ZUZANA HAVRDOVÁ, GERRI MATTHEWS-SMITH, PÄIVI HUOTARI (eds.)

Developing Cross-Cultural Competencies in Health and Social Care Management

Learning from Research and Experience of Five EU Universities

LAMK Lahden ammattikorkeakoulu
Lahti University of Applied Sciences

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Introduction

Päivi Huotari

Given the level of pressure for cost reduction within the European Health and Social Care sectors and the need for high-quality care, competent and innovative management of the workforce is now of critical importance in care organisations. Such challenges place pressure on universities to adopt new approaches to their curriculum development and pedagogical solutions to educate current and future managers to face these challenges. Internationalisation of the European higher education sector has been an integral part of the Bologna Process, and this creates a useful framework for international co-operation in Health and Social Care Management Education. The strategic framework for European co-operation in education and training ('ET 2020') stresses the need to ensure high quality teaching, lifelong learning, job-specific skills and key competences, as well as intercultural dialogue and competences. The framework further emphasises partnership between working life and higher education, which can help to ensure a better focus on the skills and competences required in the labour market. In addition, there is a high level of interest in the development of joint programmes within Europe.

This monograph aims to draw on the process of developing an international pilot programme for master's students of management, which might serve as an inspiration for other professionals in the field and provide some new outcomes. The process was supported by the Erasmus Lifelong Learning Programme funding of the project CareMan (Development of Culture and Quality of Care), which enabled it and formed an organisational framework for the process.

The monograph contains two parts. The first part starts with the theoretical underpinning of the process and describes the most important facts about its organisational framework and the methods and outcomes of the mapping of the needs and resources of four universities cooperating in this process. Based on the theoretical and organisational background and the mapping phase, several strategical principals were chosen that informed the building of the educational modules, its implementation and evaluation.

The second part of the monograph contains the theoretical chapters concerning the topics that teachers participating in this project have drafted and used as part of the theoretical resources for the practical parts of the educational modules.

The CareMan project focused on social and healthcare leadership and management. Social and healthcare organisations need educated managers, who are able to reflect and critically appraise service management and service processes. Care and care services in this project refer to the attention provided by social and healthcare professionals, especially in the public sector. Leadership and management covers all processes in order to produce effective services with good quality of care. Social and healthcare are seen as integrated services, since more clients have health and social problems intertwined. The core management themes on which this project focused were human resource and knowledge management, quality management and intercultural management.

- Human resource and knowledge management has a role in competence management in terms of managerial competencies. Knowledge management needs to ensure that employees have the necessary qualifications and competencies for delivering care services. Continuous

competency development is an essential part of human resource management in higher education.

- Quality of care is seen as a strategic choice and part of the strategic decision making at the societal, political, organisational and managerial levels. In relation to quality issues, managers have the primary responsibility for creating and maintaining the quality system and developing solutions for quality deviations. Management education is seen as the basis of good management and good quality of care. The quality of care depends on leadership, management and employees, but society and clients also have an important role in achieving good quality of care. Communication between different stakeholders is of high importance. Management and leadership skills are prerequisites for quality management and good quality, and should therefore be emphasized in social and healthcare management education.

- Organisational culture, and especially the ideals and values influencing future managers in higher education, have a crucial impact on practice in care services. The values and ideals in providing care are influenced by specific economic and socio-demographic (national) factors, which have an impact on management perceptions and decision making. These factors should therefore be reflected during the education of managers.

Based on these three management themes, the project developed and piloted 30 ECTS joint modules. Furthermore, the project demonstrated dialogue focused on the European convergence of health and social care systems and human health resources based on the universities' previous cooperation.

Part I

Theoretical and Organisational Background

Chapter 1 Theoretical and Organisational Background

Gerri Matthews-Smith, Janyne Afseth, Päivi Huotari

1.1 Theoretical Framework

In professional practice contexts, the practical questions are rarely the ones that are most difficult; rather, the real questions that prove the most challenging are those that require learners, teachers and managers to examine their own beliefs and to question their understanding and knowledge. Casimiro, MacDonald, Thompson and Stodel (2009) highlighted the importance of a theoretical framework to guide the development of inter-professional online learning and noted a shift to constructivist views of learning, where learners are encouraged to construct new learning based on their experience to underpin these courses. At the beginning of the project it was considered important to select a theoretical framework that would underpin the development, management and evaluation of the intercultural educational provision developed.

Floyd and Morrison (2014) suggest there is a relative dearth of theoretical frameworks in which to examine identities and culture in relation to collaborative education. However, Clark (2006) has proposed a number of potential inter-professional frameworks including 'cooperative, collaborative and social learning'. In essence, from this perspective, students learn "with, from and about each other using problem solving or case-based approaches to collaboratively solve complex problems" (Clark 2006, p. 579). One of the most important characteristics of this framework is the social exchange among members of the team where knowledge and understanding is gained through different backgrounds, training, perspectives and traditions. The CareMan project brought together partners educating social and health care professionals in leadership and management Masters Programmes in Europe to develop this sector. However, there was also a need to consider transformational learning – a means by which student learning could be enhanced and applied to their own learning environments.

To focus developments in these areas we chose to rely on a combination of both learning theories: 'cooperative, collaborative, social learning' and 'transformational learning'. Transformational learning theory is based on the assumption that personal meaning is constructed from experience and confirmed through discussion with others. These two theories underpinned the theoretical framework which served as a lens through which development, assessment and evaluation of the educational provision was determined. Students were guided to work together and use contextual knowledge to apply new learning to practice and reflection, as a means of increasing the effectiveness of their performance and the development of their critical thinking skills.

The development of transformational learning theory owes much to Jack Mezirow (1975). Following his comprehensive description in Mezirow (1991), transformative learning is defined as a multidimensional, continuous social process that engages the learner in a better understanding of themselves, their perspectives, and the meaning that has for them through communication with others (Mezirow, 2000). This learning process involves a complex series of interactions that takes place when learners experience an incident or question that

challenges a previously held belief about the world. The discomfort experienced by the learner incites a critical reflection of previous experiences and challenges assumptions that inhibited the way in which they perceived and understood the world (Cranston, 1994). Because transformative learning focuses on meaning, it has a direct impact on thoughts, emotions and motivation, which through this process are essentially changed.

