Public service guarantees

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Chapter 6.

Developing and implementing a service guarantee for an integrated regional stroke service: An exploratory case study[15]

[15] This chapter has been published in *BMC Health Services Research* (IF: 1.827; AI 0.68) 29 March 2014, 14:141. http://www.biomedcentral.com/1472-6963/14/141. Co-authors are Prof. C.T.B. Ahaus and Prof. S. Van de Walle. Together with my two co-authors I developed the research method for this single case study. I did the data gathering, analysed the results with an analysis team and wrote the paper. Both co-authors were involved in reviewing the results of the analysis and reviewing and improving the paper.

6.1. Introduction

Strokes are a common cause of premature death and disability and present a major global public health challenge (Murray and Lopez, 1997). They are one of the leading causes of death in the Netherlands (Minkman *et al*., 2005). Based on the concept of integrated care, regional stroke services have been established in the Netherlands. Integrated care is an organisational coordination process that seeks to achieve seamless and continuous care that is tailored to the patient's needs and based on a holistic view of the patient (Ouwens *et al.*, 2005). Three phases of the integrated stroke service can be distinguished: acute care involving the emergency department and stroke unit of the regional hospital, rehabilitation involving rehabilitation centres, specialised nursing homes and home care and, finally, long-term support. Delivering optimal care with this range of providers requires a complex mix of collaboration on operational and individual levels involving streamlining information flows and the transfer of acute patients. On a tactical level, this can involve performance indicators on the care-chain level and, on the strategic level, financial and logistical agreements (Minkman *et al*., 2011). These interventions aim to improve patient care and medical outcomes, objectives that fit into the general goals of care integration: enhancing patient satisfaction and quality of life, efficiency and outcomes (Minkman *et al*., 2009).

A service guarantee is a statement laying out the service level that patients can expect and what the organisation will do if it fails to deliver (Levy, 1999). Normally, it consists of the design elements: one or more promises to patients; the monetary or nonmonetary compensation in the event of service failure; the process to invoke the guarantee; and other service guarantee characteristics. In my setting, a guarantee should transform an intangible health product into a measurable expectation for the patient prior to receiving the healthcare service. The concept of the service guarantee was originally developed in commercial organisations (Hart, 1988) and was then adopted by public services and healthcare. In the United Kingdom, the concept has been used in all NHS hospitals since 1991 in the form of the Patient's Charter (De Uray-Ura and Pietroni, 1997). Healthcare organisations in Italy (Mussari, 1998), the USA (Lewis, 1993) and the Netherlands (Burgerlink, 2010) have also adopted the concept. In several Dutch healthcare services, the multi-attribute specific service guarantee (Wirtz and Kum, 2001) is used. This consists of a number of promises covering the patient's journey from general practitioner referral through to discharge from the hospital and follow-up arrangements. The specific goals in implementing service guarantees are: to increase the responsiveness of healthcare services to the wishes of patients; to make

healthcare services more accountable; to ensure patients know what to expect so that they can become more equal partners in the healthcare process; to be used as a listening mechanism; to increase feedback from patients; and to improve patient satisfaction. Further, communicating a service guarantee is seen as a signal of patient-centeredness that could have beneficial marketing effects (Fabien, 2005). Following the use of service guarantees in commercial organisations and public services, healthcare organisations have started using the concept in order to improve patient satisfaction by improving their patient-centeredness.

Based on their extensive research of the literature on service guarantees, Hogreve and Gremler (2009) have concluded that it is still challenging for scholars to show whether, and how, service guarantees are helpful in increasing service quality. The literature on the enablers of service guarantee implementation is dominated by citations and anecdotal evidence. Hays and Hill (2006) have conducted intensive empirical research on the effects of using service guarantees on employees and the service development process. Chapter 5 of this dissertation describes a concept mapping study involving an integrated Delphi study on the enablers in implementing service guarantees within individual public organisations. This sixth chapter contributes by offering empirical research on the enablers for a service delivery network (Tax *et al*., 2013); in this study an integrated care setting. An extensive healthcare and management literature review has resulted in the conclusion that no empirical research has been published before on the implementation of a single service guarantee in a chain of organisations.

