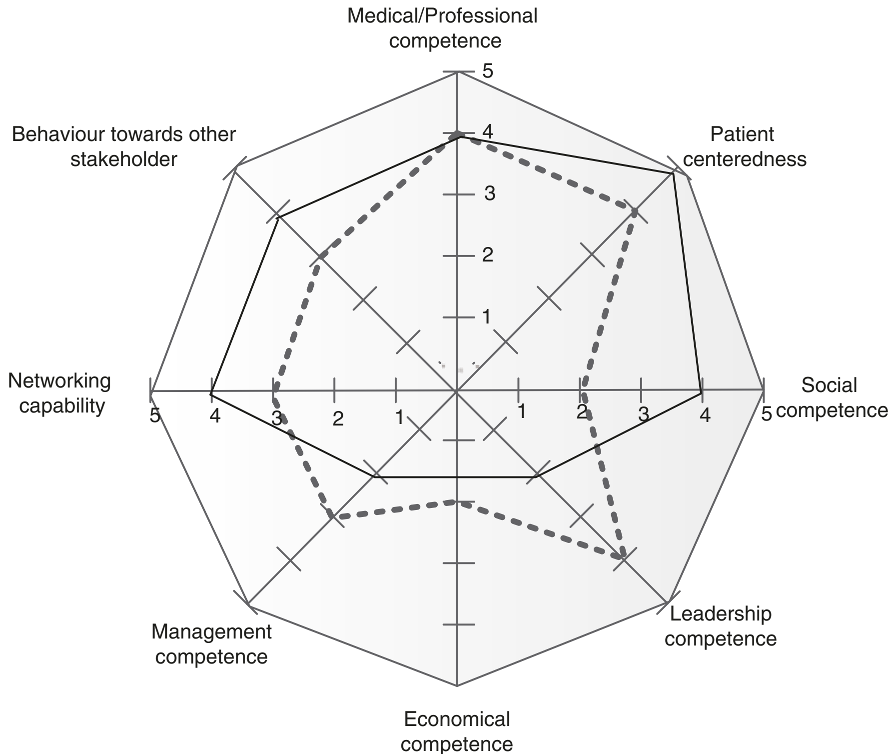

Fig. 8.1 Example of a possible job profile

Doers (‘What new thing can I implement today?’)
Compliers (‘I complete all tasks that I am asked to do without asking’)
Enthusiasts (‘Striving for excellence’)
Opposers (‘Nothing happens here without my say-so!’)

Successful hospitals and departments have a good balance of the different character groups. However, it is mandatory to attract staff that a hospital can choose its ideal candidate from amongst several applicants.

The most obvious mistakes are often made in the beginning of the selection process. Either the job profile was outlined in the wrong way, the hospital focuses on the wrong targets or the staff member has other expectations when he/she joines the hospital, which are not fulfilled in the long run. The basic trust between employer and employee is also created in the beginning of an employment relationship. If one side hears that the working conditions are significantly different from what was indicated at first or major problems were not mentioned, this inevitably causes a loss of trust. At a later stage corrections are very costly and emotionally difficult.

It is seldom possible for future staff members to get a reliable view of the hospital, the duties and the existing problems before starting in a new organisation. Existing problems are rarely mentioned openly by the future employer and solutions and support seldom offered. Both sides should aim for mutual frankness.

Case Study

An applicant for an executive position is sitting in the reception area of the hospital management, where his interview is to take place. It is already 5 p.m. He has previously received an e-mail from the personal assistant of the CEO, telling him to take a seat in the waiting area when he arrives and he will be called when it is his turn. When he arrives, the area is deserted, there is no-one to speak to, all doors are closed. After half an hour he starts to feel increasingly uneasy. Suddenly voices in one of the rooms are raised, then they calm down. A man emerges from a door and leaves without looking up. Ten minutes later a gentleman who, he recognizes, is the CEO, exits through the same door and approaches the applicant, whom he greets in a friendly manner. 'We had a business meeting, which, unfortunately, took longer than anticipated and the secretary has already left.' Although their subsequent meeting and interview are very positive and he is offered the post, he does not accept it because he feels warned by an indefinable gut feeling. Two years later he hears that the executive who was subsequently chosen has resigned because of the tense work climate.

Conclusion: The nature of the work climate is often picked up by outsiders through subtle gestures and remarks. Frequently, it becomes evident in the appreciation shown to individuals.

It would be ideal to apply a reciprocal information policy in the job application process. Not only the applicants should be obliged to answer questions and hand in references, but the employer also should reveal important information, as a sign of transparency and openness. The top applicants could, for instance, be given the opportunity of obtaining unvarnished information from the future employer and be entitled to spend a day observing behaviour there. Current problems and difficulties could then be discussed. In this way, the applicant is given the opportunity to evaluate whether s/he is willing to cope with these problems and whether s/he wants to enter a potential conflict environment at all. However, being honest with each other by putting the cards on the table requires mutual trust on both sides. Mutual confidentiality about the obtained information is mandatory in this situation.

8.5 Various Types of Employees

A team is composed of a group of people who will, typically, manifest a variety of characteristics. You need a good team mix to develop a hospital/department strategically well. A job interview must consider how a particular applicant would fit in with the current team or whether the applicant is the right person to head for new shores. Too many 'keepers', 'opposers' and 'rationals' can counteract any change in the hospital. It is just as potentially contentious if a new colleague who is creative, innovative and autonomous

should be placed in a long-standing, well attuned team. After a thorough analysis of the current situation, certain characters should be placed in other areas so that the hospital can thrive according to its strategy. Inter alia, there are the following types of personalities:

- *The keeper* prefers to continue using functions and structures that support him/her. S/He sees her/himself as traditional, conscious of values, and often has been working in the hospital for a long time. S/He will only pursue innovations after having been convinced of the advantages in many detailed discussions. If you want to initiate a renewal process, it is best to get keepers on board by giving them their own project. They respond well to being helped to believe that they are basically implementing their own ideas.
- *The opposer* is critical of everything and everyone. If a project is being implemented after a majority decision, it is the opposer who, at the last minute, can still make the project fail. Opposers are often employees who function as 'old bulls' or 'grey eminences'. Opposers, too, should be part of the process from the beginning and their personality should, ideally, be presented as innovative, that is, reframed as such.
- *The helpers* will, self-sacrificially, support wherever possible and the help they are able to provide is needed. If no-one can be found for a weekend duty or if patients come too late to a pre-surgery discussion and as a result overtime must be worked, helpers will typically step in. This will be done with moaning and complaints of their kindness being exploited. Helpers are stop-gaps in unexpectedly tight spots that crop up during daily work. Support them with appreciation and compensate them with incentives such as bonuses and congress attendance.
- *The innovative and creative* members of staff are always prepared to take up and implement the newest research outcomes or congress innovations. Seldom do they accept a verdict of 'later' or 'impossible'. They make the ideal partner for new projects, the introduction of new therapies or new treatment methods.
- *The autonomous* members need their own tasks and decision-making areas and love working independently. If direction and control from others or superiors are too tight they will experience this as an intrusion and having had a loss of competency. Placed in an appropriate position, however, they are able strategically, and successfully, to develop a hospital or a department.
- *The rational* members wish to harmonise their professional and leisure activities. Whatever does not bring them any advantage, will not excite their interest and a response can hardly be expected of them.
- *The social* members live in a group and are carried and validated by the group. If birthday presents have to be bought, signatures collected or holidays organised they are always very happy to comply. They are important for the social cohesion of a team.

If a hospital wants to move in a new direction it must be possible to restructure, reorganise and mix old and new staff members. If new, innovative employees who want to develop a department meet up with members of staff who have been employed there for many years and who see their task as defending their vested rights, conflict is likely.

Case Study
Mrs Mutius was frequently quoted by Professor Sanders as one of his unwanted legacies. She was close to retirement and vehemently defended, tooth and claw, the accumulated and personal privileges she had attained over decades. With the exception of intermittent and brief frictions that arose from time to time, even the confrontational Sanders dared not approach her. If there was an acute problem, as would arise particularly with younger colleagues who resented her imperious and know-it all kind manner, Sanders would respond, usually smugly: ‘The problem Mutius can only be resolved with time.’ He would then point to her close retirement (Mann 2006, p. 46).

8.6 Various Characteristics in Executive Positions

An analysis of the types of leaders and their likely behaviour in with staff members can help to identify the potential for possible conflict and can act as guide to possible solutions. For instance, a new, innovative HoD is allocated a conservative consultant as his deputy. This arrangement has a high potential for conflict. The following list of stereotypes and their characteristics serves as a rough guide:

– *The autocrat:* he is an executive of the old school. Where he appears, he expects due respect as well as patience with his notions of time. He accepts no contradiction and is used to shouting his demands. What he says is law. His type is frequently encountered in surgical disciplines.
– *The slob:* without his able secretary, who protects him, as well as a consultant, who deputises for him, things would get out of hand. He is always impressive in his specialisation and detailed knowledge. Matters of operational hospital routine are of less priority for him.
– *The fully committed:* he runs from appointment to appointment, but is always late. In meetings he works on his smartphone and sends out SMS messages or e-mails. However, he does not always apply himself to matters with the necessary focus. If one could check his diary, one would be surprised to see that this is not as full as he usually claims.
– *The conservative:* he acts according to the motto: ‘Never change a running system’ and is wary of innovations. He only gets involved when the executive hospital management demands it for him or the smell of the burning roof can no longer be ignored (Sect. 6.3). He does not make decisions quickly and prefers to delay making them. His colleagues seldom hear a clear ‘yes’ or ‘no’, but rather ‘perhaps’, ‘one could’ or ‘let’s see’.
– *The powerful type:* He is a key player, gatekeeper and member of important committees. All relevant information is concentrated in him. No-one gets past him. In order to gain more power, he is prepared to use unconventional ways, leave official channels behind and is prepared to accept unorthodox solutions to reach

his goals. He is happiest when he can juggle all balls at once. He receives much recognition by virtue of the fact that nothing would work without him. He will do anything to gain more power.

- *The complier:* He fulfils everyone's wishes and complies with everybody (the *laissez-faire* style of leadership). For leadership tasks, he needs a representative as a grey eminence who will keep the team together. He appears selflessly devoted to hospital matters but creates generously free spaces for his own interests.
- *The reliable type:* He seems to have read all available management books and applies them in everyday life. If you have made an agreement with him you can rely on him implementing it. However, he also assumes such reliability in his colleagues and is very disappointed when this is not the case. Power people occasionally play him off, especially if they use unexpected ways of doing things.

The above-mentioned character sketches are slightly exaggerated to highlight typical characteristics. Obviously, there are numbers of combinations.

8.7 Stages of Team Development

The various conditions of team adherence are described by the words 'individualized teams – next to each other', 'team spirit – better together' and 'brotherhood – one for another'. They describe the values of team spirit, to active coexistence, and of coping with one another.

The first phase in team-building has the members merely being next to each other. The team is characterized by a polite relationship. Contacts with each other are reduced to a minimum. There is a certain degree of superficiality. There are hardly ever any conflicts because the group does not really interact. They are in a *state of tolerant co-existence*. Discussions end in the gossip factory. Controversies are avoided. Occasionally snide and disparaging remarks occur, but generally harmony is exercised. The energy in the group is rather low, although everyone does what has to be done. There is much tolerance of other team members. If a team in this stage were to be judged from the outside, others, especially those on higher hierarchical levels, would describe them as in a harmonious state. Innovation and change have not happen for several years. The style of leadership is often one of *laissez-faire*. Many departments in hospitals function like this. This situation can also be found in a department or hospital after a longish period under an acting head.

If a group is more mature, its members enter a *state of connection*. The members deal with one another sensibly, keep within boundaries and act in a task-orientated way. Most of the professional boundaries are known and are mutually accepted. Communication is a matter-of-fact; personal matters are generally avoided. The energy in the group is average, everyone does what is necessary. Relationships at work are organised in such a way that everyone can work largely undisturbed in his field; clear rules exist regarding interfaces. Groups in this condition are managed.

Such teams can be found in departments and hospitals that are well attuned to the available resources.

The third stage is the *commitment to a leader*. The members of the group respect each other professionally and personally. Each one aims at giving and achieving his best. The energy is high and characterised by motivation and passionate concern for optimisation and change. The working relations are such that each can give the best according to the individual strengths. The team redefines itself continuously and it has a positive attitude to changes. Its members are convinced that the sum of their individual energies is greater than merely adding them up. Innovative departments and hospitals fall within this category.

