Service Quality Improvement in a Clinical Directorate: leveraging opportunities for latitude in a multiplicity of constraints, perspectives, objectives under system reform

Peter Williams[1], Stiofan de Burca[2], Christy O'Hara[3] and Claire Murphy[4]

[1] Enterprise Research Centre, and Dept. of Manuf. & Operations Eng., Univ. of Limerick (Ireland)

peter.williams@ul.ie

[2] Health Systems Research Centre, Univ. of Limerick (Ireland).

stiofan.deburca@ul.ie

[2] Galway University Hospitals (Health Service Executive), Galway (Ireland)

christy.ohara@hse.ie

[4] Kemmy Business School, Univ of Limerick (Ireland)

claire.armstrong@ul.ie

Abstract: This paper reports a mapping of constraints and enablers to quality and performance improvement in a Clinical Directorate. The site in an acute academic teaching hospital broadly follows the John Hopkins/NHS tradition. Research comprised three strands which were triangulated: documents (intent and realisation), quantitative (clinical governance extent and climate), and qualitative (semi-structured interviews). The hospital has a well developed leadership and planning processes, with Performance Indicators covering Continuous Quality Improvement, Quality and Risk. Manifest organisational complexity was observed in a multiplicity of coordinative threads. There is good perception in respect of a planned and integrated QI framework, risk management, working relationships, and important elements of Clinical Governance. To staff, the directorate is a beneficial focus for getting things done collaboratively. To management it is a coherent, visible and effective focal point for awareness, learning and development. .

1 Introduction

This project takes place in the context of the Irish publicly funded health system, and of its recent reforms, notably the launch of the Health Service Executive which replaced the former Health Boards and many other related organizations (Health Act, 2004). Many of the issues raised resonate to concerns in the broader health world.

Continuous Quality Improvement is attributed with dramatic improvements in performance and outcomes in publicly-funded hospitals such as Veterans' Administration in the US (Ashish et al 2003). In Europe, the WHO-PATH programme (Gröne et al, 2008) has demonstrated the operationalisation of a broad-ranging set of indicators and a network of peer hospitals to foster comparison and collaboration aimed at internally-focused assessment and external peer support. The MARQuIS programme (www.MARQuIS.be) is currently mapping the use of key dynamic elements of process improvement based on the Deming-inspired PDCA cycle in hospitals. Programmes like PATH, MARQuIS and the earlier ExPeRT, the OECD Quality Indicators project and so forth offer a more flexible and independent way to think about CQI systems in a more formative than prescriptive manner, compared with ISO and IHSAB systems, opening up the possibility of customised, not imposed, quality frameworks (Nabitz et al 2000, Mattke et al 2006).

The collection, transformation, and handling of information, and the service process of care are crucial in all of this, in order to develop improved clinical outcomes in the environment of more chronic disease, more powerful and expensive technologies, greater empowerment of the population, and the ever-present economic prerogatives, made worse by the current recession.

CQI projects, including those at the study site, aim to build public confidence in the health system, in the broad context of well-flagged 'ghosts' of deficient organization - eg "to err is human" (Kohn, Corrigan and Donaldson, 1999), Bristol (2001), the Lourdes Hospital Inquiry (Harding-Clarke, 2003), and a myriad of more recent reports on systems failures in the Irish system, eg Breast cancer diagnosis. While CQI draws on industrial quality management (for more ref Wadsworth, 2002) and human factors, hospitals and health systems pose substantially different context (Joss and Kogan, 1995).

There is a growing tradition for hospitals to develop clinicians in management programmes, often in concert with Clinical Directorates, in order to improve governance, drawing clinicians to understand management priorities, and vice-versa. This tradition is well developed, and shows influence of New Public Management and other movements (Hood, 1991, Scally and Donaldson 1998, Lugon and Secker-Walker, 1999; DoH, 1999). It has come in for some (constructive) criticism more recently (eg Lega, 2008, Braithewaite, 2005).

1.1 Goals

This paper reports the mapping phase of a larger project, still underway, to develop a customized quality framework for a publicly-funded acute hospital. Later stages are envisaged to constitute Reflection, Action Planning and Implementation phases. The thrust of the present approach is to identify espoused theory and theory in use, and present their divergences and similarities for reflection. The objective of the present phase is to establish the status of constraints and enablers to the development of a quality and performance framework.

2 Policy and context (reforms)

The general policy context comprises external and internal elements.