My research focuses on both the development and implementation of a service guarantee. Implementation is the process of putting a service guarantee into use, making the service guarantee work in daily practice and institutionalising it (Schmit *et al*., 2011). Implementing a service guarantee often requires a new set of behaviours; routines and ways of working that are directed at improving patients' experiences. As such, the implementation needs a set of planned and coordinated actions. In my research, I focus on enablers. Enablers are those elements of processes, structures or states that are necessary antecedents for the effective development and implementation of a service guarantee (Kashyap, 2001). Depending on their qualities, they can hamper or promote the effective implementation of a service guarantee (Holum, 2012). Within the regional stroke service, the term effectiveness refers to the aggregated consistency, quality and appropriateness of service guarantee development and use (Weiner *et al*., 2009) in achieving the two goals of the service guarantee: improving the

patient-centeredness of the chain and increasing patient satisfaction.

It has been estimated that two-thirds of all innovation implementations in healthcare fail (Damschroeder *et al*., 2009) and there is evidence of failures in the development and implementation of service guarantees. The literature presents several cases where service guarantee implementation has failed due to the absence of necessary enablers. Examples include a lack of involvement by employees and middle managers leading to an inconsequential use of service guarantees in daily practice (Sarel and Marmorstein, 2001) and the service guarantee becoming seen as a disciplinary device or as a criticism of the service offered (Wehmeyer *et al*., 1996) resulting in the guarantee being targeted for serious criticisms by employees (Farrell, 1999). Ohemeng (2010) concludes that staff resistance to customer-oriented change is one of the most underestimated aspects of introducing a service guarantee.

My research contributes to the literature on the development and implementation of service guarantees and on the patient-centeredness of integrated care. It is the first piece of research to focus on a single service guarantee for a service delivery network (Tax *et al*., 2013); a chain of health organisations. The research question driving my exploratory research is: *what, according to experienced practitioners in an integrated regional stroke service, are the important enablers of an effective development and implementation of a single service guarantee for the chain?*

I now describe the setting of my case study. This is followed by a description of the method used consisting of in-depth interviews and analysis based on Grounded Theory. Following this, I present the results of my research followed by a discussion and conclusions.

6.2. Setting

Integrated stroke service in the Netherlands can be distinguished in three phases. Phase 1 consists of acute care involving the emergency department and stroke unit of the regional hospital. Phase 2 consists of rehabilitation involving rehabilitation centres, specialised nursing homes and home care and finally phase 3 consists of long term support. The regional stroke service in this research is located in the Southern part of the Netherlands and is defined by a service delivery network consisting of five participating organisations involved in the first two phases. A regional hospital, a rehabilitation centre and three specialised nursing homes

that offer similar services but are located in various places across the region deliver the services for patients. Patients tend to be frail elderly people who have had a stroke. On the strategic level, the boards of the five organisations have signed a covenant for intensive cooperation. A tactical-level steering committee with managers from the five involved organisations develops and implements strategies that aim to optimise processes and improve patient satisfaction and reduce costs. This steering committee has been the initiator behind implementing the service guarantee for the stroke service.

The formal goals of the regional stroke service in development and implementing a service guarantee were to improve the patient-centeredness of the process and to increase patient satisfaction. After the decision by the steering committee to use a service guarantee, a project organisation was set up. The existing steering committee was in charge of the whole project. This steering committee consisted of the managers of the departments involved in stroke care. The project organisation consisted of a taskforce on the chain level with representatives (managers and employees) of all the organisations. This taskforce was responsible for implementation activities. In a later stage, additional working groups were established at each organisation. A project leader working for the hospital was put in charge of overall project management. After consensus was reached on starting the project, it was decided in May 2009 that there should be a single overall service guarantee for the whole chain and additional sub-guarantees for the hospital and the various possible patient flows on leaving the hospital. This was in order to avoid overloading patients with information. An approach consisting of three stages has been used to realise the objectives of the project: developing the service guarantee; taking measures to realise the content; and finally developing measures to sustain and continuously improve the guarantee.

In the development of the service guarantee, research was conducted by the organisation among recent stroke patients in order to gain a clear picture of patient satisfaction and patients' expectations and preferences. A survey provided an overall view of patient satisfaction with the various stages in their journey through the system. After the survey the subsequent two focus groups with patients and an additional 30 individual in-depth interviews, provided insights into patients' expectations and preferences. Further, employees were consulted on what they thought was important for patients. Based on the results of this process, the steering committee and taskforce developed a first draft of a service guarantee that consisted of a set of overall promises for the whole chain (see Table 16) and more

specific sets of promises for the various flows after leaving the hospital.