8.8 How Will a Team Become Productive?

Tuckman defines a team as a group of people having the same goal, who are put work together for a certain period and show mutual responsibility (Tuckman 1965). Whether a team is productive depends on the mix within the team, the ability of team members to solve conflicts, the process of team building and leadership.

To develop teams and organisations such as hospitals, goal-orientated personal development is a necessity. Under these conditions, development, learning and change processes can thrive. If you want to empower your employees, they must be willing to act, be entitled to act and be able to act.

To summarise: it would be ideal to analyse ahead of a work relationship what resources and characteristics exist within a team, what is missing and what is dominant. Furthermore, the hospital's management should assist to back up new processes, and new goals.

In aligning teams, the leaders recruit available colleagues with similar characteristics. A powerful or committed leader probably chooses staff members who are rational or innovative; others prefer autonomous or socially committed people to work with. A balanced mix in a hospital/department exists only in an ideal world. It is more likely that there will be certain groups that will fit in with a larger team. This aspect is often neglected when executive positions are to be filled. If a hospital is to continue to run with only slight changes, it is wise to choose someone whose characteristics suit the existing team. If a hospital is to be restructured from scratch, a candidate should be chosen who matches the job profile as closely as possible. If there are economic reasons for aligning the hospital with a new direction, the new head must have the opportunity of choosing his closest colleagues, such as the senior doctor and his secretary, himself. These days, even hospitals cannot wait for years until the one or other person retires before change processes can take place. The team is either prepared to attempt something entirely new or those on the team who oppose change might be advised to take up another post.

It is important that new executives not only get verbal, but also active support from the hospital management. As soon as the first problems and opposition occur,

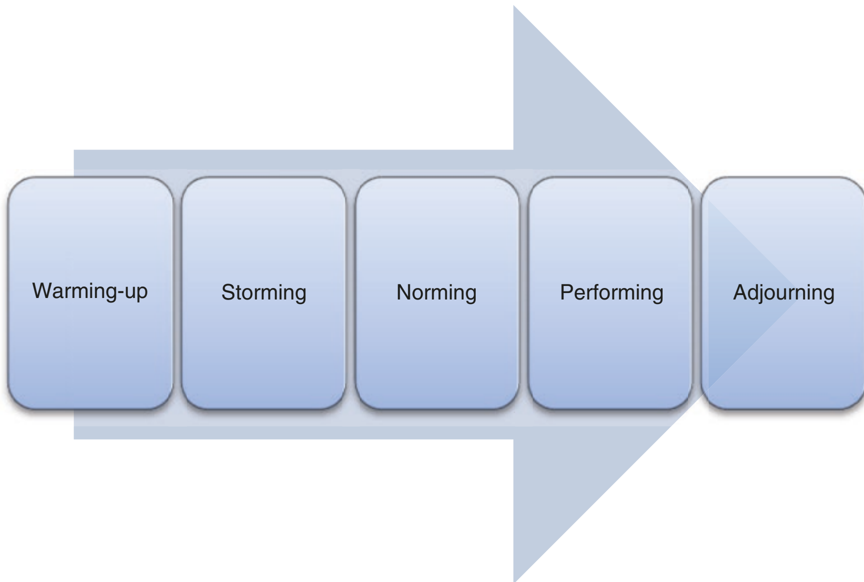

Fig. 8.2 Team-building process (Tuckman 1965)

the hospital management frequently retracts. But without receiving support from superiors, the consultant is doomed to fight against windmills. An innovative and communicative head who is confronted by a group of keepers and opposers, who, on top of everything else, are supported by management, will not be able to realise his ideas. Either he looks for a new position and leaves the hospital or he withdraws to inner isolation and resignation (Chap. 2) and will then also no longer be actively available to the hospital.

How can you build high performing teams? In the first place, you have to be entitled to make decisions without constantly checking with your superior. If your goals are different to your team and you do not have the support and back up of the hospital management, your chances of success are diminished. The best advice is to continue as before with slight modifications along the way.

If you as head or consultant have a defined concept and this is backed-up by the hospital management, you can start the team-building process as follows (Fig. 8.2) (Tuckman 1965).

There are four phases: the warming-up phase of polite interpersonal relations; the phase of storming, where polarisation becomes evident and disputes arise; the norming phase, where new behaviours and manners are regulated; and the performing phase, where the new team has found itself, people value each other and communicate openly. The aim is to reach the performing phase as soon as possible.

Based on the phrase 'you'll always meet twice in life' it is sensible to organise the parting process in good terms. The following example illustrates how important proper adjourning really is.

Case Study
The HoD has employed a consultant to become his deputy. After a couple of months, the senior doctor realises that hardly anything he was promised in the beginning has actually materialised. He discusses this with his superior in feed-back sessions. The HoD puts him off taking any serious action, saying that everything needs time and he shouldn't lose patience. When nothing changes in the following months and he sees no action from the HoD indicating that the situation will change in the near future, he explores the market and takes up a position in another hospital. When he informs the HoD of his decision he is accused of a breach of confidence. The HoD relieves him of his duties forthwith and forbids him to ever enter the hospital again. Staff and colleagues in the hospital are informed in the evening by circular letter that the consultant has been relieved of his duties with immediate effect. This behaviour astonishes the other colleagues. However, as the consultant was depicted by the HoD as being a very difficult character, they accept his approach. A few years later the HoD applies for a post in a larger hospital. He is unpleasantly surprised to find that his former deputy is a member of the executive management of the hospital.

Conclusion: An amicable adjourning process could have facilitated their next meeting with very different feelings.

In a team-building process, the team must be made aware on a regular basis of the pursued overarching goal.

Based on the South African Mont Fleur Scenario that took place between 1991 and 1992 (http://futuristablog.com/the-mont-fleur-scenarios) the following conditions can also be applied in health care setting:

- *Ostrich strategy:* burying your head in the sand. Power and privilege remain unchanged. Problems and areas of conflict are ignored.
- *Lame duck:* although every opinion is considered and complied with, no-one is satisfied.
- *Icarus:* money is spent hand over fist – until all crash together.
- *The flight of the flamingos:* the entire team heads for new shores and rises above all that is established and no longer up to date.

Many people have experienced *burying one's head in the sand and the lame duck* attitude in their everyday work and will encounter it in other departments and hospitals. It mirrors our health services: large sums are paid to the health system by tax payers, employers, employees, the state and every individual. In spite of this, we often do not

get the quality of care comparable to the economic input. To balance this out is one of the great challenges of our time.

Occasionally, someone aspires to the flight of the flamingos for his department or hospital, but it is a rare feat to achieve. If success is too striking and the attention paid becomes unbearable for others, there is always the danger of an opponent or another powerful rival wanting to shoot the flying flamingos down. In a leadership position there is no time and leisure for relaxing and resting.

8.9 Summary

An important prerequisite for becoming a high achieving hospital is to choose members of staff who are committed to the hospital, the patients and public welfare rather than merely to their own interests. Another requirement is to place staff into the correct positions according to their abilities. The executive hospital management should be aware of the goals and strategies, and choose the staff according to the resultant requirements. Members of staff and their expertise remain the most important assets of a hospital. Continuous staff development is an important function of successful hospital management. The ideal composition of the team and the deployment of employees in the right position and workplace to match their abilities and expertise are crucial for the success of a hospital.

8.10 Five Reflective Questions for Practical Application

1. What percentage of staff in your hospital/department has working experience with one or two other employers?
2. Do you possess a structured programme for promoting and developing your staff?
3. Do you regularly carry out review meetings where your employees are able to formulate their wishes and career goals?
4. How do you characterise your colleagues in terms of the composition of the team? Have you found the ideal staff mix? If not, how could you achieve this?
5. What type of bonding exists between members of your team? Is it a bond of politeness, process or of authority?

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9 Manage Your Conflicts Professionally

Goals

- Why is a positive attitude towards a conflict resolution culture good for a hospital?
- Why does a hospital need an internal dispute culture?
- Why should you avoid discussions in the drama triangle?
- What are the golden rules for conducting conflict resolution?

This chapter introduces you to the various steps of professional conflict management and advises you when to intervene in a conflict. We highlight the different escalating levels and encourage you to establish a constructive atmosphere of debate. An analysis and solution framework for conflicts is described, in addition to the golden rules of negotiation.

Large and medium-sized businesses are increasingly realising the necessity of managing conflicts professionally, as they are part of everyday work life ('you can't make an omelette without breaking some eggs'). On the contrary, in most hospitals conflicts are often 'solved' by gut feeling in the course of daily management and are frequently enhanced by personal power struggles. This often leads to an inner resignation of many employees. Internal warfare brings about energy loss, fronts divide the hospital, and in the long run the external image is affected. The Case Study describes a typical example of an escalated conflict.

Case Study

The children's hospital and its surgical department share one senior registrar. When the registrar is off duty, he has to be replaced by a registrar from the children's hospital, although their staff pool is very restricted in numbers. One day during the holiday period several staff members from the children's hospital

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are on sick leave. The surgeon insists on consistent compliance with the agreement. The head of the children's hospital, however, decides that in this case no registrar is able to help out in the surgical outpatient department; since this will affect the service delivery of the children's hospital. The surgeon has to conduct his outpatient clinic on this day without the support of a registrar. The paediatric surgeon, who is not on the best of terms with his colleague, approaches the CEO of the hospital and complains that the agreement was deliberately violated. As a result, the head of the children's hospital receives a written warning from the CEO for having arbitrarily overruled the agreement.

Conclusion: A conflict that is basically simple to solve escalates to such a degree that further constructive co-operation is significantly affected.

The first step towards professional conflict management consists of the insight that an *internal dispute culture* is encouraged. Employees and their superiors may have different opinions and still be in a position to be on good terms later. When formally contradicting a superior this should not mean having to expect animosity.

Below we take a closer look at the methods of professional conflict management.

9.1 Professional Conflict Management

In the example above we describe a typical conflict situation. Neither of the two parties could change their point of view in such a way that the requirements of the other are met. Such conflicts are part of everyday work life. Conflict management does not suppress conflicts; rather, it shows how they can be managed professionally and 'routinely' dealt with. If, however, each conflict is brought straight to 'the boss', who makes gut-feeling decisions about which head has to roll – this cannot be described as professional conflict management.

By definition, a *conflict* is a disruption in interpersonal or professional areas. Conflicts can arise between individuals or within a team and have many causes. For instance, there are conflicts between high-performance and low-performance group

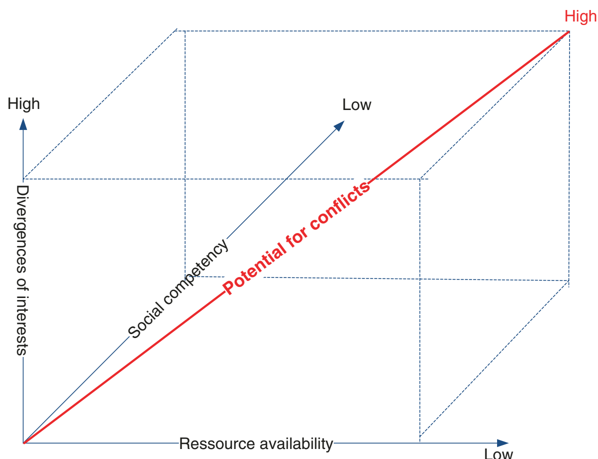

Fig. 9.1 Source of conflict potential

Table 9.1 Indications for potential conflicts

Factual controversy takes place with great intensity
Formation of groups within the team who do not want to give in
Derogatory remarks or hostile behaviour towards team members
Distrust among staff members
Members of the team do not mention their own ideas and avoid conflicts

members, power conflicts between senior registrars and the heads of departments, and conflicts fed by such fuel as contradictory or deficient information, rivalry and jealousy, conflicts of interests as well as a lack of social competence (Fig. 9.1).

Typical types of conflicts are over *objectives, solutions, resources, roles, values and interpersonal conflicts* (De Dreu and Weingart 2003). For instance, role conflicts may be based on different role expectations, e.g., that women must behave subordinately in a patriarchal society. Conflicts may derive from different underlying values and norms between varieties of nationalities, religious groups or even different organisational values.