2.1 External Policy Context

Hospital strategic, planning and operational statements, are influenced in particular by the Health Services Reform Programme (DOHC, 2003), the HSE Corporate Plan (2005/08) and Transformation Programme (2007-10) (HSE 2004, 2006). The reforms espouse and draw particular inspiration from The National Health Strategy, Quality and Fairness (DOHC 2001), which strongly reflects international concerns, especially patient-centredness, quality, access and accountability: "Patient at the centre of care delivery", "customer care programme", statutory complaints procedure, patients' management of own care / individual care planning, and participation by community in decisions, "Appropriate care in an appropriate setting", and "timely and appropriate capacity" feature strongly. Specific proposals are to provide "responsive high quality maternity care", and an undertaking to enhance the "configuration, range and delivery of paediatric services". Foreseen are a standardised quality system, safety with an evidence-based approach, quality and continuous improvement embedded in daily practice. The achievement of these objectives is seen to require considerable investment in information technology services (and strategy), as well as a comprehensive, centrally driven integrated approach. Fragmentation, duplication and lack of accountability are seen as major problems to be resolved. Planned actions focus on integration through care pathways and clinical networks, staff empowerment and teamwork (including budget devolution to clinicians), accountability with performance

management and with planning levels, reports and performance monitoring framework, and external monitoring.

Structural change yields a National Hospitals Office pillar (NHO), a Primary, Community and Continuing Care pillar (PCCC), and Shared Services as main macro-organisational blocks. Development of the Clinicians in Management programme to support governance is anticipated, as is an ethos of continuous improvement, development of a performance management system, and (centralised) integrated intelligence/analytical capability (HSE 2004, 2006).

The Clinicians in Management programme was initiated formally in 1998 (OHM 2000-2004). National Health Strategy (DOHC, 2001) envisaged the development of a seamless organisational structure that would integrate all services internally with the support of appropriately designed information systems. Greater interdisciplinary working amongst the professions was deemed necessary to extend the available skills range. There was an expectation that staff at all levels would be empowered by devolving decision making responsibility to the lowest feasible level. "old hierarchical thinking in relation to the professions" and "turf wars" were seen as barriers to patient care" (DOHC, 2001: 49). The Office for Health Management issued several review documents of experiences, e.g. in pilot hospitals, and they issued a Charter for engagement of Clinicians and Managers (OHM 2002-4). The Clinical Directorate is central in new Consultant's Contract (HSE 2008), as a basis for linking financial and clinical accountability. It is almost an axiom that there are fundamentally divergent perspectives and priorities (Degeling et al, 2003). There are mixed conclusions for clinicians in management programmes, and there is a lack of a coherent predictive design model (ref Bristol 2000, Braithewaite et al 2005, Lega 2008).

2.2 Internal policy context

The hospital's Clinicians n Management programme has established six directorates, covering the bulk of hospital activity, assisted by a mature 5-step participatory process for their development.

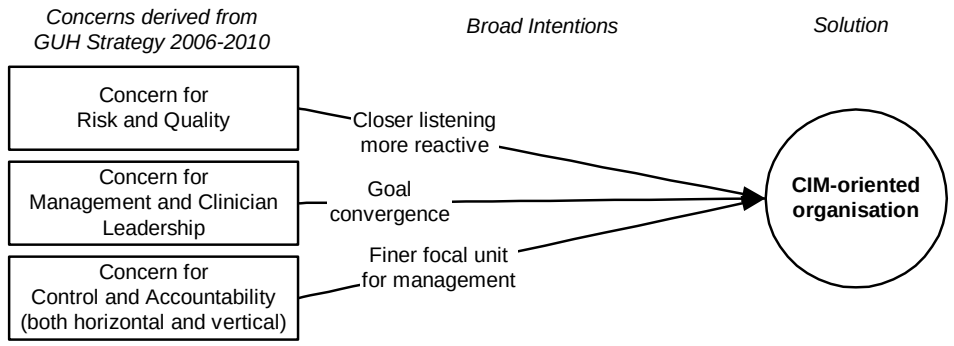


***Figure** 1. Hospital impetus for Clinicians in Management initiative.*

The hospital has a well-developed CQI framework, with overall strategies for the hospital (GUH Strategy 2006-10), and strategies and policies, and organisational committees for Continuous Quality Improvement, Clinical Audit, Integrated Care Pathways, and Risk Management (including traditional Health and Safety activities). Several awards – Baby Friendly Hospital, Best Place to Work and so forth attested to the quality and maturity of the systems in use.