Table 16. Promises in the overall service guarantee

The integrated stroke service is a collaboration of five organisations.

- All relevant information concerning you will be present on transfer to the next partner(s) involved in your care.
- The stroke-service partners will conduct an intake interview. This will provide you and/or your family/carer with information about the organisation and the department. You will receive general information on paper.
- You and/or your family/carer will be welcomed by our staff in a hospitable way and treated with respect.
- You and/or your family/carer will be intensively involved in all decisions made during the medical treatment and rehabilitation process. The treatment will be fine-tuned to be as close as possible to your situation and wishes.
- A medical treatment plan will be drawn up. The doctor will discuss this with you and/or your family/carer.
- Your questions will be answered within 24 hours.

The development of the service guarantee involved intensive co-operation between the steering committee, the taskforce and the working groups in the five organisations. This was intended to generate commitment to the content of the service guarantee and to ensure that it could be realised. Given that the steering committee had aimed to develop service promises that could easily be realised by all the involved organisations, the improvement measures required for realising the content were perceived by the organisations as feasible. By the end of 2010, the internal and external communication campaigns had started. In several organisations, seminars were organised to present the service guarantee. Following this, although the project organisation was still in place, the approach switched from a collective approach to one based on the individual organisations. Thus, in the subsequent phases of taking measures to realise the content of the service guarantee and then sustaining it, there was less central coordination.

6.3. Research methodology

In my research, I used a case-study approach since case studies have proven their usefulness in the development of new theories (Voss *et al*., 2002). I had the opportunity to carry out the research while the implementation process was ongoing, albeit approaching its end. My role was that of researcher, and I was not involved in the actual development or implementation. The case is unique in that no further cases are known in practice or in the literature where a chain of organisations has developed and implemented a service guarantee. Since this case is distinct from other implementations, there was no other option but to use a single case study

approach. The uniqueness is the rationale for this single-case design (Yin, 2009).

In my research, I drew on the opinions of the experienced practitioners who were responsible for the development and implementation of the service guarantee. I decided not to work with a sample but to involve all the members of the steering committee representing the five organisations. These members are managers working for the five organisations involved. Further, the current five members of the taskforce, the chain coordinator and the head of the supporting hospital department that coordinated the patient research were interviewed. All practitioners I have invited to participate have done so. I have thus involved all the people responsible for and intensively participating in the development and implementation of the service guarantee in the chain and in its individual organisations. I obtained informed consent by writing from the participants to use and publish quotes as stated in their interviews on an anonymous basis. For this research no approval of a medical ethical committee was required according to the criteria of the Dutch law 'Medical-scientific research among people (WMO)' of December 1st 1999.

Given that no frameworks exist for the enablers of an effective development and implementation of one single service guarantee for a chain, I used Grounded Theory to develop theory based on the data. This is an established exploratory qualitative method for analysing empirical data in order to build a general theory. After acquiring the commitment of the steering committee to start the research, relevant documents such as project documents and the results of the patient research were obtained and studied. Individual interviews were held, and the respondents were assured of anonymity to encourage them to speak freely and not be influenced by others. Interviews are seen as a highly efficient way to gather rich empirical data, especially when, as in my situation, the phenomenon of interest is highly episodic and infrequent (Eisenhardt and Graebner, 2007). I conducted a total of 12 semi-structured interviews, each of approximately 1.5 hours.

Table 17. Interview protocol[16]