Conflicts can arise on a subjective level – especially, if a discrepancy arises between tasks and personal orientation or there is a refusal to comply with working methods in the case of specific behaviours – or conflicts may arise on the level of relationships (e.g., affective conflicts caused by the forming of cliques, or the fight for power and status). Within the scope of conflict management, it is important to recognise an arising conflict in due course.

Consider the situation in your team, and tick the applicable points in Table 9.1. In the next paragraph we shall discuss whether, and when, one should intervene in a conflict.

9.2 When Should One Intervene in a Conflict?

> May you have the strength to change what can be changed. May you have the serenity to accept what cannot be changed. And may you also have the wisdom to recognise the difference. (Gregory Bateson)

A conflict requires intervention when it becomes necessary in order to prevent damaging results, if, for instance, quality of work or of patient care is suffering or going to suffer. There is a difference between conflict management and conflict resolution. Although *conflict management* does not categorically prevent every conflict, *conflict resolution* implies the reduction, elimination, and termination of conflicts.

Can it be called a matter of success if there are only a few conflicts and these are solved immediately? Probably not: a positive dispute culture is an important part of the functioning of an innovative hospital. Proactive conflict management furnishes the hospital with tools for dealing with conflicts in a positive way; it enables the hospital to use conflicts as social capital. Furthermore, focused conflict management enables learning from the conflict situation and thus contributes to the development of a team culture (Amason et al. 1995).

In short, conflicts are valuable for the hospital if they are professionally dealt with and the hospital teams can learn from them (De Church & Marks 2001). The value that it can add to the continuous learning process of an organisation is an essential feature of conflict management.

So, which conflicts require intervention? On the one hand there are *group conflicts* in a hospital that may interfere with the working atmosphere. But, there are also *interpersonal conflicts* where colleagues fail to communicate with each other. This, too, affects the working environment, but also affects efficient and trusting patient care. In such cases, you may not ignore the situation if you are responsible for the staff ('They'll sort it out amongst themselves', 'That's a hopeless case', 'Let's just ignore it.'). As one who has as a consultant, HoD, COO or CEO, managerial responsibility, you are directly involved and challenged.

In addition, there are *substantive* or *affective* conflicts. If conflicts can be divided into 'good' and 'bad' ones, substantive would be seen as 'good' and affective as 'bad' conflicts.

Substantive conflicts relate to conflicts between team members and can be linked to topics, but also to quality of work. They could stem from differences in the basic concept of ideas and in convictions held. Substantive conflicts may be assessed as entirely positive and as a part of the desired organisational conflict culture. Conflict management may not be necessary should the conflict remains on the substantive level.

Affective conflicts are the result of interpersonal differences. These differences may be related to the incompatibility of individual team members (Sect. 8.7). This type of conflict has damaging effects on the quality of the team and its work. Hence the task of successful conflict management consists of avoiding staff members' frustration, withdrawal, indifference and diminished work performance.

What would the first steps be? Ask the individual opponents to suggest possible solutions, what they expect from the other, and what they are prepared to give. Often *empathetic listening* opens the way to problem solutions.

9.3 The Various Stages of Conflict Escalation

Dealing with conflicts professionally is a key qualification for any head of a department or executive. It is important for such a managerial figure not only to get to know what has caused the conflict, but also to engage to resolve the situation. There are several stages in the escalation of conflict (Fig. 9.2).

An executive must have the ability to realise when conflicts exist, to analyse them and to resolve them. In order for *the relevant steps* to be applied, the normal course of a conflict should be understood. In addition, the necessary competency and range of action for efficient conflict resolution has to be established. The backing up and support of higher hierarchy levels in the hospital should be brought into play, depending on the stage of escalation and the type of conflict. You have to act carefully: group conflicts are frequently used by people to entrench and expand their own power. If team conflicts are scaled up and taken to the next hierarchical level, room for manoeuvring could be lost and a further escalation of the conflict could take place. However, if the upper executive level is constantly approached in cases of disagreement, the conflict is then being 'resolved' only at a higher level. This scenario does not conform to professional conflict management. Besides, the conflict team will not have learnt anything they could apply in future.

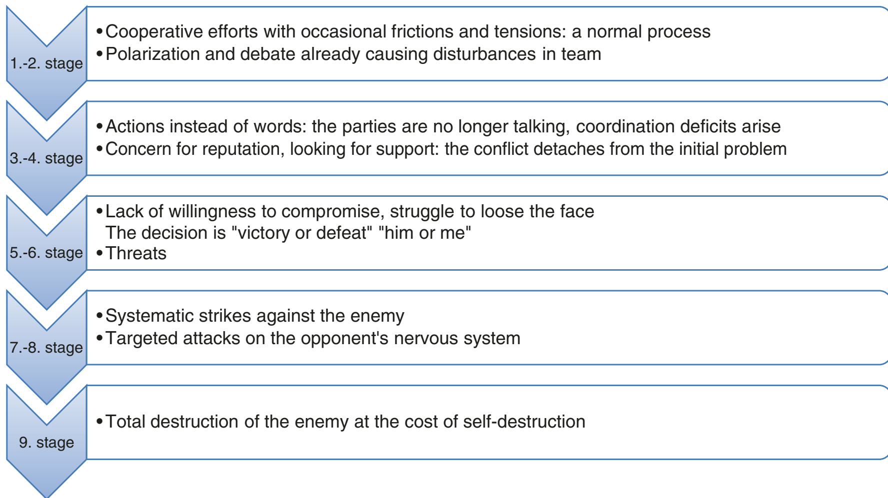

Fig. 9.2 The various stages of conflict escalation

9.4 Support the Organisational Dispute Culture

> All things come into being by conflict of opposites. (Heraclitus)

Some hospitals have a high degree of personnel turnover: instead of managing conflicts professionally and promoting a culture of dispute, they instead act according to notions such as: 'You can't change people.' and 'Those who don't fit in must leave.' In such cases, conflicts in departments are exploited as instruments for maintaining power. Such hospitals are constantly engaged in finding new employees. If they run out of applicants who would like to come and work there, an external consultant be brought in to find adequate staff, often by sugar-coating the current situation to applicants. Alternatively, the consultant could advise, for instance, that the management subdivide one department into various sub-departments, as it would make a post more attractive if it was attached to becoming head of a department, as outlined in the case study. This enables the executive hospital management to reinforce their power ("Divide et impera"; divide and rule). Problems are not solved in this way, but instead are suppressed. Frustration and resignation spread among the staff. The establishing of an organisational dispute culture would have led instead to a competitive advantage for the hospital.

Case Study

A hospital is looking for senior registrars, but can find hardly anyone who is suitable and has the necessary experience. The hospital management is well known for its 'hire and fire' methods. Besides, the hospital's location and working conditions are not very attractive. After talking to an external

consulting company, each of the departments is divided into smaller sub-departments headed by HoDs. In this way, doctors may be attracted by promise that they will become a "head of department". Furthermore HoDs have no regulations for working hours and they can take on duties without restrictions.

Some hospitals have hardly any staff turnover. In such hospitals it could happen quite frequently that a long-time staff member can make "faux pas" without having to fear severe consequences (see the following case study). Both hospitals have one thing in common, even though their strategies differ. They do not manage conflicts professionally. In the one case a 'hire and fire' mentality is applied, in the other conflicts are swept under the carpet and ignored. Neither adopts an approach that seeks a solution.

Case Study
The consultant in a department discharges a private patient without having discussed it first with the new HoD. He receives a warning from the HoD. It is pointed out to him that a second warning would result in actual dismissal.

In another hospital, the consultant regularly treats and discharges patients without having previously discussed it with the new HoD. On a regular basis, the HoD requests that he wants to be involved beforehand, but always gets the answer that this process has been followed in this hospital for years. One day a patient who was treated by a senior registrar dies several hours after having been discharged from the hospital. The head of the department receives a written warning from the CEO that is intended to reassure the public and the press. Apart from this, everything continues as before.

Conclusion: In the first example, the case was overstated and the warning was inadequately expressed; in the second one, everything went on as before, underlying reasons were neither addressed nor resolved and an iceberg of problems was ignored. Neither a change of conduct nor the gaining of insight into the cause of misconduct was requested, hence they did not take place.

Bringing in an external advisor is a well-used method resorted to in cases of conflict. Often the advisor does not know either the hospital or its internal processes: a lot of noise can be made; money spent, disturbance and uncertainty spread. The decision is taken to sacrifice a king and to constitute new principalities – yet everything continues as before. The hospital management conveys the impression to the outside world that everything possible was done and that the conflict has been resolved by mediation.

The care of patients suffers because pseudo conflict resolution is often combined with internal power struggles. Are doctors in one department not consulting colleagues in the department next door? Either they do not want to lose face or they do not have a good relationship with their colleagues: but the effort was not made to find out, the false 'resolution' has papered over the cracks, and another opportunity has been missed to improve patient-centred care.

Below, we look at analysing and solving conflicts professionally.

9.5 Conflict Analysis and Handling

Even from stumbling stones something beautiful may be built. (Johann Wolfgang von Goethe)

When problems arise, they have to be discussed and solved. The saying: 'shut your eyes and push through' should not be applied. A strong team must develop the ability to be resilient. *Resilience* means the ability to withstand stress and to overcome adversity. Resilience enables people to rebuild their lives, even after severe incidents and events. It can be learnt from having coped with crisis situations and criticism by using personal and socially determined values. Where as in the past, 'no praise means no censure', these days much praise is verbalised. However, coping with criticism is seldom taught. Nevertheless, it is only through constructive, positive evaluation of a process that attitudes can be changed and hospitals, departments, and teams can develop further. Employees and managers need to realise this. Resilience is a skill that is trainable and learnable. It is a basic condition for successful conflict management as it supports thinking in terms of resolution rather than solely questioning the underlying reasons. The process shown in Fig. 9.3 can be applied for conflict management.

Adopting roles in the drama triangle (Sect. 5.5) must be avoided because then a focused and resolution-orientated discussion becomes impossible. There, within the triangle, roles are assumed that need to be defended. Such as: 'I have been sacrificing myself for this hospital for years, have worked countless hours of overtime, and now you are blaming me?' If discussions are held at this level, it is difficult to come to a constructive, mutually acceptable solution.

The mechanisms of managing conflicts as well as the impact of conflicts on the working environment should be systematically taught (De Dreu and Weingart 2003).

Fig. 9.3 The various stages of conflict resolution

To acquire this knowledge and use it with skill, an external coach could be consulted.

A conflict usually presents three distinct parts: one's own, the opponent's and the situational part. And usually what happens is that any blind spot is turned towards one's own part. This is evident in the following example.

Case Study

Some senior doctors complain that a new colleague is reluctant to take on team tasks. Furthermore, compiling the staff duty roster with him is reported to be difficult. The team approaches the HoD asking him to dismiss the colleague during his probation period, otherwise they will resign – there are enough attractive job offers for them available on the market. They are unable either to consider or analyse the role they have played in the development of the situation. The new colleague is characterised as being 'difficult', further collaboration is seen as impossible. They go further and approach the CEO. He dismisses the new colleague during the probation period without even having heard the HoD.

Conclusion: The HoD feels bypassed and not valued by the CEO. The clinicians are at first satisfied that their demand has been met, but they subsequently become dissatisfied because their workload has increased. Applicants for the post back off when hearing of the dismissal. In summary, no constructive solution was attained for the staff and the hospital. Furthermore, the team did not learn how the conflict could have been managed professionally to achieve a win–win situation for both sides and without a loss of face.

The above example shows the consequences if an organisational dispute culture has not been established. Extreme decisions such as dismissals by the executive hospital management, but also staff resignations, are a last resort. They bring about a loss of knowledge and experience for the hospital. Furthermore, long-term employees should not insist on the rights of top dog. They, too, should realise, are part of an adaptable decision-making system within the hospital, with responsibility for the consequences of decisions made. Both parties in a conflict should be aware of the potential danger of escalation (Fig. 9.2). Emotionalism positions and opinions must be avoided. Step back and try to see the problem from a distance. This is often difficult to do when in the midst of a situation. Distance is frequently truly achieved only after a period of time. 'We always know better afterwards!'

Generally speaking, the options listed in Table 9.2 exist for solving disputes. You should aim for a *win–win situation* since it offers a problem-solving result for a team.