At the time of the field work, The hospital was undergoing a successful Accreditation by the national accreditation authority IHSAB/HIQA. Several departments in the hospital already held ISO 9001, including the Obs-Gynae Dept (from 1997). This proved timely, in that there was a sound and mature base of documentation to review.

The coordinative load is high – as demonstrated in the organisational chart in figure 1.

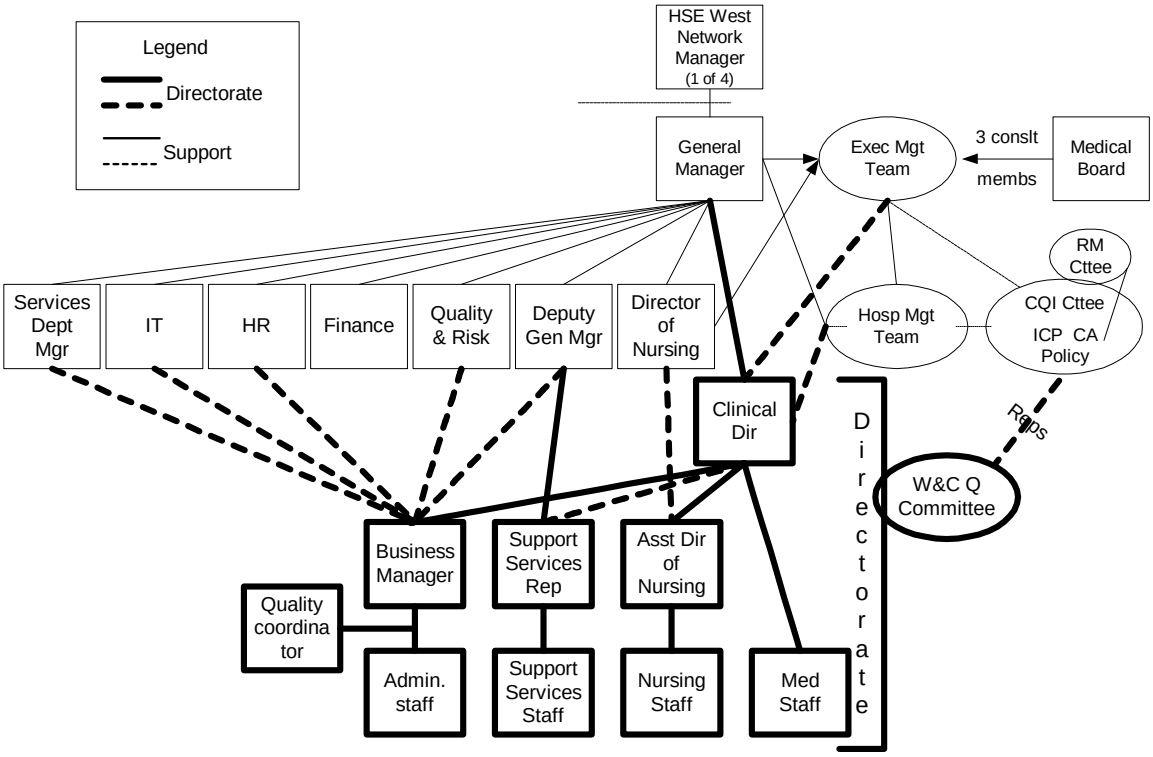


Figure 2. *Formal organisational linkages for the Directorate.*

3 Research Approach

To explore the nature of quality management in the context of a Clinical Directorate or hospital it is essential to recognise the variety of perspectives and responses that may occur - at multiple levels and within different disciplines and settings. Thus a multi-method strategy is required. Multi-method strategies accept that all research approaches may be used in the same study, provided the contribution of each approach can be identified (Denzin, 1970, Campbell & Fiske, 1959). A sequential design was adopted that commenced with survey instruments to assess the evidence of objective data. This was followed by a more dominant influence from qualitative data generated by a multilevel approach, and document analysis. Thus quantitative data is incorporated into qualitative research. Though every method has its limitations (Campbell & Fiske, 1959), the use of triangulation and pragmatism with qualitative and quantitative methods, depending on the research question and the phase of the research cycle, minimises the effect of such limitations. Pragmatics use both inductive and deductive logic (Tashakkori & Teddlie, 1998), thus providing both objective and subjective points of view. They recognise the role of values and accept external reality, whereas in self-report, there are no direct means of cross-validating peoples' descriptions of their feelings or intentions (Podsakoff and Organ, 1986). Survey research focuses upon causal explanations derived from correlations but which cannot deal with the social meanings thus described (Finch, 1986). The causal model fits with the natural sciences, but the fundamental difference with the social world is the subjective quality of human action which has an internal