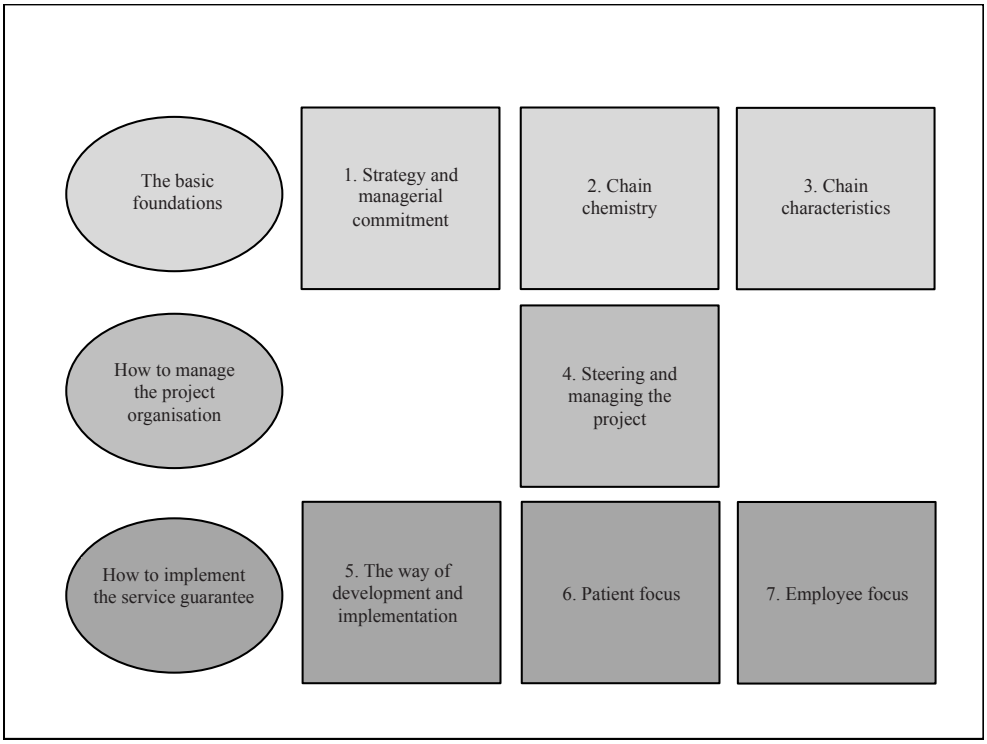
		5 steering committee members and 5 taskforce members (10 interviews)	Chain coordinator (1 interview)	Support on patient research (1 interview)
A. The organisation				
1	Which part(s) of the organisation are involved in the service guarantee	x		
2	How many employees are working here?	x		
B. Development and implementation of service guarantee				
1	How was the service guarantee developed on the chain level? What was the process?	x	x	x
2	How has the service guarantee been developed and implemented in your organisation?	x		
3	What were the goals in implementing a service guarantee?	x	x	x
C. Enablers for the effective implementation in your organisation. If you look back…				
1	What went well during the implementation in your organisation?	x		
2	What would you have done differently?	x		
3	What were the most important enablers of effective implementation in your organisation?	x		
4	Imagine that another organisation wanting to implement a service guarantee asks for your advice, what must it have in place in order to implement it effectively?	x		
D. Enablers for the effective implementation for the whole chain. If you look back …				
1	What went well during the implementation in the whole chain?	x	x	x
2	What would you have done differently?	x	x	x
3	What are the most important enablers of effective implementation on the chain level?	x	x	x
4	Imagine that another organisation wanting to implement a service guarantee asks for your advice, what must it have in place in order to implement it effectively?	x	x	x

An interview protocol was used (see Table 17) with open questions, seeking explanations of how the service guarantee was developed and implemented, the perceived enablers on both the organisational and chain levels, and what went well and what was problematic. Participants were encouraged to speak freely and share their opinions, successes and failures during the development and implementation. All the interviews were taped and later transcribed in detail in order to capture the full richness of the respondents' views. For transcript analysis, I used Glaser's 'tabula rasa approach' for coding (Glaser, 1978) and avoided forced coding based on preconceived frameworks. I used a substantive coding approach consisting of open, followed by selective, coding (Walker and Myrick, 2006). For the open coding, the interview transcripts were reviewed line-by-line by three independent researchers, and codes were placed in the margins of the transcripts. In an extensive

[16] This is the interview protocol used for the 12 interviews. The last three columns indicate (with an X) which questions were asked to which category of respondent.

consensus meeting, the three researchers established an agreed set of 44 codes. Following this, all the text fragments from the 12 transcripts were reorganised based on these 44 codes. To obtain an overview for each code, all the fragments linked to a code were combined in a single document. For each code, several sub-codes were then determined. Finally, the codes and sub-codes were analysed and re-analysed for emerging patterns and themes. This selective coding finally resulted in seven clusters with a total of 27 enablers (see Figure 5). The seven clusters can be divided into three overarching themes: 'the basic foundations', 'how to manage the project organisation' and 'how to develop and implement the service guarantee'.