9.6 How Do You Proceed in a Case of Conflict?

Let us take a closer look at the above-mentioned quality of resilience. We act with *emotional intelligence* if we are experienced in planning our actions and emotions in advance. Personal crusades, emotional action, and taking offence are the greatest

Table 9.2 Various options for solving disputes

Strategy	Winner/loser	Loser/loser	Winner/winner (win–win)
Principle	A wins what B loses	Each one lowers his sights	Overall best solution
Means	Power, competition	Negotiation, compromise	Common definition of problem and solution
Fundamental issue	Who wins?	How many concessions?	What is best?
Process	Person-orientated	Resolution-orientated	Problem orientated
Reaction	Fight	Tricks	Understanding

stumbling blocks. 'The heart's blood' should only be shed to resolve conflicts in an 'unbloody' way. It implies, in this context: resolve conflicts without hurting personal sensitivities and without losing face. This holds independently of any hierarchical levels: someone in leadership does not have the right to speak bluntly or offend others simply because their hierarchical level is higher.

The noisier your opponent gets, the calmer your reaction should be; otherwise the conflict will invariably escalate. Nevertheless, from a certain point on you have to stop your opponent, regardless of hierarchical levels. Similarly, personal boundaries should be granted and respected. Most of us tend to avoid conflicts, to avoid being personally attacked and hurt. Hence you should always try to stay on the factual level regarding what the conflict is about and enable your opponent to save face.

A hospital should have clear strategies for resolving conflicts – not only on paper but lived out, by example. A conflict arose in the past and is being resolved now – in the present – and it should not negatively influence the future. This stance cannot be attained in a short period of time, and one needs perseverance to reach it; but, in fact, many positive examples can provide important corner stones. Not only does the fish stink from the head, but good examples, too, are lived by and from the head, in the person of the CEO or the HoD.

If a conflict is to have a solution, the three C's should be applied: be *concise, concrete, and constructive*. Don't allow your voice to be led by emotion. Look for a future-orientated resolution. Let the past be the past and look to the future ("Wat verby is, is verby" , Nelson Mandela). Do not try to reconstruct everything in detail, because with enough 'evidence' anyone can be made out to have won.

Further method that may be applied in the case of a conflict is *reframing*. With the help of reframing it is possible to, for instance, reinterpret unpleasant or undesirable character traits to view them in a positive light. Instead of describing yourself as chaotic, you can present and describe yourself as being creative and forward-looking. In this way, and in relation to the conflict, you will be signalling your willingness to discuss the matter. Apart from that, reframing diminishes the tension of a situation and enables staff members to see each other in a (more) positive light.

When you analyse conflicts, you should remember that conflicts are like icebergs (Fig. 9.4): only one third is above the water, while the rest is hidden under the surface.

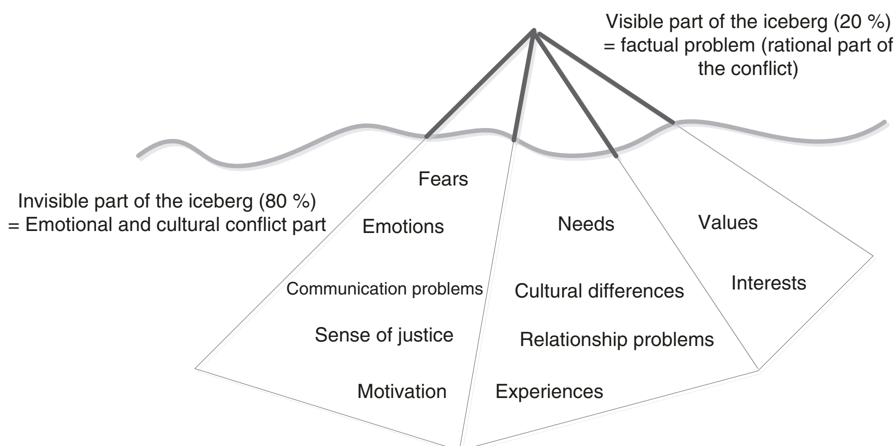

Fig. 9.4 The iceberg conflict

Successful departments and hospitals ensure that the mass under the water does not grow to huge proportions and that the hospital and department remain manoeuvrable. A typical example of an iceberg conflict is described in the following case:

Case Study

The HoD has problems with a consultant, who repeatedly challenges his position in front of others. After a number of personal conversations with the colleague and attempts to solve the problem, the HoD asks for an appointment with the CEO of the hospital to discuss the way forward. Since the CEO does not know the HoD very well, he uses the time prior to the appointment to gather opinions from various hierarchy levels about the two opponents. On the one hand, the staff members being consulted feel valued because their opinions are asked. On the other hand, they are confused ('Is the CEO only able to have an opinion by asking others? Is my opinion helpful in resolving the conflict? Do I need to know about the conflict?'). The HoD also gets irritated when he unofficially hears about the various inquiries.

Conclusion: The interaction (HoD – consultant – CEO) is already burdened before the actual discussion takes place. This makes it difficult to find an amicable solution for all involved. This is a typical example of an iceberg conflict where much conflict potential is hidden under water and will probably lead to other conflicts in future.

9.7 Strategies for Resolving Conflicts

For future team-building, the results of conflicts and the ways in which conflicts are experienced are important. This determines how future collaborations will take place. A win–win situation not only strives for the overall best solution, it also

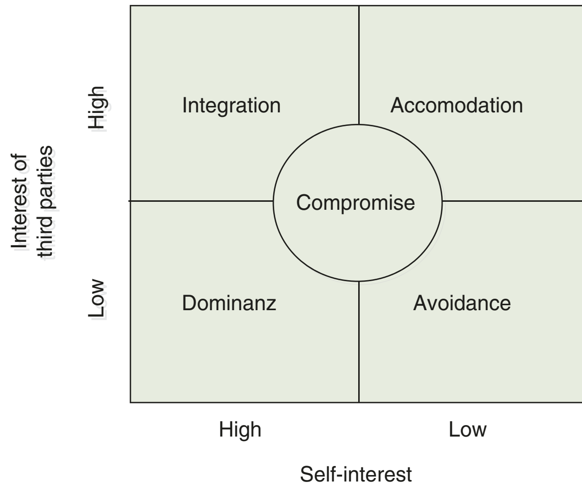

Fig. 9.5 Conflict resolution by considering the interests of third parties versus self-interest

enhances the acceptance of all parties and the maintenance of good working relationships. Crucially, no-one loses face.

In connection with conflict resolution, everyone follows their individual pattern. The question of whether the concern, while resolving the conflict, is primarily for oneself (self-interest) or for others (of benefit to others) is vital. The various styles opponents adopt can be divided into *dominant, integrative* and *accommodating, and avoiding* (Fig. 9.5).

For settling disputes constructively, it is necessary to agree on a common approach without anyone dominating and the other party giving in. If a team knows in advance that a conflict is being settled professionally, constructively, and without a power struggle, the team will emerge stronger than before.

For staff and new staff members, the resolution of past conflicts is an important indicator of the sustainability and reliability of a team. Pay careful attention to teams claiming to be working harmoniously and without conflicts. The composition of teams is discussed in detail in Chap. 8.

To resolve conflicts constructively, the following approach should be used. Initially, the superior and the team should try to solve the conflict internally, without bringing it to the notice of anyone outside the hospital or outside the department. If this does not succeed, those concerned could consult an internal, trained mediator. The mediator should develop a problem analysis together with the opposing parties and look for a common solution. In the negotiations process, the mediator remains neutral and is obliged to maintain confidentiality.

Case Study

On a yearly basis an external consultancy company carries out a survey of how the clinicians in a hospital perceive their working environment. These evaluations are published on the internet and are accessible countrywide for a benchmarking process. In the view of the external consultants the registrars have assessed their

training facility too critically in the officially published report. As a result, the two groups do not speak to one another. Even important patient data is not passed on during ward rounds and the consultants impose an unofficial information blockage. When the conflict further escalates, an appointment is arranged for a discussion. In advance of the meeting the HoD speaks to both groups and tries to moderate. The HoD succeeds in convincing the registrars to take this first important step so that the relationship between the groups can be re-established. Slowly at first, but then more intensively a debate and discourse follows.

Conclusion: To reach a win–win solution, it is often necessary to use a mediator to help overcome stumbling blocks. In the above case, the HoD facilitated the function of a mediator.

If the conflict cannot be resolved through an internal mediator, an external coach may be consulted. This, too, may have disadvantages. Since the coach is often paid by the hospital, he may not adhere to a neutral position. In addition, the coach is not familiar with the hospital; thus, he could sometimes cause more harm than good. He may leave behind mayhem, with the team then experiencing a marked loss of confidence. Table 9.3 highlights suggestions for the style of conflict management to be adopted in relation to the situation.

Table 9.3 Conflict management strategies appropriate to various situations

Conflict resolution	Appropriate situations	Inappropriate situations
Integrate	Complex factors	Task or problem is simple
	Synthesis of ideas is necessary to offer a better solution	Immediate decision is necessary
	Support by others necessary	Other parties are not affected by the outcome
	There is time available for resolving the problem	Other parties have no problem-solving skills
	The team cannot resolve the problem on its own	
	To resolve the problem, others are needed	
Concessions	You consider that you might be wrong	The subject is important to you
	The subject has more importance to others	You believe that you are right
	You are prepared to give something as compensation for something you will receive in future from the opposing party	The position of the opposing party is wrong or they are not acting in an ethically correct manner
	You act from a weak position	
	Maintaining the relationship is important	

Table 9.3 (continued)

Conflict resolution	Appropriate situations	Inappropriate situations
Dominance	The contentious point is trivial	Both parties are equally strong
	A quick decision is necessary	The subject is not important to you
	It is necessary to make an unpopular decision	The subject is complex
	It is necessary to dispose of dominant staff members	The decision does not have to be taken quickly
	An unfavourable decision by the opposing party has negative effects for you	The staff members possess a high measure of competence
	The staff members lack the expertise needed to come to a decision	
	The subject is important to you	
Avoidance	The subject is trivial	The subject is important to you
	The negative effect of confronting the opposing party cancels out the advantages	It is your responsibility to make a decision
	A cooling-off phase is necessary	The parties do not want to defer the problem, a solution must be found
		Immediate attention is necessary
Compromise	The objectives of both parties are compatible with each other	One party dominates or is stronger than the other
	Both parties are equally strong	The problem is sufficiently complex to require a problem-solving approach
	Neither an integrative nor a dominating style is successful	
	A provisional solution for a complex problem is called for	

Modified according to Rahim (2002)

9.8 The Golden Rules of Conducting Conversations

The parties involved in a dispute ought to know how important it is to communicate. The objective is to find a good solution, not only for both parties involved in the conflict, but also for the hospital and the department. In the case of conflicts, it is important to repeatedly stress that there are no winners and no losers; both sides have to make concessions and meet each other. The golden rules of conducting conversations and mediations are essential and should be known and applied by all hospital employees.

The golden rules of conducting conversations to bring about conflict resolutions are together with your opponent:

– Clarify the relationship with your opponent (if possible in mediation)
– Avoid emotions

– Do not arouse fear
– Respect your partner in the conversation and avoid a loss of face
– Avoid escalation of conflicts
– Show esteem and respect
– Allow free spaces and do not drive the opponent into a corner
– Do not offend the opponent and respect his personal boundaries
– If the problem seems to be too large, divide it into smaller sections
– Listen empathetically and ask if a fact is not clear
– Summarise the key factors and the way forward before you close the meeting

9.9 Summary

In hospital settings, professional skills in the use of *conflict management tools* are still rare. Whereas in many enterprises professional strategies and measures are in place, in hospitals conflicts are frequently managed intuitively and in terms of gut feelings. They are also often ignored, are swept under the carpet or are 'solved' as top–down decisions. By involving an external consultant, conflict resolution can often be achieved. This approach, though is not always the best one for the hospital. It is more advisable to establish a culture of conflict management and *conflict solution* within a team. If hospital managers and heads of department are able to create a *positive organisational culture* of conflict resolution, and enable the staff to cope with *criticism* and practice *resilience*, the conflicting parties often will emerge strengthened from a conflict. It would be ideal to establish organisational and preventative strategies for conflict management and conflict resolution ahead of time, as teams and the hospital can then learn and gain from transparent and solution-orientated management of conflicts.