logic of its own (Laing, 1967: 53). In qualitative research the focus is on meaning whereas in quantitative research the researcher attempts to measure variables. A reliance on self-reports limits the opportunity for discovery of ambiguities, of tasks and of social relations (Hamlin, 2002). Qualitative approaches involve observation, in-depth interviews and the detailed examination of documents, and are acutely sensitive to context and processes (Bryman, 1997). The Project aim and methodology were cleared with the Chairman of the UL Ethics Committee in August 2007.

3.1 Quantitative Research Methodology and Procedure:

The following instruments were administered: MARQuIS survey (hospital), Quality Audit template (CD), Clinical Governance Survey (CD), Clinical Governance Climate Questionnaire (CD). SPSS software was used to analyse the Clinical Governance Survey and the Clinical Governance Climate Questionnaire (Field, 2005). The MARQuIS survey instrument was developed under the EU FP6 project Method for Assessing Response of Quality Improvement Systems. The instrument queries the hospital strategy, structure, planning, and QI policy/strategy/structure/processes/outcomes, with particular reference to PDCA. It assesses the degree of use and implementation of QI systems and activities, including formal external accreditation or quality award systems. It assesses the linkage between leadership and implementation. The range and extent of implementation activities and patient involvement is reported. The instrument was already completed by GUH for inclusion in the overall European analysis, in which 28 Irish hospitals took part. The Quality Audit Template of Lugon & Secker-Walker (1999) queried information on cost of quality especially of failure of control at specialty level, so important to driving quality activity. The Clinical Governance Survey (CGS) of Lugon & Secker-Walker (1999) consists of 14 questions, comprising a total of 30 items. These items can be conceptually grouped into three main categories: presence of key clinical governance infrastructure (including personnel); actions associated with good clinical governance; and overall perception of the quality of clinical governance in the directorate. Consistent with quality theory and practice, it is assumed in this project that organisational culture and climate provides the ecology within which clinical service reliability and organisational performance outcomes in general may develop. The Clinical Governance Climate Questionnaire (CGCQ) of Freeman (2003) was developed specifically to examine the link between organisational culture, climate and performance in clinical governance. It has consistently attained high internal consistency and external validity in a study population of NHS Healthcare Trust staff. It consists of 60 items distributed across six sub-scales of clinical governance: planned and integrated quality improvement, pro-active risk management, absence of unjust blame and punishment, positive working relationships with colleagues, training and development opportunities and organizational learning.

The responding sample for CGS and CGCQ Surveys consisted of 110 health professionals working in a single CD. Three years before this study commenced, two departments within the hospital had combined to form a single Clinical Directorate. The total population of personnel on the CD staff roll was 390, including staff working or assigned less than full time to the Directorate. Survey instruments and cover letter from the clinical director were distributed to staff in the CD through internal mail. A number of visits were made throughout the CD, including presenting to a Clinical Review Meeting by the researchers, to explain the nature of the study and encourage participation. The Clinical Governance Survey – CGS (Lugon & Secker-Walker, 1999) CGS assessed orientation towards the concepts of clinical governance and quality improvement. The Clinical Governance Climate Questionnaire – CGCQ (Freeman, 1999) CGCQ examined the respondent's perceptions of different aspects of clinical governance within their CD. Every person on the roll received a survey set, and response was entirely voluntary. Usable response rates were: overall 27.9%; managerial/ supervisory 72.5%, and non-supervisory 21.2%; Medical 37.5%, Nursing/Midwifery 25.2%, AHP/Administration/Management 48%.