Figure 5. The seven clusters of enablers



6.4. Results

The extensive analysis based on Grounded Theory has resulted in a Network Framework consisting of seven clusters of enablers. These clusters are derived from the empirical study without using any predetermined or existing model or framework. The clusters and their 27 associated enablers are presented in Table 18. As illustrated in Figure 5, the first three clusters

focus on the basic foundations for developing and implementing a service guarantee in an integrated regional stroke service. The fourth cluster addresses how to manage the project organisation, and the final three clusters address the way to develop and implement a service guarantee with a special focus on patients and employees. Of these seven clusters, the third cluster 'chain characteristics' has a special position since it contains three enablers that describe the context of the chain and which have an impact on the development and implementation but cannot be influenced during it. The seven clusters will be briefly described below. These are illustrated by quotes of the participants that best describe the general opinion of the participants.

Strategy and managerial commitment

A fundamental difference between the development and implementation of a service guarantee on the chain level with that in a single organisation is that not one but several, in this case five, boards of organisations with different cultures and views on quality control, quality improvement and patient-centeredness are involved in the project. Aligning the visions and goals of using a service guarantee is much more difficult and important in such situations. In my case subject, a well-structured approach was used between 2009 and 2012 with many enthusiastic project members involved and this resulted in the first service guarantee for a healthcare chain. The data show that a number of aspects concerning strategy and managerial commitment are important. The first is a clear understanding by management and board members of the impact of the concept on the organisation. The formal objectives in using the service guarantee for the integrated stroke service were to improve patient-centeredness and patient satisfaction. In order to realise these two objectives, it is crucial that each participating organisation embraces them. As one of the steering committee members stated: '*The most important condition is that the organisation is really interested in the content of the service guarantee and wants it to actually improve care, not just so they can say they have one. This is an important difference. Depending on their goals, organisations act differently and this complicates implementation. Depending on their goal, organisations take different actions, facilitate the implementation differently and communicate differently'*. In order to stimulate the development and implementation, it is important to allocate sufficient appropriate resources to it.

Chain chemistry

A specific cluster of enablers for developing and implementing a service guarantee in a chain

is the importance of having the right chemistry between the organisations involved. Here, an important enabler is trust, trust in each other and that the implementation will work. As one steering committee member expressed it: *'If there is no basis for trust, don't start with it '*. The commitment of all organisations to jointly develop and implement a single service guarantee based on compromises and consensus is essential. As such, it is necessary to put the interests of the chain above those of the individual organisations. As one of the members of the taskforce put it: *'It is important that each partner in the chain is willing to give up some of its own advantages'*. Further, openness and transparency are important. Here, the organisations involved were informed about patient satisfaction in the other's organisations, teams visited each others' organisation in the chain to learn from their practices and certain procedures were standardised. In achieving this, feelings of competitiveness might have negative consequences. As a steering committee member of one of the specialised nursing homes stated: *'Our cooperation is now good but the government is promoting competition. One effect is that we, as similar specialised nursing homes, might be forced to compete'*. Finally, participants stated that it is important that one organisation takes the lead in the development and implementation.

Chain characteristics

The characteristics of the chain have an effect on the development and implementation of the service guarantee. As one of the steering committee members stated: *'It is much easier to implement a service guarantee with two organisations than with five of which three undertake the same activities'*. Besides the structure of the chain, the extent of integration is an important enabler. This chain consists of a patient's journey through several organisations resulting in several logistical interdependencies among the organisations. Having standardised processes makes implementing a service guarantee much easier. This is illustrated by one of the steering committee members: *'Still today, our processes are not sufficiently structured. Before implementing the service* guarantee *we should have structured and standardised our processes in the chain'*. Another chain characteristic concerns the kind of patients. In this instance, they are mainly frail and elderly with an extreme focus on their health following a stroke. Some respondents expressed doubts about the effectiveness of a service guarantee for this patient group. Many patients, they felt, would not be interested in the content, would not consult it and would not react if promises were not kept.

Steering and managing the project

Developing and implementing a service guarantee within an integrated stroke service involving five organisations demands an extensive project organisation. Here, the regional stroke service set up a project structure consisting of a steering committee, a project leader, a taskforce and support on the chain level and a working group within each organisation. Participants in my research believed this extensive project organisation to be essential for achieving commitment in all organisations. The steering committee has an important role in this structure. To give it sufficient power, it is necessary for each organisation to be represented on this committee with broad and uniform mandates. As one of the steering committee members observed: *'What you see is that there are differences between the organisations. If we have a mandate, we have the authority to use it and take all necessary actions. In other involved organisations, members of the steering committee have a mandate, but it is very limited. The result is that these people have to check decisions with their superiors, and that takes time'*. Further, the project leader has a crucial role. Several respondents stated that it is important to have an independent project leader who is not working for one of the participating organisations and with enough authority to act as a trouble-shooter when necessary.