9.10 Five Reflective Questions for Practical Application

1. How do you handle adverse opinion and conflicts in your team? Are conflicts stigmatised as being bad for the department or the hospital?
2. How high do you estimate the number of conflicts to be that are not noticed, are played down or are deferred? High/middle/low
3. Briefly summarise the various steps that are used in your department and within the hospital if conflicts arise?
4. Who is responsible for conflict management? Does it always become a matter for the boss? What are the stages of conflict escalation in your department/hospital?
5. Is there an established conflict and dispute culture in your department/hospital?

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Be a Visionary Leader

10

Goals

- How can you become a visionary leader?
- How can you avoid frequent errors in leadership?
- How can you motivate your colleagues and co-workers?
- How do you prevent identity crises for yourself and your subordinates?

This chapter outlines the key characteristics of a good leader. It depicts leadership styles and describes methods of leadership, empathy, authenticity and anticipation. To understand how you can motivate your co-workers, Maslow's hierarchy of needs and other motivational theories are explained. The term 'noetive dissonance' is described, as are measures to avoid it. The hassles of the first 100 days in a new workplace are outlined. We describe how a burn-out syndrome can be detected and avoided.

10.1 How to Be a Good Leader

Two things prevent advances in medicine: authorities and systems. (Rudolf Virchow)

As early as the 16th century, Niccolò Machiavelli challenged the Republic of Florence with his book *The Prince*. Much of what he said is still valid today and applicable in hospitals. In contrast to purely market economy–orientated service providers, hospitals have an ethically-orientated focus. Nevertheless, the everyday hospital routine occasionally tells a different story: in historically established autocratic structures, power and influence still play an important – sometimes even the central – role.

To the modern way of thinking, the ideal leader does not exist and is seen as representing a permanent goal that one can only strive for. To become a good leader you should be

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familiar with the different management instruments and be able to apply them accordingly. The underlying theory, in addition to practical experience, should enable you to make decisions based on evidence. You should not be tempted to give in to certain interest groups without being convinced that to do so would be best for the hospital.

Being the CEO of a hospital or the head of a medical department means to balance responsibilities and interests for the sake of the institution. A head of a department (HoD) may be highly regarded by his colleagues because he prioritises their interests and subordinates everything else to that. Accordingly, staff fluctuation and resignations are low. However, he will not have properly fulfilled his role if this is achieved at the expense of the patients' interests or at the cost effectiveness or efficiency of the hospital. A leader must free him- or herself of wishing to be 'everybody's darling' – of the desire to be popular, loved, and acknowledged. Executives need to have the ability to face opposition – even storms – to enforce unpopular but necessary changes.

The following mistake is often made on all executive levels – including political leaders: despite representing a rationally understandable proposition for change, the initiator buckles at the first sign of opposition, which usually comes from some interest groups. The leader backtracks, perhaps tries 'to put things into perspective'. Finally, the good idea is watered down or not implemented at all. More courage and the necessary backbone are needed when implementing change (see Chap. 6). Here are some key abilities that are expected of executives:

- Integrity towards colleagues and the employer
- Confidentiality (e.g., treat confidential and personal documentation or conversations as such and do not pass them on to third parties for tactical or strategic reasons)
- Transparency of decisions and the decision-making process
- Loyalty to colleagues and subordinates, patients, and referring doctors
- Good communication skills
- Appropriate behaviour and action

Ethical behaviour plays a central part in medicine. Medical staff is not only bound by the Hippocratic Oath when treating patients. Ethical behaviour is also associated with correct behaviour towards colleagues and staff members. In this context, it is of particular importance that words and deeds match. The entire comportment of an executive should follow ethical principles. Executives have to be open to new information and must be able to change opinions and attitudes. Beyond that, they should accept that subordinates might disagree with the decisions of their superiors. This attitude also affects successful conflict management (Chap. 9).

10.2 Leadership Styles

> Visionaries will always meet opposition from weak minds but the seeds they plant save the world. (B. Habyarinama)

To fulfil the functions of a head and executive, you need to apply the various leadership styles to the context.

The major leadership styles can be grouped as *autocratic-hierarchic*, *democratic-cooperative*, and *laissez faire*. Although many executives declare themselves to be a cooperative leader, their style is often a mixture of autocratic-hierarchic and democratic-cooperative. People with a mixed leadership style are *situational* leaders. An authoritarian decision is, in fact, required for certain problems and critical situations in a hospital. It is not always possible to discuss everything in great detail; hospitals would then become unmanageable.

Staff members experience the greatest freedom with the *laissez faire* leadership style. The leader does not intervene in the processes. However, due to a lack of discipline (for example, staff in a department take leave or attend a conference at the same time), conflict of competence or the forming of cliques, this style can lead to decreased cost effectiveness and a decline in the quality of care offered to patients.

Leadership qualities can be further split into four main behaviours:

Driver (example: Hilary Clinton): competitive, experimental, focussed, direct, tough-minded

Pioneer (example: Steve Jobs): energetic, spontaneous, brainstormer, innovator, networker

Integrator (example: Nelson Mandela): diplomatic, empathetic, helpful, consensus-orientated, relationship-orientated, big picture thinker

Populist (example: Donald Trump): tells the mass what they want to hear and pursues his own interests behind the scene

Guardian (example: Angela Merkel): loyal, realistic, methodical, structured, cautious

The staff must be able to rely on the HoD or CEO making the right decisions by showing leadership qualities. Above all, decisions should be situation-specific and comprehensible (Carter et al. 2005).

You should avoid the following *leadership flaws:*

- Successes are attributed only to the head or CEO
- Decisions are taken top–down and are not explained
- Discussions with staff members do not take place unless they concern a particular interest of the HoD or CEO
- The boss interferes with task and competency areas
- Competencies are not or only inadequately assigned
- Instructions are distributed in an autocratic manner
- Controlling habits that demotivate the staff
- Offensive and confrontational behaviour
- Personal problems and difficulties that colleagues are experiencing are not taken care of
- Preference is given to certain interest groups
- There is an atmosphere of moods, arbitrariness, and harassment
- There is a lack of confidence in colleagues
- Actions by others are always regarded with great scepticism

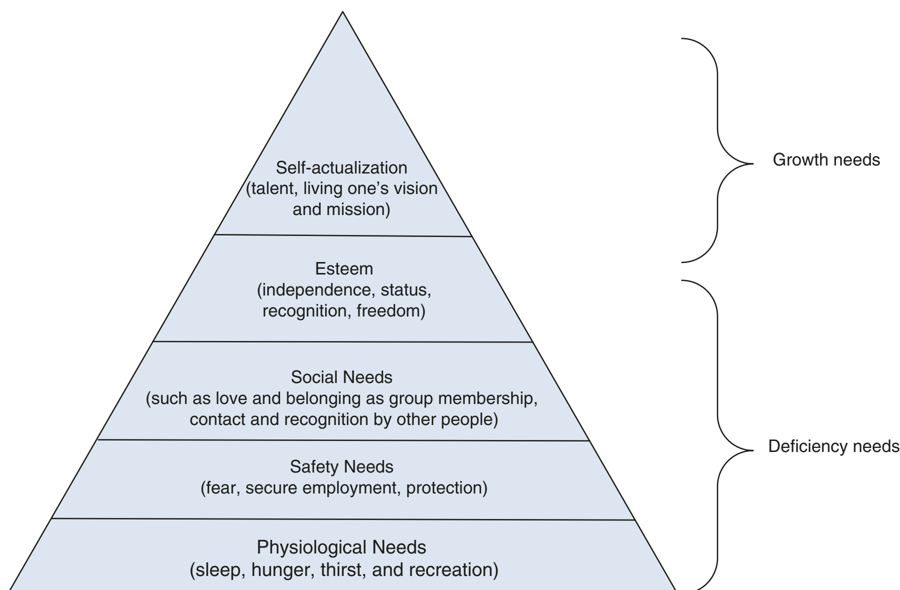

Fig. 10.1 Maslow's hierarchy of needs

10.3 Maslow's Hierarchy of Needs

The motivation of staff is a major pillar of effective leadership. A good and reliable boss tries to address the needs of the staff and keeps them motivated. This can be achieved by creating an adequate work environment, incentives, expressing appreciation of their work, good working conditions and acceptable working hours, and facilitating self-actualisation.

Abraham Maslow, a US American psychologist, conducted his basic studies on the hierarchy of needs and motivation in 1943. He drew a holistic picture: human beings are usually motivated and seek self-fulfilment; but only once physiological needs are satisfied a high degree of self-fulfilment can be achieved.

Maslow organised the different needs in the shape of a pyramid, which is called *Maslow's hierarchy of needs*. The individual needs must be met from the bottom up. On the first level, physiological needs like sleep, hunger, thirst and recreation are addressed. On the second level, safety needs must be met (fear, secure employment, protection). The third level depicts social needs such as love and belonging (as group membership, contact and recognition by other people). The fourth level covers esteem, being respected and valued by others (independence, status, recognition, freedom). This is followed by self-actualization 'What you can be, you should be.' (talent, living one's vision and mission) at the top of the pyramid. The first four levels of needs are named as *deficiency need*, the self-actualization level is categorised as response to *growth need*. The different levels blend into each other (Fig. 10.1).

The following quote from a hospital novel illustrates that hospital staff can neither achieve self-actualization nor a high degree of motivation without first satisfying their basic needs.

Case Study

Staff shortages have become so extreme over the last few months that doctors in the Emergency Department and the Day Clinic had to cover tasks previously done by nurses and secretaries whose vacant posts have not been filled: making appointments, writing letters, admitting patients, creating new folders, drawing blood and many other of the small tasks that are necessary when careing for patients.

The HoD, Professor Sanders, complains regularly about decreasing patient numbers. He opposes any carefully placed remarks about the inefficiencies of the organisation of his department. He wants to maintain the good working relationship to Mrs Adlmaier, the head of nursing. He shields away from dealing with her directly, preferring to delegate direct communication to his colleagues. 'If you don't like the way nursing is organised in the hospital, go and speak to Mrs. Adlmaier', was his standard answer to all complaints.

Conclusion: Colleagues will be motivated to work to the best of their abilities only if their basic needs, such as good working conditions, tasks appropriate to their professional status, and appreciation of their work are met. Without these, self-actualization and thus professional perfection will not be achieved and performance will reach only an average level at best.

10.4 Leadership Methods

> Leadership is the capacity to translate vision into reality. (Warren Bennis)

Performance agreements can effectively measure staff accomplishments, and they belong to the leadership tools. These agreements are binding. You can support their acceptance when you draw them up together with your subordinates: carry out regular reviews with your subordinates and apply agreed-upon procedures and measurements. Set dates in advance when these reviews will take place. However, if you can praise someone, do it immediately. Praise wherever possible, especially with new team members so that they feel acknowledged and welcome, only dispraise when necessary. Praise in a tangible way by going into detail. Convey the message 'Keep it up!' However, *praise and reprimand* must be genuine. Express your own positive emotions, authentically. Encourage your colleagues! Look for opportunities to praise. Praising staff members in front of others doubles the effect, as it motivates staff who overhear to work harder.

If you have to reprimand someone, do it immediately. Reprimand in a concrete way by going into detail, yet do it without accusing or harassing. Always show your colleagues that you value them. Then discuss the next steps in their professional career and, whenever possible, give *support*.

However, the choice of your leadership style, whether you are delegating, participating or training, depends on the degree of *maturity of your subordinates* (Table 10.1). A registrar delegates and trains interns differently from a consultant

Table 10.1 Type of leadership dependent on the degree of maturity of the employees

Degree of maturity	Type	Implementation
High	Delegation	Hands over responsibility for decisions and implementation
Moderate	Participation	Shares ideas and supports decision-making
Average	Training	Explains decisions and gives the opportunity for questions
Low	Delegation	Gives precise instructions and strictly monitors performance

who allows his senior registrars to participate and delegate relevant tasks. Do not allow responsibilities you have delegated to revert back to you: your staff is employed to solve problems!

Besides having the responsibility to lead, your role is to motivate others to get active and do things; manage and coach your subordinates.

The management function requires that you monitor tasks, manage complex situations, and ensure that there is a good work flow. *Managing* also entails achieving results through your subordinates and colleagues. *Leadership* consists in implementing change processes, developing visions, setting goals, and inspiring others to strive for completion of common goals (Cook and Hunsacker 2001). This illustrates why only a few CEOs and politicians can also call themselves true leaders. By *coaching* you are supporting your staff in their development and fulfilment of their duties, so ensuring that the standard of work is constantly raised.