3.2 Qualitative Research Methodology and Procedure:

Methodology: Interviewing is most valuable when the person engaged in the fieldwork comprehends the fundamentals of a community from the insider's perspective, as the questions are more likely to conform to the native's perception of reality. Open and closed questions help discover and confirm the participant's experience and perception. Tape recording is used judiciously and with consent and facilitates transcribing that is necessary for analysis (Hammersley & Atkinson, 1983). Focus group research involves a moderated group discussion and may produce a rich body of data in the respondents` own words and context. Stewart & Shamdasani (1990) refer to a variety of research needs which lend themselves to the use of focus groups: obtaining general information about a topic of interest; learning how respondents talk about a phenomenon of interest and generating research hypotheses. They are a useful vehicle for facilitating a common understanding of issues and problems. Limitations arise in respondent interaction or bias introduced by a dominant member. Template Analysis (King, 1998) was used to thematically analyse the qualitative data from interview transcripts. It involved the development of a coding template, which summarised themes in the data set and organised them in a meaningful manner. Hierarchical coding was emphasised; in other words, broad themes encompassed successively narrower, more specific ones. The analysis started with some a priori codes, which identify themes strongly expected to be relevant to the analysis. An initial template was developed after initial coding. This was applied to the entire data set and modified in the light of careful consideration of each transcript.

Procedure: Following preliminary analysis of the results from these two questionnaires, interviews and focus groups were carried out. This was to allow the researchers to gain a more in-depth understanding of how key individual staff members believed the CD was operating, and of the facilitating and constraining factors present within the health service and that influenced the success or otherwise of the CD. Qualitative data collection was undertaken with semi-structured interviews at manager/supervisor levels, and focus groups with frontline ward staff:

(a) Semi-structured interviews were undertaken at three organisational levels i.e. hospital (n=8), clinical directorate (n=4) and department (n=6) based on role relevance and availability. The time range of the interviews was from 30 minutes to one hour. The interviewer/facilitator used a five-question schedule and prompts to elicit responses relevant to the topic while a research colleague digitally recorded the interview and simultaneously recorded clarificatory observations.

(b) Focus Groups constituted of two mixed discipline groups of frontline staff were invited to participate in focus group discussions, each one hour in duration. The two constituent departments provided five staff members representing for example nursing, midwifery, HCA and administration. The discussion was facilitated by the same interviewer/facilitator as above.

Qualitative Analysis. Each interview and focus group session was recorded and transcribed in strict confidence.

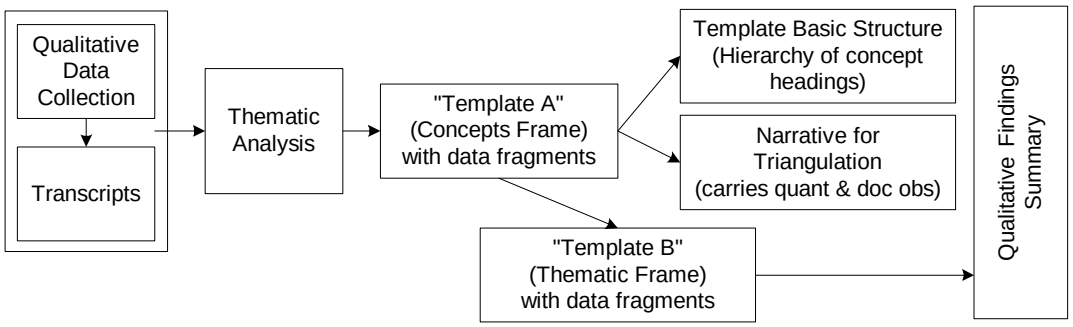


Figure 2. Development of Qualitative Findings

Texts were formatted in accordance with question and response, and coded line by line. This generated working categories, sub-categories and properties. A grounded template for

comprehensive data analysis emerged for comparison across texts. This was tested by comparing themes/categories within and across data groups. The outcome was a "Template A" (Report and its Basic Framework and Origins). This was re-analysed thematically to produce a second analytic report "Template B", which provides the summary qualitative findings. Both templates have a common database and constitute auditable documents with data fragments traceable to levels, departments and disciplines (ie Origins).