Other writers have contributed to develop and enhance the theory, and a review of the literature indicates that four main schools of thought have emerged, including Freire's (1972) emancipatory approach; Boyd's (1989) extra-rational approach; Mezirow's (1991) rational approach and Daloz's (1999) developmental approach. Taxonomies of transformational learning have also been proposed by Cranston in 2006 and Taylor in 2007. However, for the purposes of this study we have chosen to use Mezirow's 1991 perspective of transformative learning, as this process aims to challenge established biases, assumptions and behaviours.

Implementation of the Theoretical Framework into the Design of the Learning Process

When faced with new learning experiences students need to be encouraged to critically reassess what is often well-established knowledge and policy constructed through prior experience in relation to new, sometimes contradictory information and events (Mezirow, 1997). The modules to be developed should prepare individuals with the management and leadership skills needed for the future. It was also acknowledged that, in particular, collaborative learning and education provided the opportunity to address many of the differences in practice among students who were from many cultural backgrounds and different schools of thoughts. When designing the educational module delivery, one of the key chosen learning strategies was collaborative group work, delivered through intensive teaching weeks, where students would be encouraged to work together, share practice experience and identify potential solutions to real life practice problems.

The notion of reflection is widely promoted in educational settings as a means of subtle continual feedback enhancing critical thinking in relation to practice (Taylor, 2007), a key component relevant here where our aim was to impact on practice. The concept of transformative learning offers one of the most sophisticated conceptualisations of reflection within the larger frame of theory in adult learning (Mezirow, 2009) and offers a clear theoretical lens to investigate levels of reflective processes demonstrated by students at this level. This particular component was highly influential in the decision to use portfolio and practice examples in the overall assessment process.

Within the modules, delivery examples of different practices and beliefs were chosen as the basis of student learning. Discussion was seen as a way to identify, critically evaluate and review various practice options from across the member countries. Students' self-perception and interpretation of their experiences have an essential role in personal empowerment and transformative learning as a basis for identity development and capacity building. Indeed, Mezirow (1994, p. 224) was quite clear that "the most significant learning involved critical reflection around premises about oneself". The nature of classroom interactions plays a significant role in students' perceptions and experience of transformative learning. In these mixed classes students needed to learn to engage in public discussions, where they may have been inhibited by their own perceptions of their ability to answer the questions.

Discussion is central to human communication and learning specifically. In each module delivery space for discussion groups was planned to allow new concepts to be opened to critical review and whilst this form of challenge might be uncomfortable at the early stages it should enable review of thinking and

beliefs. This further level of reflection can allow innovation to problem solving and prompt students to enlarge their thinking beyond their own specific professional norms and values.

Our theoretical underpinnings provided a basis to improve competencies such as leadership, communication and conflict management through social learning. Current health and social care challenges are exacerbated by tightening economies, diverse workforces and different challenges in health and social care delivery. It was necessary to allow students, within a safe environment, to question and explore some of the challenges and assumptions in practice from a multicultural and multi-professional perspective. It was expected that this process of collaborative learning would challenge previous beliefs, leading to a process of decentering of their current knowledge and resulting in different learning outcomes including enrichment, deepening modification or elimination of doubt. At the same time, improved intercultural competence was developed due to guided reflection in the inter-culturally mixed groups.

Assessments were designed to use both aspects of practice and reflection. Students addressed new learning through examples from their practice such as portfolios and case studies to encourage reflection and transformational learning. An agreed marking key ensured that students were aware of how they would be assessed.

The drive to produce innovative and progressive teaching experiences that demonstrate engagement, encourage insights, foster independent thinking and facilitate student abilities to realise their potential sits well with the overall motivation to develop this project. In the early stages of the project a number of exploratory activities conducted by the project team such as curriculum review and scoping exercises with students helped to identify the key theoretical content required for the development of the competency framework and subsequently the concrete learning modules.

1.2 Higher Education and Competency Framework

The overall aim of the project was to develop a joint common educational programme in health and social care management. In the design of the programme a number of underlying structures and principles of the European Higher Education framework required consideration. Shared standards and guidelines that helped to guide the process stem from the Bologna process, the Lisbon Convention, the European Qualifications Framework and Educational Quality assurance standards. This chapter briefly discusses these standards and guidelines, which informed the development of the programme.

The Bologna declaration, first signed in 1999, helped to align European standards of Higher Education (European Commission, 2016). This process focused on implementing student-centred, outcomes-based and transparent educational programmes. This process allowed European countries to have comparability of the standards and quality of educational qualifications within academic institutions. This process improved the quality assurance of any qualification, but also promoted student mobility across regions while studying.

An important aspect to support the implementation of the Bologna process is the European Qualifications Framework (EQF), which has played an important role in developing comparable degrees and levels of study in higher education. This has supported the development of the European Credit Transfer System (ECTS), which has facilitated the mobility of students through Europe (European Commission, 2015). The EQF has also further facilitated the recognition of qualifications, and this is important for those who make use of qualifications, in particular learners and employers.

In recent years, the development of National Qualifications Frameworks has gathered considerable momentum. As of 2014, the EQF has catalysed 34 out of 38 countries surveyed to develop and implement transparent frameworks based on learning outcomes (European Centre for the Development of Vocational Training (ECDVT), 2014). To establish a national framework, each country sets it standards within its structures. They must also set out the interface with the EQF so that students, employers and relevant agencies can compare and benchmark the requirements and/or achievements of students within the national framework (Lokhoff et al., 2010). The drivers for this have helped improve transferability but also in many cases helped reform national priorities in relation to education and policies for lifelong learning (ECDVT, 2014).

The EQF defines competence as 'the proven ability to use knowledge, skills and personal, social and/or methodological abilities, in work or study situations and in professional and personal development' (European Commission, 2015). According to the Tuning project, competences represent "a dynamic combination of cognitive and metacognitive, skills, demonstration of knowledge and understanding, interpersonal, intellectual and practical skills, and ethical values" (Lokhoff et al., 2010, p. 21). Developing competence is the object of a process of learning of an educational programme and therefore should guide the content and outcomes proposed by the modules.

The ETCS handbook emphasises the inclusion of learning outcomes as a strategy to provide clarity for students and employers on what will be achieved through completion of the module (European Commission, 2015). The international definition of learning outcomes found in the literature is these "…are statements of what a student is expected to know, understand and / or be able to demonstrate after completion of a process of learning" (European Commission, 2015). These learning outcomes give coherence and focus the students' learning – facilitating a student-centred approach linking design, delivery and assessment to clearly state what will be achieved by the student at the end of the course.