For each of the three tasks (*managing, leadership, and coaching*) different skills come into play. Apart from analytical capabilities, an executive needs to understand human nature. This can best be gained by working for different employers and in various work settings. Furthermore, an executive should be able to develop the potential of staff members enabling them to unfold their best abilities. You, as an executive, have to believe in the potential of your employees and help them to develop their potential.

For *coaching* – i.e., supporting staff to reach their best performance – you need skills such as selflessness, the ability to encourage people, credibility, and well-developed communication and behaviour patterns.

Have the courage to lead people and to stand by your decisions, even if you are facing headwinds. Don't immediately bend and leave things the way they were, on familiar, worn-out tracks. Repeatedly illustrate the process of change to your colleagues and subordinates. In this way you can gather an increasing number of people who support you.

10.5 Empathy, Authenticity and Anticipation

Make your actions look like your words. (Severn Cullis-Skukuzi)

When you are dealing with your staff, you should show empathy, authenticity, and anticipation. *Empathy* means the ability to walk in another person's shoes and sympathise with him. *Authenticity* in your own behaviour implies that words and actions match. You are reliable in your actions your behaviour today being no different from your behaviour

yesterday. *Anticipation* describes an ability to foresee, an alertness to, what is likely to be required in any situation.

These characteristics give you the ability to recognise calls for help and other signals: if you are confronted with criticism or requests for changes in a discussion, take these points seriously. Substantiate, discuss, and summarise them. After the dialogue, both of you should have a clear picture of the underlying problem and how it can be solved. Ask for the solution that your colleague or subordinate would suggest. Do not delegate problems to other colleagues, but hold yourself responsible for them (Sutton 2010). Assume that a colleague may be under psychological strain before s/he articulates problems in a face-to-face interview. Emphasise that you will definitely tackle this problem and look for a constructive solution. If you expect something in return, be as specific as possible in formulating what the colleague has to do within a specific time period.

The higher you are placed in the hierarchy the more critically people will monitor you (Pfeffer 2010). Be conscious of the fact that your manner, your remarks and gestures are carefully weighed (Sect. 5.2.2). Even if appearance isn't your primary interest, it starts with your clothes and hairstyle, as simple as that may sound. And the less you conform to the usual and accepted standards, the more critically everything about you will be questioned. Women in leadership positions or executives of foreign origin will feel this in particular. Nevertheless, be authentic in your actions and behaviour. You will not be credible if you constantly change your behaviour because of external advisors. Deliver an authentic image and consider beforehand how your actions might appear to others.

Case Study

Two patients are in their ward, waiting for the morning round. Suddenly a large group enters the room. A gentleman in a dark suit approaches them, greets them by handshake and asks if they are satisfied with the services. Slightly befuddled, they nod. One minute later the group leaves. They look at one another and ask themselves: 'What was that?' To a later question the nurse explains that this was the CEO, who uses an unannounced 'walk in' strategy to find out how satisfied patients are.

Conclusion: The image you deliver must be appropriate and should not cause consternation.

The empathy you have for your staff will be carefully analysed, as other aspects of your behaviour. Who do you greet? Do you greet others first? How do you behave towards your subordinates? How do you react in meetings? How do you act towards people who are placed higher than you in the hierarchy? Are you mentally present in meetings or do you spend your time sending messages and e-mails on your smartphone? How do you react when someone disagrees with you? Do you insult people with your comments? Do you allow your displeasure to be felt the next time you meet that person?

Empathy and anticipation are important characteristics and determine how you are accepted by your staff. Let your staff know that you appreciate their work. Allow them to enjoy your optimism and the pleasure you take in their work. In this way you can motivate your staff to enjoy doing their work. This should result in a self-fulfilling prophecy: what many say and do will eventually become true.

10.6 How Do I Motivate My Colleagues?

Motivated staff will engage in their work with keenness and enthusiasm, and so will benefit the development of the hospital. They should enjoy coming to work. Sharing work motivation is another important tool in management, and it is also one that responds to training. As a leader you have to engage in building up trusting relationships and open communication between staff members. Besides, members of staff have to become involved in decision-making and need to be informed about what is happening in the hospital (Chap. 5).

Motivation develops from intrinsic and extrinsic factors. *Intrinsic* describes holistic and self-generated motivation. It originates around a sense of responsibility and the feeling that the work is important. It presupposes that you have control over your own area and a certain degree of autonomy in your work; you are able to develop and increase your competence and know that you have an exciting and challenging job (Chap. 9). *Extrinsic motivation* is the result of external influences. Among them are incentives, praise, support, promotion, or, as negative factors, disciplinary measures, criticism and lack of praise (Herzberg et al. 1959).

John Stacy Adams, a behavioural and workplace psychologist, developed the equity theory of motivation (Fig. 10.2). Everyone pays attention to a balanced degree of equality and harmony (Adams 1965). The balance can be judged by what one receives as an output (salary, appreciation, etc.) in exchange for one's own input (work). Ideally, this should feel fair and balanced. Otherwise, balancing acts will be performed to counteract the imbalance. Yet the weighting of input and output are subjectively sensed values and depend on an individual's personality and experiences.

According to Frederick Herzberg, the *two-factor theory* or dual factor theory presents another approach to explaining motivation and work satisfaction (Herzberg et al. 1959). It includes the *hygiene factors* (factors that do not give positive satisfaction or result in a higher motivation) and *motivators* (factors causing satisfaction), which compete with each other. Hygiene factors are created by general conditions; motivators originate from the content of the task. Hygiene factors include work conditions, status, relationships within the team, team culture, security, pay, benefits and access to information and sources of knowledge. Among the motivators are responsibility, challenging work, recognition, and job opportunities.

How can the needs of staff be met? Working conditions will have to improve, and solutions are not to be delegated to others, as is illustrated in the above example referring to the head of nursing (Sect. 10.3). Staff should have access to department and hospital information, for example, by enabling them to access minutes of meetings via the intranet. Engage in an appropriate *communication culture* in meetings.

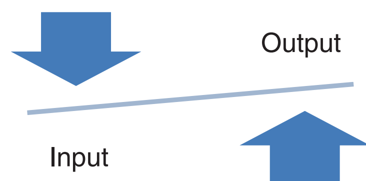

Fig. 10.2 Theory of equity or fairness

To improve motivation, individuals should be given the chance to receive regular feedback on their performance (Sect. 5.6).

The *inner resignation* of staff (Chap. 2) has to be avoided because it is counterproductive for the hospital. A frequent reason for this mechanism is the feeling of not being involved. This may be reflected in remarks such as 'In any case, decisions about my unit are being taken over my head'. Other reasons may be that staff members cannot identify themselves with the hospital's mission statement. Furthermore, they may not feel able to fully apply their abilities at their workplace and therefore, feel under-challenged.

Self-actualisation at the workplace only happens when you can use your professional competence, demonstrate your effectiveness, and are given the opportunity for creating your own tasks. This will only take place if you can (pro-) actively practise your social and self-competence and feel accepted (Graf 2007). This can make a big difference to the competitive advantages of organisations and hospitals. If there is a strong focus on cost cutting, as it is frequently the case, staff are often regarded as the main cost factor that can be replaced at will. In the health care system, appreciation and development of staff are still rare. However, nursing, organisational structures and management tools are frequently much better implemented than for clinicians.

10.7 How You Create a Meaningful Work Environment

> Live as if you were to die tomorrow. Learn as if you were to live forever. (M. K. Ghandi)

A number of studies have shown that staff members are usually only 60 % productive. Hence, many abilities and talents are not utilised to the hospital's advantage. One reason might be that staff members are facing *noetive dissonance* (Graf 2007). The concept of noetive dissonance portrays the intensive endeavour by a person to work towards a goal, to implement projects, and to put ideas into practice. But external circumstances, such as harmful competitiveness within the department (e.g., various divisions within the department are fighting for dominance) and parties pitting against others, are jeopardising the ambitious goals of individuals.

A meaningful work environment remains the biggest motivator. Most objectives set by decision-makers are aligned to economic considerations. Nevertheless, a boss is not going to develop himself to become a good leader if he sees the main objective in his work only to be earning a good salary and getting the annual bonus. On the other hand, meaningful self-recognition cannot be simply prescribed or instructed, but must be developed and striven for.

Most employees start their new work with a lot of enthusiasm and goodwill. As a leader you should attempt to maintain this commitment, support and promote it, and consequently counteract the effects of noetive dissonance. Employees often perceive their superior to be hazy about or uninterested in ethical ideas and beliefs. However, frequently, it is not satisfying for the staff to pursue the only goal they have in common, to make a profit and frame the margin for the next year. In the long run, motivating your staff in this manner will not succeed. You, as the leader, have

to be able to describe meaningful work apart from economic considerations, and especially in a health care setting. Goals, values, and ethics have to be discussed and implemented with regard to: What is important for health care workers, nurses, and doctors? How can the hospital as an organisation enable them to apply ethical considerations? How would they describe the current quality of their interpersonal relationships within the team? To achieve a high level of motivation, the general conditions provided by the hospital should enable exciting, meaningful, and valued work. For this reason, leaders have to be authentic and real. Words have to be followed by actions. If you demand transparency, but sweep problems under the carpet, fail to discuss matters, and carry on as normal assuming that nobody will notice you've done this or if you leave problems to solve themselves, you are creating an authenticity problem for yourself.

One dilemma is that many people only tolerate people around them who confirm their opinions. For your personal development, but also for the development of any organisation, it is crucial to permit critical voices to emerge around you, to listen to them, and consider them. This is why 'think tanks' are so successful. In leadership positions there are a considerable number of people who try to hide a lack of self-esteem by adopting a particularly aggressive manner. This produces a bad mix. On the one hand, openness is demanded; everyone is invited to have their say. But particularly when those who demand openness are unable to live the values they expect from others contention may arise (Graf 2007). Propagating a transparent leadership model does not guarantee that this model will really be lived. Paper is patient, however, ultimately leaders are evaluated by their peers on what they do and not simply by what they say.

Even today, an interdisciplinary treatment approach is still not common in hospitals. Resources are wasted and staff is not appropriately involved. Only a few people are capable of working in an interdisciplinary team since opinions may have to be subordinated and agreement to be found. Motivational approaches are aligned to power, needs, and the idea of self-actualisation ('live your dream'). By manipulating feelings (e.g., with rewards) you can control, stimulate, and motivate colleagues.

Around 1930, the Austrian psychiatrist and neurologist Viktor Frankl founded a neo-dynamic approach, which is spirit and meaning-orientated. Power struggles in or among departments often dominate the daily activities and may result in noetive dissonance. They may also be partly consciously and partly unconsciously entertained by the executive hospital management. If the performance and the requirements of the customers (referring doctors and patients) no longer motivate the staff, they will be more concerned with defending benefits than market orientation, and when this happens, the striving for power and pleasure has won over the striving for deeper meaning. The result is existential frustration, leading to *an inner emptiness* and a sense of meaninglessness. The motivation committing you to a goal disappears. This is especially difficult for staff members who are committed to pursuing these goals. This commitment has been destroyed by external circumstances, internal quarrels, and power struggles to secure vested rights. People in leadership positions and staff members for whom a meaningful work environment, team spirit, service, and client orientation are important values are particularly vulnerable. This

is especially the case when the facilitation of their goals is prevented by their superiors. This leads to existential frustration (Graf 2007). At this stage, communication workshops or changes in organisational structures are no longer sufficient. Their identity crisis can only be solved with meaningful work and a holistic concept.

In summary, some basic principles for staff motivation can be recommended:

- Place meaningful work higher in value than financial aspects.
- A department and hospital can only function well if all work as a team. It is the task of the departmental heads and CEO to support the staff in finding their self-fulfilment and to make sure they are involved in the team process.
- Create a work environment where creativity and interdisciplinary work are supported, so as to counteract the growth of noetive dissonance.
- Give people space, but also clearly define existing boundaries (e.g., 'You can make the decision on one training course that you would like to complete; the other courses I would like to select with you and advise you.').
- Create a network of appreciation. It may cause inner conflict if, for instance, the head of a department endeavours to express appreciation of the work of his staff, but his own work is not acknowledged by the executive management. Exemplify transparency and openness.
- Give your staff the opportunity to find self-fulfilment in the work place.