3.3 Document Analysis Methodology and Procedure

Methodology: Documentation provides evidence of espoused theory and of theory in use (Argyris and Schon, 1978). This translates into "intent" and "realisation". Intent comprises policy, strategy, planning and evaluation. Realisation is characterised by Donabedian's classical triad i.e. structure, process and outcome (Donabedian 1968). This approach is resonant with planning and doing as emergent, socially-distributed and cognitive activities, drawing on cognitive work analysis and activity theory. Each of these aspects are likely to be further differentiated in terms of formal policy-formulated perspectives (Jaques, 1978).
Procedure: Requests for documentation relevant to quality management in the Women's and Children's Clinical Directorate were channelled through the Business Manager and HR department. The Obs/Gynae quality coordinator explained the ISO quality manual, the associated central master filing system, guidelines and protocols and so forth, located at the directorate wards. HR staff provided copies of numerous documents relating to staffing, training and performance. The IT Manager provided information on systems in place and the current IT work plan, locating it with respect to national developments. The Risk Manager provided significant documents, including a copy of the Incidents Report Summary for the CD, and the MARQuIS survey.
Document Analysis : The documents were arranged according to intent (espoused) and realisation. Intent includes policy context, strategy, planning, and evaluation. Realisation includes structure, process, and outcomes (not evaluated), following Donabedian (1968). This framing of planning and control reflects an activity theoretic perspective, and resonates to Situation Awareness in the human factors literature. These headings are elaborated as follows: Policy Context(external documents that directly informed strategy, planning and so forth); Strategy.(highest level thinking, internal to the organization) Planning. (annual rounds of plans) Evaluation. (interpretation of performance with regard to intent). Structure. (stable elements within which healthcare processes are carried out) Process. (operationalisation of policy and planning on a day-to-day basis) Outcomes. (information / data that represent the result of process, with change in health status.

4 Findings

Specific findings relate to this hospital's context. It is difficult to give a fair reflection of content generated but the following points are indicative.

4.1 Qualitative

Template A. The main emergent concepts are: Clinical Directorate (origins, structure); Performance Management (including ISIT), Quality Management (Model, and Overview), Constraints, and What Should Change? These headings are coded to at least two more levels of conceptual detail. ***Template B:*** The main emergent domains are: **Leadership** The CD team is democratic and service- and quality- oriented strong rationale to engage clinicians in management yet it took significant time to achieve full commitment **Management** (characteristics and constraints). portrayed with reference to resource, performance and quality management. All levels report the absence of a specific budget and a lack of control of staff numbers. **CD role and functions** devolved authority, good teamwork and unity enabled service and quality improvement. limited awareness of the change, buy-in, recognition and blurred roles and dual reporting, **Performance management** is reflected in roles, resources, standards, and data. The ISIT constraints at national and local levels affect performance. Overall more investment is required to

enable self-regulation and control. **Quality management**: good leadership from the CQI committee, Clinical Risk Management Committee; CD ownership is emphasised. The O/G Dept has ISO since 1996. It has generated good policies and procedures; accreditation process is a catalyst for improvement: It has facilitated team working and placed quality on everyone's agenda. The process is generally reported as very beneficial. Annual Clinical Report is exceptional. Formal benchmarking is operational in Paediatrics' neonatal service (Vermont-Oxford). **Change Priorities?** budget, staff control and information feature strongly. Improvement is sought in management training, communications and participation.

4.2 Quantitative

MARQuIS data showed presence of a CQI programme and identified some aspects that are very well addressed and some that are less well systematized. It will be interesting to compare with published data for Europe in due course. CGS and CGCQ response data was analysed in great detail, and key observations are summarized as follows.

Main Dimensions	Perceived Strengths	Perceived Weaknesses
Presence of plans and actions	strong - risk register, audit, consequent corrective action	weaker: review accuracy of record-keeping
Awareness of process	Good - EBP, development programmes, QA, Learning from complaints	weaker - professional procedure - with notable exception of medics who have high awareness
Awareness of people in roles	Very strong - individuals for RM, CA, Complaints Strong - multidisciplinary Q meetings/process	person(s) and Q in business planning, workforce planning, cinical effectiveness information; involve all relevant staff in CA
Comments to note	-	*NB: these are predominantly less visible to many eg ward staff on a day-day basis*

Figure 4. Qualitative summary for Clinical Governance Survey (Lugon and Secker-Walker)