European Higher Education Area

Another important aspect of standards and guidelines in European Higher Education is the importance ascribed to the evaluative framework. Quality assurance must be considered during the processes that adhere to the EQF. All stages of programmes and courses under the ECTS should be quality assured through appropriate evaluation processes (e.g. monitoring, internal and external quality reviews and students' feedback), which should lead to continuous quality enhancement. In terms of curriculum development and design a number of areas should be considered:

- development and publication of explicit intended learning outcomes;
- careful attention to curriculum and programme design and content;
- specific needs of different modes of delivery (e.g. full time, part-time, distance learning, e-learning)
- formal programme approval procedures by a body other than that teaching the programme;
  (European Association for Quality Assurance in Higher Education, 2009)

1.3. Organisational Framework

The CareMan project brought together university partners actively involved in educating social and health care professionals in leadership and management at master's level in Europe. The five partners of the consortium were Lahti Univer-

sity of Applied Sciences – Lahti UAS (administrative and academic coordinator, Finland), Charles University – CU (the Czech Republic), Edinburgh Napier University – ENU (Scotland), Hammeline University of Applied Sciences – HAMK (Finland), and University of Évora – UoE (Portugal). This group had previously worked together on an LLP Erasmus Intensive Programme "Human Resource and Knowledge Management in Social and Health Care" from 2012 – 2014. From experience the partners knew that the consortium offered not only a diversified competency base, but also different geographic, economic, and cultural experiences covering a large part of Europe and this helped to cross-fertilise current approaches to lead to a truly European and novel way to address the pressing social and healthcare managerial challenges.

The objectives of the project were to:

i. Compare, contrast and map the views, values and ideals taught in the participating master's degree programmes and those practiced in social and health care organisations.
ii. Use the mapping process outlined in objective 1 to develop a common part of curricula that will meet the aims of a joint degree programme.
iii. Evaluate the joint degree process with a sample of students.

The project was divided into six work packages (WP 1–6), with each university having the main responsibility and a leading role in one work package, ultimately leading to accomplishment of the overall project purpose and aims. The six work packages were Project Management (WP1), Quality Assurance (WP2), Curriculum Development (WP3), Joint Degree Master's Programme Proposal (WP4), Dissemination (WP5), and Exploitation of Results (WP6). In this monograph only the process and results of curriculum development and piloting of three modules of the foreseen Master's programme proposal will be presented. However, all work packages contributed to this crucial aspect of the project, therefore a short description of each work package follows.

In work package one (WP1) Lahti UAS, as responsible for the project management, established a project management group (PMG). The PMG had one representative of each university apart from Lahti UAS, which had two representatives, an academic and administrative project coordinator. The PMG all together had five face-to-face meetings and, in addition, virtual meetings once every two months (Adobe Connect Pro guided by Lahti UAS). The meetings and the CareMan Moodle platform ensured transparent progression of the project, real-time work progress monitoring and the continuous updating of results.

The second work package (WP2) was led by Edinburgh Napier University (ENU) and was concerned with the development of the quality assurance protocol. The aim was to ensure high quality delivery of the CareMan project outcomes, as well as to organise self-evaluation and external audit of the delivered joint modules.

Work package three (WP3), led by Charles University (CU) focused on the development of three 10-credit ECTS joint modules. This package was developed in two phases. In phase one the potential content of the modules was identified following an educational needs analysis and curriculum comparison of the partner universities' provision of culture and quality management in social and health care services (chapter 2). The aim of mapping the situation in social and health care organisations was to explore and document the current situation of quality and cultural content, but also with an emphasis on real world situations that future master's degree programmes need to address. The second phase in WP3 compared the present social and health care management and business management curricula of participating master's programmes, highlighting the similarities and differences. The outcome of the above was that cultural leadership and quality management competences essential in social and health care were defined. These outcomes were then incorporated into the development

of three 10-credit ECTS module descriptors, namely Human Resource and Knowledge Management, Quality Management and Intercultural Management (chapter 3). The Human Resource and Knowledge Management module was written based on the cooperation and experiences in the previous Erasmus IP.

The module descriptors developed in WP3 were used to operationalise the pilot of the three modules in work package four (WP4).

Work package five (WP5) focused on the overall dissemination activities of the project and this process was evident throughout the life of the project. This included the CareMan website, newsletters, workshops, articles, seminars and this monograph. This monograph represents the first commitment of work package six (WP6).

Chapter 2 Educational Analysis

Petr Vrzáček, Manuel Agostinho, Mikko Mäntyneva,
Päivi Huotari, Zuzana Havrdová

The initial aim of the CareMan project was to develop a joint degree programme that combined and utilised the strengths of the five collaborating universities that were already involved in delivering social and health care management education. Because the project was to be implemented in collaboration between educational institutions, the collaboration had to be based on a detailed understanding of the national and institutional specifics of each of the individual academic entities. During this process it was recognised that, due to a number of regulation issues, achieving the original aim would not be possible; ultimately, following a series of analytical works, which are presented below, it was decided that a set of three master's level modules should be developed. One of the reasons was that the Finnish law on master's degrees at universities of applied sciences (UAS) stated that the requirement for entry to a UAS master's programme was a bachelor degree from a UAS or equivalent, plus a minimum of three years of work experience in an appropriate field. The three years' work experience is also required from international students. In practice this meant that the participating Finnish UASs, Lahti and HAMK, could not award a diploma for foreign students without this work experience. The other European universities do not have the work experience requirement, although some take it as a bonus for admission (FHS UK). There were also other differences in law (e.g., requirements for minimum standards in Social Work education at FHS UK) that could not have been overcome during the period of project realisation.

Consequently, the outcome was the development of only three common educational modules, each for 10 ECTS, which were developed, delivered and assessed during the lifetime of the project. The intention was that these would be integrated into the current masters' level provision in each of the universities. This enhanced the opportunity for the participating universities to construct a more international and European perspective within their education provision; it also had the implicit aim of producing high calibre post-graduates equipped with the appropriate skills, theory and competence to effectively manage social and health care organisations within their culture in order to achieve optimal quality of care.

The theoretical framework of the project informed the learning approaches and the design of the modules, and the European higher education framework informed the standards and outcomes on the masters' level. In this chapter, a process of identification of the learning modules content will be presented.

In the design and teaching of programmes, universities need to ensure their teaching is relevant by monitoring advances in knowledge, the needs of industry, market demands, and government and institutional requirements (Bentley et al., 2012). There are many strategies to help achieve this, such as the expertise of teaching staff and current curriculums in the sector. However, a very important consultation needs to take place with the prospective employers of the students; in particular, if they are already practitioners they can advise on sector trends and suggest where the curriculum needs developing (Zahra, Newey, and Shaver, 2011).