Depending on your dominant characteristics (e.g., www.enneagramm.com), you will make your decisions. They will also guide your reaction in inter-personal conflicts. Everyday life is certainly made easier if crises affect you like "water off a duck's back" rather than you feeling you are "wearing shoes that don't fit". Nevertheless, in certain situations it can be helpful to be more sensitive than others. In this way, *weaknesses* can become *strengths*. Sensitivity or a lack thereof is not what distinguishes a good boss from a bad boss. In critical situations, be continually aware of your particular 'strengths' and your 'weaknesses'. This will enable you to be a good leader.

10.8 The First 100 Days in the Job

> The difference between the impossible and the possible lies in a person's determination. (Tommy Lasorda)

The first 100 days in a new working environment are often called the 'window of opportunity'. The challenge is to innovate, set goals or get the department or the hospital back on track. It is a sensitive time for initiating change, to address people, to carry them along with you, and not to put them off. Changes are often accompanied by the question: 'What's in it for me?' You should address this concern and engage staff in the new process.

Joining a new organisation or taking on a new hierarchical role is a critical period. Your statements, comments, your gestures, and expressions will all be scrutinised. It is important when issuing a mission statement to remember that the

organisation existed and functioned before you joined it. If processes are running smoothly, you should take the time to observe, analyse, and familiarise yourself with your new environment before developing your own strategies. This approach will give you the opportunity to assess and evaluate things appropriately.

However, settling into a new job is not always as smooth and harmonious as described in books and articles. Due to previous long-term tenure there may be an urgent need for innovation and change. Sometimes, the staff has waited years for a new superior to take over and make imminent improvements. Alternatively, a laissez faire style may have become established during a period when there was an acting executive manager or acting head of department (Chap. 9). Consequently, you cannot spend the first 100 days merely observing, but will have to start acting fairly quickly. This could lead to conflicts because different management styles and visions clash, while the staff may have developed a longterm bond and therefore are well-attuned to each others. In such a situation, conflicts can be expected. A visionary hospital executive or your superior would ideally have drawn your attention to such potential problems and will offer help and support. However, you cannot expect other people to make the effort to understand your troubles and concerns. *Empathy* may be a virtue, but it is not a widespread trait. Imagine, instead, colleagues who enjoy the sorrows of others without offering any constructive help. All too often, the messsage is: take care of your problems yourself; don't expect help from anyone else. It might help to get external support. In this case, make sure that the values and views of the coach or facilitator are similar to yours. Sometimes, the involvement of external coaches can cause more calamity than salvation.

Case Study

One evening around 6 p.m. the CEO of the hospital comes along to have an informal talk with the new HoD. After a few introductory words he volunteers to provide some local background information, since the new head has worked abroad for some years. The CEO emphasises that he wants to distribute the 'right' information by avoiding influences from other 'sources'. First, he tells of the seemingly unbridgeable problems with his predecessor, who eventually had to be evicted. Little by little and almost by-the-way he mentions that during the last 5 years several departmental heads have had to leave. They all appear to have been complicated characters. He closes the conversation with the conclusion that all difficulties have been overcome, the hospital is now in good shape, and he as the CEO is facing the future with confidence. After an hour, he leaves a rather puzzled HoD behind, who asks himself whether he would have accepted the position if he had had this information beforehand. His position now seems far less glamorous than before.

How would you react to this situation? Decide on an answer that is closest to your likely response:

1. That happened all in the past. There have been some personality clashes between people who had to work together. But I'm smarter than they were and get along well with people. I won't let anyone have the power to force me to leave this job.
2. Oh dear, they seem to enjoy showing people who the boss is. I'm sitting in an ejection seat. I'll have to look for a new post as soon as possible. I can't expect my family to live under such uncertain circumstances. I could be the next to go.
3. They don't seem to be particularly concerned about trust. How am I supposed to build a relationship of mutual trust if I'm only told such important information after already starting the new job? Could all of those HoDs have been difficult people. Or is it the CEO who's the difficult one? I'll have to be very careful and watch my step to survive here.

An interpretation to the question of the case study is given at the end of the chapter.

10.9 Prevent Burnout

The burnout syndrome describes a condition of emotional exhaustion due to work overload, which causes reduced performance. The burnout syndrome is increasingly seen in hospitals, independently of hierarchies. Nursing staff and doctors are at elevated risk as they are continually confronted with highly emotionally-charged *life and death* situations. In their every day work they often feel externally driven and not self-determined. Treatment processes are subdivided into small sub-steps and the patient is no longer seen holistically. Doctors and nurses no longer participate in the recovery process of a patient and often do not get to experience the patient's joy and gratitude.

Symptoms of burnout are an emotional state of exhaustion, detachment, and ineffectiveness (Maslach 2001) and are listed in the Maslach and Copenhagen Burnout inventory (Table 10.2). The Burnout Syndrome includes, too, feelings of: depersonalisation and the sense of being a failure. Many small events can cumulatively result in a state of exhaustion, which cannot be fixed by a free week-end. A contributing factor is the above-mentioned noetive dissonance. There could be *conflicts on various levels*: role and goal conflict (lack of autonomy) or relationship and expectation conflicts (discrepancy between one's own demands and expectations and the everyday work). Additionally, an overburdened situation due to a lack of resources may be a contributing factor.

When it comes to recognising the signs of threatening burnout, everyone is responsible not only for him/herself but also has a responsibility towards others. The lowering of self-esteem is a first sign, which may be expressed in repeated remarks such as: 'In any case, what I say doesn't matter', 'Everyone makes decisions without me', 'I always make the same mistakes'. Such signs should not be ignored and professional help should be sought although it should not be organised behind the back of the person causing concern. To do so would risk a breakdown in trust.

Table 10.2 The Maslach and Copenhagen Burnout inventory

Type of burnout	Dimension	Symptoms	Example
Related to patients	Depersonalisation	Indifference	'I find it hard to focus on my patients.'
		Detachment	
		Cynicism	
Personal	Emotional exhaustion	Poor motivation	'I no longer enjoy my work.'
		Irritability	
		Tension	
Task-related	Experiencing failure	Feeling of futility	'I seldom feel that I can really help someone else or that I relevantly contribute to the system.'
		Ineffectiveness	
		Hyperactivity	

10.10 Summary

You can only pass on your values to your staff if you are in harmony with yourself. This is not all that easy to achieve, especially in a demanding and busy working environment. For this, self-confidence is needed, but also reflection and a critical distance from your own actions. You should ask yourself regularly whether you are on track together with your hospital or your department. Avoid being surrounded only by people who count the remaining years to their pension, have always stayed in the same position. Do not tend to eliminate critical voices. A good boss should have the ability to manage, coach, and lead. Furthermore, empathy, anticipation and authenticity are sought after characteristics in leaders. In the long run, staff can only be motivated successfully if both the leader and the staff can define their work beyond the limits of financial aspects and in this way counteract identity crises and noetive dissonances.

10.11 Five Reflective Questions for Practical Application

1. Who belongs to your peer group? Are they people that you have known for a long time and are in tune with or is the group repeatedly re-constituted?
2. How do you react to criticism? Do you possess a systematic way of coping with it? In what respects are you influenced by extrinsic motivation?
3. Which points do you consider to be important for your first 100 days in a new position?
4. What proportion of your time at work is taken up by each of the three tasks of managing, coaching and leading?
5. What strategies do you have for preventing noetive dissonances and identity crisis for yourself and your staff?

A possible interpretation of the case study question from Sect. 10.8. Agreement with:

- Answer 1: You are an optimist. You have the good fortune to see the world through rose-tinted spectacles and you don't concern yourself with matters that don't affect you.
- Answer 2: You have a pessimistic approach to life; you dwell on matters that have been reported to you from second-hand and anticipate rain clouds even though others don't yet even see rain on the horizon.
- Answer 3: You are a realist. You see differences between yourself and others and don't automatically relate everything back to yourself. However, a relationship of mutual trust is very important for you and enables you to work well with others.

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Glossary

ABC Analysis Prioritises the tasks, problems, products, and other similar elements on three levels: A = very important, B = important, C = less important.

Activity Task that is focused on achieving a specific outcome in a *project*.

Advocates Individuals or groups who desire change through *business engineering* but have no power in the organisation.

Affected persons People who have to change and are affected by *change management processes*.

Agents Persons or a group of people who are responsible for the implementation of *change management*.

Architecture Structure of a system and the rules on which such a structure is based.

Balanced scorecard (BSC) A holistic management and *performance indicator* system that includes financial and non-financial key data in the control process. It aligns the actions (processes, measures) of a group of people (organisations, companies, institutions, fields, departments, project groups etc.) to a common goal.

Base rate Established by dividing the hospital budget by the case mix index. The hospital-specific base rate is founded on a benchmarking process between hospitals. It provides information about how economically efficient the hospital is in comparison with other hospitals.

Benchmarking The implementation of a competitive comparison analysis. Normally, this is done by using a system of *performance indicators* that defines the criteria being compared and their quantitative definitions.

Best practices 'Objective' empirical values that help to carry out a *project*. Successful methods, tools or measures are applied.

Business architecture A business system or partial system and the result of planning the structure of the business. It includes the general structure of a business and the necessary design rules.

Business engineering/business process management An integrated concept of control, organisation, and *monitoring* that enables an objective-orientated control of *business processes*. It is geared towards fulfilling the needs of clients (patients, referring doctors) and other interest groups (stakeholders), such as sup-

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pliers, partners, staff and owners, and contributes to achieving the strategic and operative goals of the hospital.

Business engineering map A map that describes how change processes can be implemented throughout various areas of a business. It is based on information and communication technology developed during the past few decades and the new economic system resulting from it.

Business model The *business processes* of a company on various levels and from different viewpoints: structure, functions (operations), data, and performance (processes).

Business process A logically connected chain of *activities* that have to be performed in a given sequence and aims at a certain process performance. Initiated by a defined event, specific input is transformed into output by considering regulations and using various *resources*.

Business process management An integrated concept of leadership, organisation, and *controlling* that enables the objectively-orientated control of *business processes*. It is geared towards fulfilling the needs of clients and other interest groups (stakeholders), such as suppliers, partners, staff, and owners, and contributes materially to achieving the strategic and operative goals of the business.

Business process model Usually hierarchically modelled, purpose-orientated, and simplified representations of *business processes*.

Business process re-engineering (BPR) The optimisation of *business processes*. It is the fundamental re-thinking and the radical new structuring of *business processes* to achieve a dramatic improvement in costs, quality, service, and speed. BPR is often linked to significant cultural and technological changes.

Business strategy A long-term plan of action designed to achieve a particular goal or set of goals or objectives. In this sense, the business strategy of management indicates the way in which a medium-term or long-term goal can be achieved.

Case mix index A parameter that relates to the severity of cases and reflects the amount of complex cases being dealt with at a hospital.

Cash flow An economic measure presenting the cash flow generated by business activities during a certain period of time.

Change management The management and design of planned change processes within an organisation.

Critical incident reporting system (CIRS) A voluntary report by hospital staff of critical incidents or violations of processes where a patient has been or could have been harmed. The aim is to increase patient safety.

Client orientation Operational thinking and action focused on clients, i.e., their needs, wishes and problems.

Competitive advantage Realised by a business by offering one or several strategically important activities at a cheaper rate or at improved service delivery than one's competitors.

Conflict management Professional dealing with conflict according to in-hospital standards so that conflict teams can independently develop workable solutions and profit from the solutions.

Conflict resolution Reduction, elimination, and ending of any type of conflict.

Continual improvement process (CIP) A core value and attitude of participants that implies constant improvement with long lasting impact. This staff attitude ideally permeates all areas of business activities. CIP relates to product, process and service quality. CIP is implemented by a process of steady small improvement steps in a continuous teamwork process. CIP can be compared with the Japanese *Kaizen*. Because of its success, it is often used synonymously with *Kaizen*.

Controlling A goal- and profit-orientated activity. Controlling may take the form of *self-controlling* (the manager exercises the controlling duties himself) or in the form of *institutional controlling* (the controlling is exercised by a specialised body that supports management). Controlling functions include planning, monitoring, co-ordination and information dissemination.

Core competencies The abilities or activities that lead to a competitive advantage. They are achieved by consolidating and linking the company's resources to improve its position with regard to competitors and hence achieving a *competitive advantage*. If the business processes of a company represent core competencies or contribute significantly to the structure or upgrading of core competencies, they are also called *core processes*.

Core processes *Business processes* with a high degree of added value for the client. All core processes within an organisation are taken together and into account for its *competitive advantage*.