The way of development and implementation

Respondents mentioned several enablers relating to the way of developing and implementing a service guarantee. Having a specific and detailed planning on the chain and organisational levels was often mentioned. Since all the organisations had to commit to the content of the guarantee, the organisations spent a lot of time discussing the content and ensuring that there was full commitment to the promises in the guarantee. As a member of the task force explained: *'We have listened carefully to each other and have given each organisation adequate room for comments'*. Further, it is important to use a structured and well-coordinated approach in all phases of the development and implementation. This is required to ensure that the coordination does not stop once the service guarantee has been defined on the chain level but is extended to making the service guarantee work and then sustaining it. Participants commented that they underestimated the resources necessary for making the service guarantee work. A steering committee member commented: '*My general criticism is that we spent a lot of time and attention on the development, describing and communicating the service guarantee and profiling our organisations, but we underestimated the effort required to make the service guarantee really work. We thought we could simply tell our*

employees who have to work with the service guarantee and they would do it. We have learnt that it doesn't work that way. We have learnt that making a service guarantee work is difficult: making the service guarantee work takes as much or even more time and energy than developing it.'

Patient focus

Most of the respondents expressed the view that patient needs should be central when developing the service guarantee. As such, the involved organisations had conducted a survey, organised focus groups and held in-depth interviews prior to implementing the guarantee. The goals in conducting this extensive research were to gain a sense of current patient satisfaction and to determine the desirable content of a service guarantee. The implementation of the guarantee in this integrated stroke service showed that qualitative research is essential for gaining an in-depth understanding of patients and their preferences. Further, the research needs to be anonymous and easy for the participants. For the frail elderly patients, it was important that the research was anonymous in order to create a safe environment in which they could be open. Furthermore, making it easy for patients to participate by visiting them at home was important. As such, in this instance, focus groups appeared to be less appropriate than individual interviews.

For the service guarantee to work in daily practice, it is important that patients are informed about it. The method and intensity of communicating the service guarantee should be the same in all organisations. One of the members of the taskforce who had spent a lot of time and energy on personally informing patients about the service guarantee explained: *'It is personally explained to new patients what a service guarantee is, what our promises are, why we are doing this, what the patient can do when we do not deliver and that we offer small compensation in these cases'*. This was to ensure that patients knew about the service guarantee and could use it when interacting with employees on the basis that this would lead to concrete improvements. At the time of my research, the chain had yet to implement a well-structured system for evaluating the realisation of the promises for each patient. Participants recognised that this is key for the effective use and sustainability of the guarantee. A taskforce member observed: *'We should have a standard evaluation instrument to check the realisation of the promises in the service guarantee with each patient when or after leaving the organisation'*.

Employee focus

Also focusing on employees during the implementation is very important since they are the ones who will make the content of the guarantee a reality in their daily contacts with patients. Managers have a crucial role in creating motivation, enthusiasm and a sense of urgency. As one of the steering committee members stated: '*Assemble your employees and convince them of the necessity of the service guarantee'*. A member of the taskforce provided an illustration of this happening where a manager had gathered his employees together and passionately explained, the background, the reasons for and opportunities of the service guarantee. This had convinced many employees.

To gain the commitment of employees it is first important to involve them in the working groups. However, this is not enough as the experience of several of the involved organisations is that all employees, both nurses and physicians, have to become involved. Just relying on working groups is insufficient. When forming working groups it is also important to involve not only volunteers but also the opinion leaders of teams since they are able to contribute to changing the culture. The aim of all this is to achieve the full realisation of the contents of the service guarantee in daily practice. The different starting positions of the various organisations and teams within them seem to play a role. There were organisations where the service guarantee fitted perfectly with their patient-centred culture but others where it seemed not to be fully accepted or understood. Within individual organisations, different teams also accepted the philosophy and content of the guarantee in various ways.