Developing educational modules that would provide instruction to present and future managers active in the fields of social or health services could not have been achieved, as stated, without the initial analytical work conducted by the team. The methodological approach of the analyses mainly relied on comparisons.

Pasch (1995, p. 50) mentions a method for classifying general educational goals, depending on whether their fulfilment means that students acquire knowledge, learn skills or develop necessary attitudes. In this classification, educational objectives may be assigned to the affective, psychomotor or cognitive domain. Using this model, the education process may be perceived as an operationalisation of the fulfilment of general educational objectives. This is most often achieved by cascading lower-level objectives, which should then contribute to the fulfilment of the general educational goal. Lower-level objectives include content goals. The formulation of these goals helps determine the scope and depth of education in a given subject. A crucial role in the process of defining content goals is played by the ability of the creators of curricula to utilise internal thematic links. A different method, suggested by Bruner (1977), proposed that each educational topic is structured to consist of concepts, generalisations and facts. Bruner is convinced that the structure of every subject is created by generalisation, which means that education should primarily focus on an understanding of those generalisations and applied concepts.

In tertiary education, the unification of approaches to education can be primarily documented by the process of creating European and National Qualifications Frameworks. Nantl et al. (2014, p. 8) date the first attempts to create qualification frameworks to the early 1990s. The creators of new degree programmes can draw on the experience of their predecessors captured in various types of methodological tools. For example, in 2010 a team of authors led by Lokhoff and Wegewijs published A Tuning Guide to Formulating Degree Programme Profiles, Including Programme Competences and Programme Learning Outcomes. The guide was the result of a two-year project which aimed to describe the possible ways of defining competence and the learning outcomes of any degree programme (Tuning, 2010: 12).

Tuning was originally conceived as a tool that could help with the implementation of the Bologna Process in tertiary education, which in the spirit of personality progressivism emphasised the needs of students. It was oriented toward achievements in the education process and a desire for transparency at Bachelor, Master and Doctoral level of the education cycle. The authors of the guide are convinced that the creation of degree profiles in the defined structure (Tuning, 2010, p. 20) will help increase the transparency of tertiary education and improve the communication between all actors involved in the educational process. For this purpose, each degree profile should define the following basic elements: purpose, characteristics, employability and further education, education style, programme competencies and a list of programme learning objectives. According to Lokhoff et. al. (Tuning, 2010, p. 21), the most important parts of profiles are the formulations of competencies and learning outcomes, where a competence is defined as a "quality, ability, capacity or skill that is developed by and that belongs to the student". Learning outcomes are, according to the same authors (2010: 21), "a measurable result of a learning experience that allows us to ascertain to what extent/level/standard a competence has been formed or enhanced."

As discussed earlier, the content and implementation of a degree programme is also shaped by the European and National Qualifications Frameworks. Tuning (2010, p. 23–24) reaffirms the existence of three levels that influence the final form of each programme descriptor. These are the European, National and Programme level, also reflecting international reference points for the subject. Overviews of already processed programme descriptors show that in the field of management, let alone the management of social or health services, there is so far no descriptor that would contain a specific definition of competencies and learning outcomes (Tuning,2010). The process of creating national qualifications frameworks also has not yet been completed in all EU member states (European Commission, 2016). Despite the existence of many qualification frameworks on various levels and many supporting materials, determining competencies and learning outcomes, particularly if they include elements of

international mobility, remains a challenging intellectual task, as evidenced, e.g., by Grewe et al. (2008, p. 11).

As described earlier, the working team represented a new collaboration between five universities including two from Finland (HAMK and Lahti UAS), one from Scotland (Edinburgh Napier University), one from the Czech Republic (Charles University), and one from Portugal (University of Evora). Developing educational provision that would provide instruction to present and future managers active in the field of health or social services was developed from the analytic work reported below. The analysis was conducted in three stages:

Stage 1 – Focus groups with students

Series of local and international focus groups with postgraduate students who were also practitioners to identify key learning requirements.

Stage 2 – Curriculum comparison based on framework analysis

Application of an analysis framework adapted from the European Tuning Project.

Stage 3 – Identification of cross-sectional skills matrix

Identification of a cross-sectional skills matrix that would underpin the development of the learning outcomes for module development.

2.1 Focus Groups with the Students

It was important for the team to consider how the proposed programme might meet the needs of future employers and individuals seeking to gain or advance employment, but also for personal development and citizenship. According to Zahra, Newey, and Shaver (2011), students – particularly if they were already practitioners – could advise on sector trends and suggest where the curriculum needed to be developed. Therefore, in the early part of the development the team decided to 'map the situation' in health and social services through focus groups with students of management.

The purpose of the focus groups was to map the position of culture and quality management in social and healthcare (SH) services as experienced by management students in the Czech Republic, Finland and Portugal. The overall aims of the focus groups were: to explore the differences in the SH management students' perceptions between the ideal and realistic situations (values vs. practices) that characterize the SH sector; to determine the underlying ideals mirrored in the discrepancies in perceptions; and finally, to determine whether cultural differences emerge from the materials produced during focus group interviews.

The intercultural theories and contemporary principles of healthcare management formed the theoretical background of the research. The explored central phenomenon was conceptualised as the experience of the differences between ideal and real-world situations in the SH sector. Three mutually dependent analytical categories — management perceptions, environment for SH services, and country-level perceptions with 12 subcategories — were constructed from the interviews. The common underlying ideals mirrored in the perceptions have been deconstructed as the result of the cultures of business management and care, which influence the students' perceptions. This exploration has been valuable in defining an under-researched territory of cross-cultural management in healthcare. Specific variables and potential dynamics among them are identified, allowing for a more focused study of the participants. The focus groups allowed the individual institutions to elicit from their current students, in a very efficient way, deep opinions and perspectives on this specific topic (Masadeh, 2012).

Ethical approval was obtained from each university attended by the students. The students consented to participate in the group and, following explanation of the study's aims and their right to freely decide on participating in or withdraw-

ing from the study, the groups commenced. All the participants were assured anonymity and confidentiality. Individual universities involved in the project conducted the focus group in their national languages, after the translation and validation of the questions. The international focus group was conducted in English. All focus group sessions lasted for 1.5 hours and were audio and/or video-recorded. The subjects were requested to answer the questions based on their own experience in the workplace, so the participants had previous real-world experiences in social and healthcare practice. The transcripts of the national focus group testimonies were translated into English and provided to the team. The key questions identified for the focus groups were:

i. Do any similarities in the perceived difference between ideals and reality (I-R) exist among the students from Portugal, Finland and the Czech Republic?
ii. Do any experiential differences in I-R exist among the students from these countries?
iii. Are the similarities and differences related to the cultures in which the students live?