Critical success factors Features that significantly contribute to the success of a company and/or a business unit.

Current assets Items on an entity's balance sheet that are cash or a cash equivalent, or which can be converted into cash within one year.

Customer relationship management (CRM) The alignment of processes within a company to its clients and consequently the outline of customer relationship processes. A CRM system is application software supporting CRM.

Data integration Combining data residing in different sources and providing users with a unified view of these data. All data for a *business process* should be integrated. If this does not take place, media breaks occur.

DMAIC cycle The systematic, phased procedure of *Six Sigma* is known as a DMAIC cycle. The DMAIC cycle is used to improve existing processes and constitutes the core element of the Six Sigma improvement process. The DMAIC cycle is related to the *PDCA cycle* and stands for: 'define, measure, analyse, improve, control'.

Effectiveness The degree to which the achieved goal fulfils the desired outcome is evaluated independently of the required input.

Efficiency The cost–benefit ratio is generally the effectiveness and the suitability of the actions by which the specified goals were achieved. It is defined as the economic achievement of set goals (resource utilisation).

Enterprise resource planning system (ERP system) A complex programme integrating a common data base into several standard business applications. Consequently, only business-consistent transactions are carried out. Data consistency is maintained. Cross-company *business processes* are supported and repeated and redundant data capturing is avoided.

Equilibrium theory The return of input (work performance) balanced against output (salary, recognition).

External benchmarking Uses comparative values not originating in the business itself. If these standards result from the comparison with competitors it is known as competitive benchmarking.

Feasibility study It assesses whether suggested solutions(s) can realistically be implemented under the specific business conditions.

Five forces model Developed by Porter, the model asserts that competition in any branch of business is determined by five factors: (1) new competitors, (2) new products and services, (3) clients' scope to negotiate, (4) suppliers' scope to negotiate, (5) traditional competitors.

Functional benchmarking Occasionally, it is an advantage to conduct comparative analyses beyond one's own business and study the successes of non-competitors and role-models. This is described as functional *benchmarking*, as typically one is looking at optimal organisational solutions or processes (e.g., best of country). Functional benchmarking is also used if no reference values are available.

Gantt chart It is a type of bar chart that illustrates a project schedule. A Gantt chart shows the start and finish dates of the tasks of a project. It helps the project manager to visualize the project timeline and completed work over a period of time.

Gross domestic product (GPD) The monetary value of all goods and services produced inside a country's borders within a specific time period, usually calculated on an annual basis.

Globalisation A development trend in the global economy. Globalisation is the strategic alignment of companies and financial markets operating internationally; utilising the respectively feasible advantages of cost and location in various countries so that an increase in competitive opportunities is achieved.

Internal benchmarking Comparison within a company (best of company).

Ishikawa diagram (cause–effect diagram) Also known as the fishbone or cause–effect diagram, it serves to visualise a problem-solving process where the primary causes of a problem are sought.

ISO 9000ff. A coherent set of norms documenting the basis of measures for *quality management*. Within the ISO 9000:2000 norms, process orientation has a special significance. In many places, the role of process management within a quality management system is indicated.

Kaizen Meaning 'change for the better', a Japanese management philosophy focused on continuous, systematic and step-by-step improvement of *business processes* with the involvement of employees. The *continuous improvement process* (CIP) can be compared with the Japanese Kaizen. Because of the success of Kaizen, it is often used synonymously.

Lagging indicator Key data of results. These are *performance indicators* in a *balanced scorecard* and show whether the organisation was able to achieve its goals.

Leading indicators They provide information of the course the organisation is taking and highlight how the organisation will develop and whether it will achieve its objectives. They are therefore also called performance drivers and are *performance indicators* used in a *balanced scorecard*.

Leadership Provision of a guiding principle, a vision and a long-term goal and their realisation.

Leadership processes/management processes *Business processes* serving the planning, monitoring and evaluation of objectives, strategies and measures for an organisation or hospital.

Lean management Methods and principles applied to the entire company for efficient operations. Lean management is aimed at increasing efficiency.

Management processes Within a company, they serve the planning, monitoring and the control of goals, including strategies and measures.

Marketing A concept of the company's management that aligns all aspects and activities of a company to the requirements of the market. In this sense, marketing includes all activities of a business that are sales-related; specifically, the policies that address products and the product range, price and conditions, sales, communications and service policies.

Media breaks The lack of integration of all data necessary for a *business process*. Media breaks should be avoided. For instance, a media break exists if an order is captured in an *ERP system*. To calculate one day's turnover, the volume of orders must also be captured in an Excel table.

Mentor An experienced and trustworthy advisor and teacher. Odysseus entrusted his son Telemachus to a man called Mentor, who could act as his advisor and confidante during his absence in the battle for Troy.

Milestone The control points of a *project*. They are important constituents of project management as they conclude *phases* or present project reviews.

Mind map A mind map is a map of thoughts, i.e., a graphic representation of the relationship of concepts and key words relating to a complex topic.

Mission The reason and goal for a hospital is stated in a promise for its stakeholders (patients, referring doctors). The function, market and competitive advantages, together with the business goals and company policy, are outlined briefly and concisely in a short statement.

Motivation, extrinsic Influence from an external source (e.g., by salary, status, social acknowledgement).

Motivation, intrinsic Holistic, self-generated motivation.

Non-profit organisation (NPO) Also called *not-for profit*, as they are allowed to work for profits. These must be reinvested in the organisation and do not serve to make a profit as this would be the case in *for-profit organisations*.

Organisation of economic cooperation and development (OECD) At present, 34 member states of developed countries with a high per capita income that follow democratic and market economy goals.

Out of pocket payment (OOP) Individual health service contribution.

Orbis Software for hospitals and other health care professionals.

Organisational management All tasks related to the organisational structure of a company. Core tasks of organisational management are conceptualisation and implementation of the *structural and operational organisation*.

Organisational structure This outlines relationships and authorities within an organisation and indicates how they function. The organisational structure specifies: communication structure (how information is distributed) and authorities (which authorities and powers exist).

Outsourcing The allocation of company processes to an external enterprise. Reasons for outsourcing could include: concentration on *core competencies* (*operating processes*), savings and/or freeing up of *resources*, utilisation of the competencies of other companies, greater financial flexibility.

Picture archiving and communication system (PACS) Used in radiology to store images electronically.

Pareto principle The name is derived from the Italian economist Vilfredo Pareto, who postulated the 80–20 rule. This constant probability distribution describes a static phenomenon, that 80 % of influence can be traced to 20 % of the cause variable. These ratios have been confirmed in various studies. Examples: 80 % of product defects are caused by 20 % of all possible causes of defects. 20 % of tasks block 80 % of working time.

Parkinson's law Bureaucratisation: the bureaucratic administration in offices and businesses grows at a predictable rate, regardless of whether the work load remains the same, increases or decreases.

PDCA cycle (Deming cycle) An iterative four-step management method used in business for the control and continuous improvement of processes and products. It orders the improvement process of *business processes* in four *phases*: 'plan, do, check, act'.

Performance indicators Values (key data) providing quantitative information with specific significance for the performance of an organisation.

Portfolio Collection of objects (projects), tools, methods and options for activities.

Potential analysis Analysis of the resources of a business when it becomes available for strategic decisions. It reflects the strengths and weaknesses of the business.

Process A temporal and logically coherent sequence of functions necessary for carrying out an activity. A process consists of a sequence of steps producing output from a series of inputs.

Process benchmarking The *business processes* of different companies are compared.

Process flow chart Summarises and shows the flow of economic *processes*. Process flow charts depict operations, points of decision-making and the sequence of executing tasks.

Process map Depicts all *processes* carried out by an organisation (including *interfaces* to the outside). It gives an overview of all the essential *processes* of a business. The process map is thus a higher level view (meta level) of the processes within an organisation. It describes the structure of *business processes* of a company and the interaction of individual partial processes.

Process organisation Process organisation describes the *business processes* of an organisation on various levels, right down to the level of operations. The individual processes and their dependencies and interactions are analysed.

Process portfolio An analytical tool specifically focussed on *business processes*. The process portfolio can be used as a method for prioritising; for instance, to evaluate business processes according to client benefits and business success.

Project A project is a complex plan by which a clearly defined goal is to be achieved, considering all circumstances (such as time, costs and *resources*).

Project management A leadership concept that serves the goal-orientated and efficient implementation of *projects*. This includes organisational, methodical and interpersonal aspects.

Project portfolio management Overarching project planning within multi-project management. Projects are selected and developed in terms of the strategic and economic alignment of a hospital.

Quality management This includes all activities of management that determine quality policy, the goals and responsibilities within the framework of quality management. It implements them by means such as quality planning, quality control, quality assurance and quality improvement.

Resilience Mastering crises and criticism by recourse to personal and socially mediated values for personal development.

Resources The amount of personnel and material necessary to carry out actions, processes or *projects*.

Return on Equity Return on equity (ROE) is the amount of net income returned as a percentage of shareholders equity. Return on equity measures a corporation's profitability by revealing how much profit a company generates with the money shareholders have invested.

Risk management The systematic capture and evaluation of risks and the subsequent reaction to identified risks. It contributes to the improvement of productivity and efficiency of a hospital and is aimed at increasing patient safety. Indicators are, for instance, the rate of complaints and legal–medical cases.

SDCA cycle When the PDCA cycle is successfully implemented in a business engineering project, the new business process is ratified as the new standard so that errors are not repeated and the learning experience is enhanced. This is referred to as the *standardise–do–check–Act (SDCA) cycle*.

Service process *Business processes* producing external services, i.e., for the respective clients. Performance processes are frequently called *core processes*.

Shareholder Owner of shares in a hospital or a business.

Shareholder analysis The value of a process from the point of view of the owner or shareholder.

Situational analysis Forms the basis for future concepts. It provides a detailed description of the initial situation of a business. The situational analysis includes a survey of the framework, a description of the actual situation and an analysis of the data.

SMART method Serves to unequivocally define goals (smart = clever). SMART stands for: 'specific, measurable, achievable, and relevant, time bound'.

Sponsors Persons or a group of persons who have the power to restructure the framework of *business engineering* and/or *change management*.

St Gallen approach Developed in the early 1990s at the University of St Gallen. It includes the basics and methods for business transformation caused by information technology. The approach encompasses three levels of design: strategy, process (organisation) and information system.

Stakeholder A person or a group (i.e., colleagues, CEO, patients, referring doctors, suppliers, cost carriers) whose interests are affected by events or the results of the *project* or processes.

Standard software A term used for programmes that offer a pre-set solution for a clearly defined area of application. Normally, this software must be purchased or leased.

Strategic management A way of conducting business in terms of goals, principles and strategies. In the past, conducting business was largely a matter of principles of liquidity or profitability; strategic management is guided by existing (or new) success or market potential.

Support process *Business processes* required for the successful completion of *service processes* through subsequent actions or functions. Support services are all the activities necessary for the implementation of management and *core processes* (invisible and meaningless to the clients); these are processes producing no, or low *added value* for the client; they serve to support the implementation of core processes, have no strategic value for the business and can be partially outsourced.

SWOT analysis Serves to highlight internal strengths and weaknesses, external opportunities and threats. A SWOT analysis can guide the direction and development of *business processes* in a situational analysis.

Time to market The time it takes for a product to be developed before being put on the market. During this time period the product creates costs, but does not generate income.

Two factor theory Motivation theory according to Herzberg. It highlights job satisfaction and consists of hygiene factors (dissatisfaction factors) as well as motivational factors.

Value-added chain Divides the business into strategically relevant activities to understand their role and to identify their potential to gain a competitive advantage. The *value-added chain* is a simple aid for investigating all *activities* (*processes*) in a business. In this way, you get an understanding how activities are related and the roles they play within one's *competitive advantage*.

Vision An imagined concept of a specific future situation. In business, this is often identical with a strategic aim. Vision is one of the management instruments in the change management processes.

Weak-point analysis An investigation for the purposes of identifying weaknesses, errors and reasons for errors in a process or a system.

Work-breakdown structure (WBS) This documents all activities of a project; it is a deliverable-orientated subdivision of the project into smaller tasks and describes the plan for the structure of a project. It serves to divide a project into controllable, manageable and plannable tasks.

Workflow A sequence of process steps through which an automated business process passes from initiation to completion.

Workflow management Support of business processes through automation or information technology. This enables to support business process management by means of technology.

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