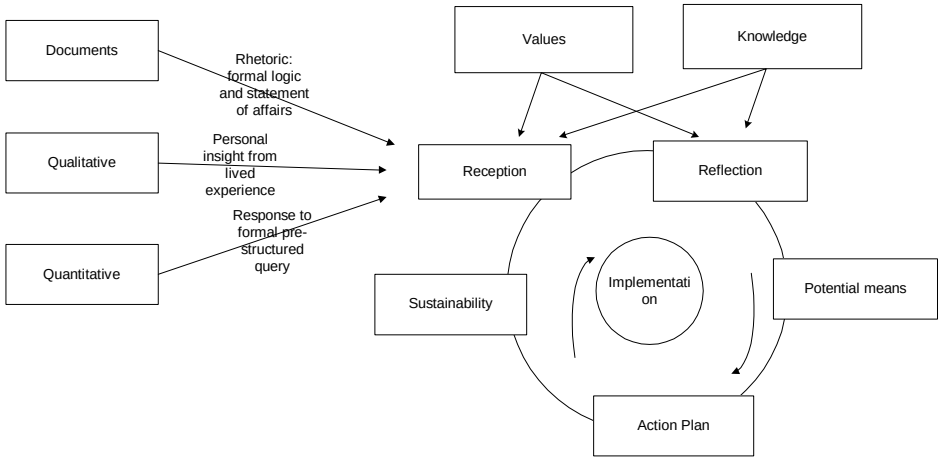
CG Climate Factor	Level Effect	Department Effect	Role/Profession Effect	Observations (based on individual items)
1. Planned and Integrated QI Framework	not strong no difference	not strong Close	Neut: Med & AHP weaker: Nur&Adm	Strong/neutral: vision/motivation Weaker: Reactionary; short on time to reflec/ immediacy over long-term
2. Proactive Risk Management	Good: Sup Neutral: non-sup	Fair close	Good: Med Fair: AHP, Admin, Nursing	Overall: good/neutral Good on assessment/learning Ward dubious re assessment
3. Absence of Blame	Good: Sup Neutral: Non-sup	Fair: close	VG: Med Good: AHP Fair: Nurs & Admin	Generally: Absence of punishment, good atmosphere but, Ward level less strong
4. Working with Colleagues	Fair Close	Good: Gynae Fair: Paeds Neutral: Obs	Good: Med Fair: Nursing, AHP weaker: Admin	Generally positive:- Know, understand, and respect each other Some evidence of 'pecking order'
5. Training and Development	weaker Close	weaker: Close	Neut: Med & Admin weaker: Nurs/AHP	Generally neutral/negative: Absence of time to reflect Development needs (of individuals)
6. Organisational Learning	Fair: Sup Neutral: non-sup (close)	some specialisation difference	Fair: Med Neutral: AHP, Nursing, Admin	People rather than teams share practice issues

Figure 4. Qualitative summary for Clinical Governance Climate Questionnaire (Freeman)

Triangulation.
Template A – the hierarchical concept framework – formed the basis of a triangulation between documents, qualitative and quantitative findings. This document runs into many pages.

5 Postscript

This Mapping Study forms the baseline for a phase to reflect upon Intent of policy and procedure (Espoused theory, in documentation) and Realisation in practice (Theory in action, in documentation and from interviews and questionnaires). It provides a grounded basis from which to adjust or modify in a contextual learning process. The reflection phase relates to values,



leadership/followership, attitudes, capability, capacity and knowledge/information, and it offers the potential to clarify and support the what, who and how of the hospital's trajectory

Figure 8. Prospective: Next Steps

6 References

Argyris, C., and Schon, D.A. (1978). Organizational learning: a theory of action perspective. Reading MA: Addison-Wesley.

Ashish, KJ, Perlin, JB, Kizer, KW, Dudley, RA (2003) Effect of Transformation of the Veterans Affairs Health Care System on the Quality of Care. NEJM 348,22: 2218-2226

Braithwaite, J., Westbrook, M. & Iedema, R. (2005). Giving voice to health professionals' attitudes about their clinical service structures in theoretical context, Health Care Analysis, 13(4): 315-335.

Bristol, 2001. Bristol Royal Infirmary Inquiry, Learning from Bristol: The Report of the Public Inquiry into Children's Heart Surgery at the Bristol Royal Infirmary, 1984–1995. London: Stationary Office.

Bryman, A., (1997). Leadership in Organisations: in Clegg, S, Hardy, C., and Nord, W. eds. Handbook of Organisation Studies. London: Sage, 276-292.

Campbell DT & Fiske, DW. (1959) Convergent & discriminant validation by the multi-trait - multimethod matrix. Psychological Bulletin. 56, 81-5

Degeling, P, Maxwell, S, Kennedy, J, and Coyle, B. (2003). Medicine, management, and modernisation: a "danse macabre"? BMJ 2004;329;679-681.

Denzin,N K (1989) The Research Act: A Theoretical Introduction to Sociological Methods. Chicago: Aldine

DOHC (2001). The National Health Strategy: Quality and fairness. Dublin: Dept of Health and Children DOHC (1994). National Health Strategy: Shaping a Healthier Future. DoHC Dublin: GPSO.