In this section of the project four focus groups were conducted: the first three were held in the Czech Republic (Charles University in Prague), Finland (Lahti UAS) and Portugal (University of Évora), with students from the respective universities enrolled in management courses. The last focus group in this section of the project was an international one, comprising two students from each university involved in the previous focus groups. Each group had from 3 to 10 students and the data were collected in 2013.

All the participants had completed a Bachelor's Degree in Social Care or Healthcare, were enrolled in second level courses at their home university and had working experience in the field. Some of them were employed as supervisors and others worked as nurses or social workers. The participant composition enabled the acquisition of various perspectives from social and healthcare organisations (direct level and management). A total of 29 students participated in the focus groups (Havrdová & Huotari, 2014). In these early focus groups, the discussions also related to questions concerning their understanding of the role of different actors in the health and social field, and their role in quality management. Examples of good practice in quality management fulfilling the ideals and values in the respective countries were also collected.

Data Analysis

The testimonies from the focus groups were coded. Clusters of similar testimonies were conceptualised; first- and second-order clusters were categorised. These clusters were then related to the original testimonies (triangulation was particularly necessary because four languages were used in the process) during team discussions. The similarities and differences within the categories were identified by the same procedure (a draft was discussed and then presented for approval in a triangulation process). Three substantial analytical categories – management perceptions, environment for SH services and country-level perceptions – were constructed. A more detailed account of the focus groups and outcomes is available in Havrdová & Huotari (2014) and Huotari, Havrdová (2016).

Several conclusions were drawn from the focus groups data analysis, which informed the future module content and development:

1) A common basis of values and ideals in management and quality of care exists in education among all three countries.
2) Quality management represents an important aspect of culture and values in social and healthcare and according to students should cross

professional and political boundaries and boundaries between professionals and clients by collaboration and communication.
3) Socio-cultural (country level) differences have an impact on attitudes and behaviour of employees and management students.
4) Inter-cultural reflection in groups supports the development of intercultural sensitivity of students, which can have an impact on management strategies and decision making.

2.2 Curriculum Comparison

At the start of the analytical process the working team requested copies of the master's curricular documents from each of the five institutions. It was anticipated that all the curricula would vary in their construction, implementation and style of education. In the event, the five universities proved to be sufficiently diverse in their infrastructures, approach to curriculum development, module delivery and regulatory frameworks, which enabled the working team to gain a clear understanding of the contextual factors that could assist them in their development of the set of three modules. However, it was also considered important to acknowledge that all five universities had designed curricula to meet the needs of their different health systems, situated within different social and political contexts and legislative frameworks. Consequently, the professional profiles, academic requirements and employment expectations of the graduates varied considerably. Therefore, the key challenge for the group was to develop three modules with core competencies and learning outcomes that would be both coherent in terms of the curriculum but also applicable across all the practice environments.

Theoreticians, such as Oliva (1997), perceive the evaluation of a curriculum as a complex process that typically assesses an entire curricular model. They suggest that this model consists of four basic components: curriculum goals, curriculum objectives, organisation and implementation of the curriculum, and evaluation of the curriculum. The team responsible for comparing curricula worked with the assumption that all degree programmes should be striving to achieve the same objectives, defined for the individual educational cycles of tertiary education by the Dublin Descriptors. Based on these descriptors, the Master's Degree should be awarded to students who:

- Have demonstrated knowledge and understanding that is founded upon and extends and/or enhances that which is typically associated with a bachelor's level. It provides a basis or opportunity for originality in developing and/or applying ideas, often within a research context;
- Can apply their knowledge, understanding and problem-solving abilities in new or unfamiliar environments within broader or multidisciplinary contexts related to their field of study;
- Have the ability to integrate knowledge and handle complexity and formulate judgements with incomplete or limited information to include, however, the reflection on social and ethical responsibilities linked to the application of their knowledge and judgements;
- Can communicate their conclusions, along with the knowledge and rationale underpinning these, to specialist and non-specialist audiences clearly and unambiguously;
- Have the learning skills to allow them to continue to study in a manner that may be largely self-directed or autonomous.

The team primarily focused on content analysis of the primary documentation, which in most cases consisted of documents specifying individual degree programmes including the module descriptors. This stage was complemented with online discussions with the team representatives from each of the individual

universities, with the aim to verify the relevance of obtained findings and gather any missing information.

The main factor that influenced the formal appearance of the documents analysed was that all of the universities came from the countries taking part in the Bologna Process. Therefore, the founders of the study programmes had to somehow consider the recommendations of the Framework of Qualifications for the Higher Education Area (EHEA Framework). Specifically, they had to consider the recommended educational outcomes for the second study cycle. Yet, from the results of the comparison, it is obvious that there were notable differences among the universities in relation to their health and social care programmes. Some can be observed just by comparing the general descriptions of the study programmes as shown in Table 1. For others, more in-depth analysis was needed.

A lot could be surmised just from reflecting on the titles of each programme. Consequently, the programmes were divided into two groups. The first one comprised those oriented purely on Health Administration, which was the case in UoE and ENU. The remaining three programmes were specialised in the management of social and healthcare organisations (CU, HAMK, Lahti UAS). CU students can choose either management or supervision specialisation.

Minimal entry requirements at all universities were similar, as only Bachelor Degree students can be enrolled for study. Moreover, CU students must successfully pass an entrance exam. Official country languages were in all cases also languages of instruction. Only at Lahti UAS was the programme also taught in English. This was a result of CU seeking permission in 2014 from the National Accreditation Commission to also teach their programme in English. Finally, studies, except those in UoE, last four semesters, or two years; furthermore, a different number of ECTS credits must be obtained to graduate. 60 ECTS credits must be collected in UoE, 90 in HAMK, Lahti UAS and ENU, and CU students must earn 120 ECTS credits.