Table 18. Network Framework: clusters and their enablers

1. Strategy and managerial commitment
A. *Strategic alignment*: The service guarantee fits the vision of all involved organisations and the goals of the chain.
B. *A concrete and shared goal*: There is a clear goal in using the service guarantee that is genuinely supported by all the organisations involved. It is to improve patient-centeredness and customer satisfaction.
C. *Commitment and support*: All the organisational boards fully understand the concept of a service guarantee, the consequences of using it and are committed to using it.
D. *Resources*: The involved organisations dedicate the appropriate people and other resources to the project.
2. Chain chemistry
A. *Trust*: Being open and transparent with each other and trusting in the other organisations that the initiative will be successful.
B. *Willingness to cooperate*: The commitment of all organisations to develop a single service guarantee for the whole chain. The capacity to listen to and to respect the opinions of the other organisations involved in the chain.
C. *Chain before organisation*: Having the courage to prioritise the chain over the interests of the individual organisation.
D. *One organisation in the lead*: Having one organisation in the lead in implementing the service guarantee and leading by example.
3. Chain characteristics
A. *Structure of the chain*: The number of organisations in the chain, the degree of competitiveness and the division of

power within the chain. Plus, the way the chain has dedicated organisational units for stroke services in the involved organisations.

B. *Extent of integration*: The way processes in the chain are standardised and the chain works as a coordinated integrated care and patient journey.

C. *Characteristics of patients*: The age of patients, their diseases, their physical and emotional condition and the effects of these aspects on the way they want to be involved in the development of the service guarantee and are interested in using it.

4. Steering and managing the project

A. *Project structure*: Having a well-structured project structure and committees involving all participating organisations on the strategic, tactical and operational levels.

B. *Steering Committee*: Having a steering committee including members of all organisations with a broad and uniform mandate. This steers and systematically monitors progress in all phases of development using measures to realise the content of the guarantee and sustain the change.

C. *Project leader*: Having an independent, stimulating and active project leader in charge of the daily coordination of the project.

D. *Support*: Having experienced support from the project organisation that infuses know-how and delivers supporting activities.

5. The way of implementation

A. *Action plan*: Having an action plan for all measures on both chain and organisation levels.

B. *Timing*: Having the right timing: not so fast that commitment is not obtained, and not so slow that momentum is lost. Ensuring that all organisations work at the same pace.

C. *Improvement actions*: Investing the attention, time and energy to implement all the measures necessary to realise the content of the service guarantee in all organisations in a uniform manner.

D. *Sustaining*: Regularly and objectively measuring the structural realisation of the content of the service guarantee on the chain and organisational levels.

E. *Continuous improvement*: Regularly evaluating and updating the service guarantee to match changing demands and preferences of patients. Taking corrective actions if necessary as part of the regular quality control of the chain.

6. Patient focus

A. *Patient-focused service guarantee*: The content of the service guarantee is based on needs and preferences of patients. Further, service levels are only promised that can be realised in practice. If levels are not met, there is compensation.

B. *Patient research:* The chain uses methods to research the needs and preferences of patients that give valid and reliable results for the entire patient group.

C. *Patients understand the service guarantee:* Using effective means to inform patients at the right moments about the philosophy and content of the service guarantee in order that patients fully understand and can use it.

D. *Continuous feedback from patients:* Using methods to obtain continuous patient feedback on the realisation of the promises in the service guarantee

7. Employee focus

A. *Motivation and stimulation*: Managers motivate and stimulate employees over the service guarantee.

B. *Commitment of employees*: Creating commitment in each employee to the goals and content of the service guarantee. Achieved by using the power of opinion leaders, involving all employees, creating a sense of urgency and defining a service guarantee that employees believe to be realisable.

C. *Willingness to realise the promises*: There has to be a willingness to ensure the culture change necessary to achieve the patient focus. It is essential that each employee sees the promises in the service guarantee as his/her personal commitment/promise to each patient every day.

6.5. Discussion

In Chapter 5 I described the PSGI-Framework consisting of three main clusters and ten sub-clusters of enablers. This was the first empirical research on enablers for the effective development and implementation of a service guarantee that focused on individual public organisations. The exploratory research for this chapter has extended the knowledge on this subject by conducting research on the development and implementation of a single service guarantee covering a chain of organisations. It has resulted in a Network Framework

consisting of clusters of enablers for the development and implementation of a service guarantee for an integrated stroke service. It consists of seven clusters containing 27 enablers. The results of my research contribute to the literature on service guarantees, patient-centred integrated care and the implementation of innovations.

The results show that the enablers are not only related to the organisational level but that there are additional enablers on the chain level related to strategy and managerial commitment, the chemistry in the chain and the characteristics and context of the chain.