DoH (1999) Clinical Governance: Quality in the New NHS (HSC 1999/05). NHS Executive.

Donabedian, Avedis (1966). The Quality of Medical Care. Milbank Quarterly.

Edmondstone, J. 1995. Managing change: an emerging new consensus. Health Manpower Management. 21(1) 16-19.

Ferlie, E, Ashbourner L., Fitzgerald L. and Pettigrew, A. (1996). The New Public Management in Practice. Buckingham: Open University Press.

Finch, A.J., (1986). Relationships between organisational climate and Nurses' Ethical Decisions. PhD Thesis, University of Texas at Austin.

Freeman T. (2003). Measuring progress in clinical governance: assessing the reliability and validity of the Clinical Governance Climate Questionnaire (CGCQ). Health Services Management Research, 16: 234-250

Gröne, O, Klazinga, N, Kazandjian, V, and Lombrail, P. (2008) The WHO Performance Assessment Tool for Quality Improvement in Hospitals (PATH): An Analysis of the Pilot Implementation in 37 Hospitals. Int J for Quality in Health Care 2008 20(3) 155-161

Hamlin, R.G., (2002). A Study and Comparative Analysis of Managerial and Leader Effectiveness in the NHS: an empirical factor analytic study within an NHS Trust hospital. Health Services Management Research: 15(4): 245-63.

Harding-Clark, Judge M (2006). The Lourdes Hospital Inquiry (Report). Dublin: Stationary Office

HSE (2004, 2006). HSE Corporate Plan 2005-2008; Transformation Programme 2007-10; Dublin: Health Service Executive

HSE (2008). Addendum: Appointment of CDs, Aug 2008. ref. Consultants' Contract, 25July 2008.

Hood, C. (1991) A Public Management for all Seasons? Public Administration, 69 (1), 3-19.

Jaques, E (1978). General Theory of Bureaucracy. Exeter NH: Heinemann.

Joss, Richard, and Kogan, Maurice. 1995. Advancing Quality: Total Quality Management in the National Health Service. Buckingham: Open University Press. ealth Service.

King, N. (1998). Template Analysis. In G. Symon & C Cassell (eds) Qualitative Methods and Analysis in Organisational Research. London: Sage.

Kohn, Corrigan, and Donaldson. 1999. To Err Is Human. Institute of Medicine.

Kouse, J. And Mico, P. (1979) Domain Theory: an introduction to organisational behaviour in human service organisations. Journal of Applied Behavioural Science. 15 (4), 449-469.

Laing, R.D. (1967). The Politics of Experience and the Birds of Paradise. Penguin.

Lega, F. (2008) The rise and fall(acy) of clinical directorates in Italy. Health Policy 85, 252–262

Lugon, M. & Secker-Walker, J. (1999). Clinical governance: Making it happen. London: Royal Society of Medicine Press Limited.

Mattke, S, Kelley, E, Scherer, P, Hurst, J, Lapetra, MLG, and the HCQI Expert Group Members. (2006). Health Care Quality Indicators Project: Initial Indicators Report, 9th March. Paris: OECD Health Working Papers No. 22.

McColl E et al. (2001). The conduct and design of questionnaire surveys in healthcare research. In: Methods in Evidence-Based Healthcare. Edited by Andrew Stevens et al., London: Sage Publications.

Nabitz, Udo, Niek Klazinga, and Jan Walburg. The EFQM excellence model: European and Dutch experiences with EFQM approach in health care. International Journal for Quality in Health Care. 2000: 12 (3) pp191-201.

OHM 2004. Clinicians in Management: Disc papers 1 – 6. eg 1. Introduction and Case Studies. 2. Clinicians in Management: A review of the Initiative and Pointers to the Way Forward. 5. CIM at Work in Mayo General Hospital. Dublin: Office for Health Management.

Podsakoff, P.M, and Organ, D.W. (1986). Self-reports in organisational research: problems and prospects. Journal of Management, 125(4).

Scally, G, and Donaldson, L., 1998. Clinical Governance and the drive for quality improvement in the new NHS in England. BMJ. 317: 61-3.

Wadsworth, Harrison M., Stephens, Kenneth S., and Godfrey, A. Blanton. 2002. Modern methods for quality control and improvement. New York: John Wiley and Sons. 2nd ed.