Only three universities had defined their graduate profiles (CU, Lahti UAS and ENU). All curricula, however, contained the goals of study programmes, and CU also adds its programme mission. The study programme founders believe that its graduates must be able: "To function more effectively within the complex and rapidly evolving environments of health and social care" (ENU). Lahti UAS aims: "To provide students with the competence to work in expert, leadership and management roles in the social and health care sector." CU seeks for the graduates that they: "…will be well-oriented in European systems of social and health care and social policy. They must understand relationships between socio-economic factors and their consequences in management decisions and they must be capable of realising a complex analysis of social or health organisations. For CU, it is also important that its graduates are: "… well-oriented in the specific needs of physically disadvantaged groups, in their rights and in the ethics of social and health professions."

Common features were determined from the formulated graduate profiles (CU, Lahti UAS, ENU), mission statements (CU) and/or aims of the study programmes (UoE) of the curricula. In essence, all universities sought graduates who were well prepared to work in managerial positions (in the case of CU, they can be also supervisors) in social and/or health care. Additionally, graduates should have leadership skills, be active as experts at both national and international levels, be prepared to manage the provision of quality services in a rapidly changing and uncertain environment and manage social and health care services, by knowing the specifics of national and international health and social care systems. Finally, graduates must adopt managerial skills and, in managing organisations, must be able to use knowledge gained through social research, must be skilled in their ability to work as part of a multidisciplinary team, be able to undertake lifelong learning and act ethically while being responsible for health and/or social care providing organisations.

In addition to the above, some of the universities stressed specific requirements in their graduates' profiles and/or mission and statements of the goals of their study programmes. For CU, for instance, it was important that graduates understood and could react to the needs of disadvantaged groups, while ENU expects its graduates to perform well at an international level. UoE requested that their graduates got involved in processes that support social stability and social cohesion. Only two universities (Lahti UAS and ENU) defined their curricula learning outcomes in the format recommended by the EHEA Framework for the second study cycle. Lahti UAS presents the competencies described in the Finnish National Qualification Framework. ENU formulates its own learning outcomes on the platform of the Scottish National Qualification Framework.

None of the universities used the EHEA Framework descriptors while defining learning outcomes. However, two approaches to identifying learning outcomes were observed. While Lahti UAS chooses mainly general formulations, ENU is far more specific. Lahti UAS stresses the "use of knowledge as the basis for original thinking and/or research." Lahti UAS graduates should have knowledge appropriate for leadership and management in health and social care, as well as in other fields related to the subject of their studies. Gaining knowledge should be realised especially in management areas such as: strategic and operational administration, leadership, change management, human resource management, quality management and project management. Both universities emphasise the graduate's ability to apply their knowledge in real-life situations.

In the case of skills, identified as the learning outcomes of the study programme, Lahti UAS strives to ensure that its graduates are able to solve problems using research and innovative methods. Lahti UAS also considers it to be important that its graduates are able to work with knowledge derived from different fields and integrate it into proposed solutions of various managerial problems that the graduates will face at the workplace. ENU also strengthens the graduate's abilities to successfully face problems in the workplace. It strives to prepare graduates so that they are critical, creative, and also independent in their opinions. The graduates also have to be ready to undertake lifelong learning, and to learn from feedback. They must be good at time management, problem solving and teamwork, and should have highly developed presentation skills.

For Lahti UAS, it was important that its graduates acquired high competencies in another four fields: the graduates must be able to perform well either as independent experts or as entrepreneurs; they must have evaluation skills and be able to bear responsibility for the personal and professional development of other employees; they should be capable of lifelong learning, oral and written communication with different audiences, and finally, they should be able to act within the scene of international professionals, and therefore they must be able to communicate in at least one foreign language.

Table 1 below clearly demonstrates the different approaches in designing the structure of a study programme module in particular universities. UoE offered its students only compulsory modules, with no space for individual choice. The remaining universities combine compulsory with optional modules. CU added "compulsory optional" modules that all students of management specialisation must select. The specialisation in supervision has its own composition of compulsory optional modules. Besides UoE, students at all of the other universities must finish their studies by defending their thesis. Students at Lahti UAS, HAMK and ENU receive 30 ECTS credits for this, while CU students receive just 28 ECTS credits for their thesis defences.

The number of compulsory modules varies from university to university. While the ENU study programme consists of five compulsory modules with the conferral of 10 ECTS credits for each module, in the case of CU there are 13 modules, each with a different number of credits. The reason for such a high number of modules is that the Faculty makes use of practice or work-based modules, allowing the student to complete the module over two trimesters. HAMK offered

seven 5 ECTS-credited compulsory modules, Lahti UAS 10 and UoE 12. As for the composition of the modules, they can be divided into three main thematic groups. The first group can be called Management. Table 1 shows the compulsory modules that might be classified into this group.

	Czech Republic Charles University, Faculty of Humanities	Finland HAMK University of Applied Sciences	Finland Lahti University of Applied Sciences	Portugal University of Évora	Scotland Edinburgh Napier University
Compulsory	Human Resource Management 4	Dimensions of management 5	Management & Workplace Organisation 5	Strategic Management of Health Units 5	Leadership & Finance for Effective Service Delivery 10
	Supervision in Social & Health Care Organisations 5	Strategic Leadership & Economy in Social & Health Care Fields 5	Management Theory & Practice 5	Marketing & Communication in Healthcare Units 5	Behaviour & Management in Organisations 10
	Communication workshop 5	Human Resource Management in Social & Health Care 5	Strategic Management 5	Accounting & Finance of Healthcare Units 5	Contemporary Human Resource Management 10
	Law in Management Practice 2	Management in projects 5	HR & Competence Management 5	Health Information System Management 5	Clinical Governance & Improvement Practice 10
	Quality in Health & Social Care 4		Operational Quality & Performance Assessment 5	Logistics in Health 5	
				Health Organisation Quality Management 5	
				Organisational Behaviour & Human Resource Management 5	
Compulsory optional	Law in Management Practice 2				
	Practice in Management 5				
	Introduction to Financial Management 4				
	Management Theory and Practice 6				
	Financial Management and Business plan 6				

Table 1. Modules with Management Orientation

The orientation of thematic modules can be further categorised. The study programmes of all of the universities contain a module oriented toward gaining competencies in the area of Human Resource Management. Financial Management (CU, UoE, ENU), Quality Management (CU, Lahti UAS, UoE, ENU) and Strategic Management (CU, HAMK, Lahti UAS, UoE) are also frequently represented in the structures of these study programmes. Some modules can be found among the compulsory modules of just one university. CU's Law in Management Practice, HAMK's Management in Projects, Lahti UAS's Management and Workplace Organisation, and UoE's Marketing and Communication in Health Care Units belong to those modules.

The thematic group of the second compulsory modules can be called Social Research in Management. Table 2 presents the Social Research modules belonging to this group.