My research has contributed to knowledge on improving patient-centeredness and patient satisfaction in an integrated care setting. Along with functional status, quality of life and costs, patient satisfaction is one of the most important outcome measures of integrated care. Nevertheless, in research on integrated care, patient satisfaction and patient centeredness have received little attention. As Howarth and Haigh (2007) observe: 'evidence of patient centrality from the service user perspective has not been satisfactorily explored'. Only a few studies have researched the effects of implementing the concept of integrated care on patient satisfaction. Rosendal *et al*. (2002) concluded from their study that patient satisfaction increased after implementing integrated stroke care. The further optimisation of integrated stroke care, in order to enhance patient satisfaction, is seen as an important field for research worldwide (Heijnen *et al*., 2012). The use of service guarantees could be seen as a concept for further optimising patient centeredness in integrated care. It is a means for improving communication with patients and the patient centeredness of employees and processes.

The effectiveness of an implementation depends on *power, culture and structure* (Mur-Veenman *et al*., 2001). *Power* reflects the capacity to influence people in a desired direction. In the stroke service investigated, nobody is the 'boss'. None of the organisations has enough power to force the others to participate fully. A consequence is that the content of the service guarantee is based on consensus, and the speed of implementation is determined by the slowest organisation. Power in the chain would seem to be helpful in achieving a successful implementation. *Culture* reflects the set of values, guiding beliefs, understandings and ways of thinking shared by members of the chain. The main goals of using a service guarantee were to increase patient-centeredness and patient satisfaction. Developing and implementing this concept and achieving its goals seemed to be smoother in those organisations that already had a dominant patient-centred culture because the guarantee corresponded with existing values,

strategies, goals, skills and ways of working. Culture will also be reflected in the actual organisational goals of implementing a service guarantee. The alignment of goals within the chain is a core factor for effective change; a misalignment is a source of potential tension. Congruent goals among all five involved organisations are essential for an effective implementation. Although the formal goals were to increase patient-centeredness and patient satisfaction, some of the organisations had other goals such as having a service guarantee as a marketing tool or avoiding becoming separated from the chain through non-participation. This resulted in differences in the implementation of the necessary measures and in the effectiveness of using the service guarantee in the various organisations. Having a patient-centred culture and alignment on objectives seems to be very important when using a common service guarantee. Finally, *structure* also has an impact on development and implementation. Implementing a service guarantee across five organisations forces micro-level standardisation of practices within the healthcare system. Leutz (2005) has described three prototypical models and phases in increasing integration: linkage, co-ordination and full integration. Based on the results of the interviews, I was able to conclude that the stroke service acts somewhere between linkage and co-ordination phases. The consistent use of a service guarantee is probably best achieved when embedded in a chain in the co-ordination or full integration phases. In my case, the development of the service guarantee was a joint operation, but its implementation was carried out independently by each organisation. Due to differences in the approaches adopted, this led to some tensions in the chain. As such, it is important that there is a central approach not only in the development of the service guarantee but also in the implementation of the measures in order to realise and sustain the guarantee's content in all the involved organisations.

My research shows that beside power, culture and structure also mutual trust influences the effectiveness of an implementation. Trust among organisations is essential for the development and implementation of a joint service guarantee. Managing the integration necessary for the implementation of the service guarantee has been shown to be more of a process of deliberation and negotiation between organisations than one of ideology and prescription (Grenier, 2011). A lack of trust in this process could be a barrier and could block the necessary integration (Delnoij *et al.*, 2002). Working together and jointly achieving successes can develop trust. However, miscommunications as a result of prioritising one's own organisation, a lack of communication and uncertainty can all be barriers to integration and sources of distrust (Williams and Sullivan, 2009).

Five organisations delivering health care in two of the three phases of an integrated regional stroke service have developed and implemented a service guarantee. My research is based on the opinions of experienced practitioners working in these five organisations. As such, the external validity of the study is limited: the framework could be improved by conducting similar studies on integrated healthcare and on chains in general. Since the goal of my research was to determine the organisational enablers, I have included experienced managers and employees. In my research I did not use the opinions of patients and their relatives. Follow up research could study the expectations and preferences of this important group on the relevant aspects of the implementation for patients. By using qualitative research methods preferences concerning e.g. how to communicate and use a service guarantee could be researched. Furthermore research could be done on the actual effectiveness of service guarantees. Do they really contribute in improving the patient-centeredness and increasing patient satisfaction? This follow-up research could address the relationships between the enablers and actual results in terms of patient-centeredness and patient satisfaction. In a healthcare setting no research on this issue has been done till now.