	Czech Republic Charles University, Faculty of Humanities	Finland HAMK University of Applied Sciences	Finland Lahti University of Applied Sciences	Portugal University of Évora	Scotland Edinburgh Napier University
Compulsory	Qualitative research in health & social organisations 6	Work-related Research & Development skills 5	Research-Based Development 5	Research Methods in Healthcare Services 5	Exploring Evidence to Improve Practice 10
	Quantitative Research Methods in Practice 3	Societal Change & Foresight Methods 5			
	Diagnosing Organisations 5				

Table 2. Social Research in Management Modules

As can be seen, all the universities except UoE focused on building competencies strengthening their graduates' abilities in the use of social research outcomes while managing social and/or health care organisations. The founders of the study programmes wanted the graduates to be able to meaningfully incorporate the outcomes of social research into their work and to understand both its limits and possibilities. In the case of credits conferred by these modules, Lahti UAS and UoE can be put on one side. Their students receive 5 ECTS credits after the accomplishment of all social research oriented compulsory modules. CU stands on the other side with 18 ECTS credits. In HAMK's case, the amount of credits obtained can vary based upon the choice of the student, from 5 to a maximum of 10 ECTS credits. Students at ENU receive 10 ECTS credits. CU asks its students to diagnose the management practices of one specific organisation in the second semester, and subsequently to implement an organisational change in the same organisation. Other universities do not impose a similar requirement on their students. They remain either at the level of an introduction of research methods (UoE), or describe the use of social research in organisational development.

Social and/or health care systems and policies is the last thematic category. It was clear that particular universities pay differing attention to the introduction and/or comparison of health and/or social care, which can be determined. While ENU considers this module optional, for other universities it is compulsory. The required competencies are built with the help of one (HAMK, UoE), two (Lahti UAS) or three modules (CU). The founders of the study programme believe that the graduates must be able to describe the systems of health and/or social care, and they must also be well informed about actual health and/or social care policies. CU wants its graduates to be able to compare adjustments and the performance of different health and social care systems. Taking into consideration the time consumption of the study, measured by the number of ECTS credits, then the fulfilment of all study obligations at HAMK and UoE awards 5 ECTS credits, at Lahti UAS and ENU awards 10 credits, and at CU 13 ECTS credits.

2.3 Identification of a Cross-Sectional Matrix

The third stage of work package 3 was to identify the core competencies evident across the five curricula documents. Here the group focused on the curricular module descriptors. Each module developed was based on a set of key competences to be developed by the learner in the framework of the master's programme. Competences can be described as dynamic combination of cognitive and metacognitive skills, demonstration of knowledge and understanding, interpersonal, intellectual and practical skills and ethical values. They are developed in all course units and assessed at different stages of a programme. Some competences are subject-area related (specific to a field of studies), while others are generic (common to any degree programme). The competence proceeds in an integrated and cyclical manner throughout the programme. The key programme competences should be the most important ones that the graduate will have achieved as a result of the specific programme.

All stakeholder groups, society, managers, employees and clients have their own roles and responsibilities in quality of care, but in this section the focus was on the competences required for a management position. The key competences according to the findings include a number of skills including general management and leadership, cooperation and communication, strategic management, competence to develop a service system as a whole, quality management, resource allocation, and human resource management including knowledge and competence management. Good management and leadership skills are also strongly emphasised in the data. Health and social-specific management education was seen as the basis of good and efficient management processes and good quality of care. All these competence areas ensure good quality of care and ideal care.

The competences are seen as a collective in that they are all needed in order to cover the aims of achieving good service quality. It was suggested that as managers forecast the future and create a vision and strategic goals for their organisation and future quality of care, they need to involve the employees in discussions about what is ideal care and what it takes to ensure the quality of care. In addition, with the involvement of employees, managers need to be able to hear clients' perceptions and experience on quality of care. They are responsible for creating and ensuring an efficient, continuous, and client-oriented service system and service chains and are often seen as the ones taking the initiative, innovating new quality strategies and implementing quality policies and projects in collaboration with other stakeholders.

An important role of management is resource allocation; this includes ensuring an adequate number of employees and finding the right people and competences for different service processes and tasks. As more different cultural backgrounds may create different views on ideal care and the quality of care, diversity management is a competence of crucial importance. The findings addressed the skills of critical thinking and reflective learning in relation to intercultural management issues. Managers need cooperation and communication skills in order to cross professional and organisational boundaries. Finally, it was suggested that managers need skills to ensure societal and political integrity and an incorruptible service system. Professional values, principles and culture are the basis of good quality of care, and a crucial part of management competences. The discrepancy among the values, principles, and practices model and the rhetoric and results model taught in schools of management and actual practice should be clearly addressed in education.

Tables 3, 4 and 5 below provide a detailed account of how the competences from across the five curricula were identified, assessed and incorporated into the three new shared master's modules. Each of the three tables is broken into three sections, which identify the modules (in green), the themes (in blue) that influenced the development of the module, and the key competencies (in black) that formed the basis of the module outcomes. Sixteen key themes were identified that

related to strategy, knowledge, human resources, performance and change management and these were distributed across the three modules, as described below.

Table 3. HR and Knowledge Management Competences

Module	Themes	Learning outcomes
		Student should be able to:
HR and Knowledge Management.	Human resource management	
		Recruit and select based on qualifications, competences, experience, and other determinants (values, match person-organisation, motivation, specific personal characteristics).
		Manage Human Resources focusing client needs as the main objective of health and social service organizations.
		Ensure the employees have a good attitude and communication skills, as well as adequate professional and personal competences.
		Create and promote a good psychological, mental, and emotional environment at work.
		Create conditions at work for a sustainable work-life balance among employees.
	Performance management	
		Assess individual and group level work performance on strategic terms.
		Assess individual and group level work performance on operational terms.
		Improve organisational performance.
		Improve individual and group level work performance.
		Distinguish performance from competence and understand the role of other variables underlying performance and manage them.
	Knowledge management	
		Understand and recognise tacit and explicit knowledge within an organisation.
		Manage organisational knowledge.
		Understand the role of information technology to support knowledge management within an organisation.
		Recognise and utilise knowledge external to own organisation.
		Combine knowledge from different fields to support own organisation's operational processes and improvement activities.
		Understand and manage the core role of people in knowledge management processes.
	Learning organisation	
		Systematically manage and develop organisational competences.
		Promote and implement strategic learning and renewal within an organisation.
		Promote and implement operational learning and renewal within an organisation.
		Have skills and abilities for life-long learning and continuous professional development.
	Leadership	
		Understand the role of leadership skills in the core of management processes.
		Have a critical understanding of the social, political and personal context of leadership.
		Motivate and encourage subordinates to fulfil an organisation's vision, mission and strategic objectives.
		Motivate and encourage subordinates to fulfil an organisation's operational objectives.

	Lead oneself to work independently in demanding expert roles.
	Promote the development of subordinates.
	Co-operate with other persons whether in leadership functions, in subordinate functions or superior functions.
	Represent others both internally and externally.
	Distinguish between management and leadership functions.
	Take positive sense-making as a core function of leadership.
	Assure ethical standards within the organization and promote systematic ethical development among employees.
Employee engagement	
	Engage other employees to work towards an organisation's strategic and operational objectives.
	Motivate and engage oneself to work towards an organisation's strategic and operational objectives.
	Observe and measure employee engagement within an organisation.
	Create and promote an engaged workplace.

Table 4. Quality Management and Assurance Competences

Module	Themes	Learning outcomes
		Student should be able to:
Quality Management and Assurance (including International Social and Health Care Systems)		
Quality management and assurance		
		Define and describe quality policies and projects in collaboration with political, management, employee and client stakeholders.
		Define good quality of care at an organisational level.
		Estimate the ethical and normative aspects of quality care.
		Select and apply relevant techniques in quality management and assurance.
		Plan, implement and assess the quality of implemented care.
		Define, describe, implement and assess care quality standards and criteria.
		Define, describe, implement and assess quality assurance and improvement processes.
		Create corrective actions and solutions for improvement in terms of quality deviations.
		Compare and evaluate different quality systems.
		Enable and empower staff members to manage risk.
International social and health care systems		
		Understand the structure of social and health care systems in European countries.
		Have in-depth knowledge of the social and healthcare sector and its role in the wider economy and society.
		Create and maintain a holistic understanding of the social and health care system.
		Ensure continuous, customer-oriented service chains and processes.
Strategic management		
		Build and utilise alternative scenarios for the organisation's future by applying suitable foresight methods.

	Contribute to creating a vision for an organisation.
	Commit to and engage in an organisation's mission, vision, values and strategic objectives.
	Plan strategically to guide and lead the organisation to meet its strategic objectives.
	Monitor and measure whether an organisation meets its strategic objectives and plan potential corrective measures.
	Evaluate to what extent the organizations is hitting its purposes (vision, mission, objectives and at same time complying with its principles and policies).
Resource allocation	
	Capable of allocating financial, human and other resources to enable good quality care.
	Act as an advocator of care in resource allocation between different service sectors.
Change management	
	Recognise a need for change within an organisation.
	Clarify the direction and smooth the process of change.
	Facilitate change within an organisation.
	Monitor organisational readiness for change.
	Distinguish between good and bad change and choose the good one.
	Manage and evaluate a change process.

Table 5. Intercultural Management Competencies

Module	Themes	Learning outcomes
		Student should be able to:
Intercultural Management	**Diversity and intercultural management**	
		Understand multiple cultural frameworks, values, and norms.
		Recognise and utilise various strengths within a diverse work place.
		Recognise and manage conflict between diverse groups.
		Negotiate in an integrative way, both internally and externally.
		Recognise and explain the common basis of values and moral expectations concerning human behaviour and attitudes in social and health care management in Europe
		Demonstrate understanding of current theories and comparative research results on intercultural dimensions in management.
		Demonstrate commitment and respect to difference in multicultural teamwork.
		Demonstrate good practice in knowledge management in a multicultural setting.
		Critically analyse the influence of socio-cultural dimensions on organisational culture and employee attitudes to leadership, rules or other aspects of HRM in social and health care.
	Client-oriented culture	
		Create a customer-oriented and holistic atmosphere in care.
		Map and reflect customers' service expectations.
		Recognise customers' needs and fulfil those needs.
		Ensure customer-oriented approach in care.

Culture of continuous improvement	
	Promote a culture of continuous improvement.
	Recognise needs and objectives for improving operational performance.
	Utilise alternative problem solving methods to suit a particular problem
	Plan, implement and follow-up continuous improvement activities
Culture of collaboration	
	Collaborate with employees in strategic management.
	Collaborate with employees in defining what is ideal and good care
	Collaborate with other people while crossing professional and organisational boundaries within care services and the social and health care sectors.
	Collaborate with other team members to provide quality care.
	Network and co-operate to promote meeting organisational and professional objectives.
Culture of open, clear and transparent communication	
	Communicate orally and in writing to both specialist and non-specialist audiences.
	Give correct information at a correct organizational level.
	Create and promote a culture of open, clear and transparent communication within an organisation.

2.4 Decision Concerning Educational Modules

As formulated above, the education process may be perceived as an operationalisation of the fulfilment of general educational objectives. This is most often achieved by cascading lower-level objectives, which then should contribute to the fulfilment of the general educational goal. The general educational goal of the participating universities was to ensure that future health and social care managers are equipped with the appropriate skills and competences to deliver efficient and effective services with high quality care. These were supposed to be based on lower-level objectives that included, as supposed already at the beginning of the project, the cultural and value-driven leadership, quality of care and quality management to effectively manage an integrated health and social care service.

The analytical work in mapping the situation and curriculum comparison brought data and findings that further supported and even better specified these lower-level objectives and helped to formulate competence and content goals. The formulation of content goals, as Pasch (1995, p. 50) stated, helps determine the scope and depth of education in a given subject. A crucial role in the process of defining content goals is played by the ability of the creators of curricula to utilise internal thematic links.

Based on all data and findings during mapping the situation in SH care, the educational needs and interests of students, and the comparison of management curricula in the five participating universities, the project management group went through an inductive process of deciding what content of the modules might be most efficient for achieving expected competence and also feasible within the available time and resources to achieve the educational objectives. At the end of this project it was intended that all created modules would be virtually available to the participating programmes and their students and contribute some added value to existing curricula. In the future it was intended that these

ready-to-use modules were to be taught in cooperation with the participating universities or as a separate module in each university.

The analysis of the curricula highlighted the importance of human resource management (HRM), which was evident in different form throughout all curricula. Each university had been involved in a previous Erasmus programme on HRM and there was already considerable experience with developing this topic. It was important to start with a topic that was common to all participating universities and was also crucial for all managers, so it was agreed this would be the first module designed. However, there was a need to ensure that the module addressed international as well as European issues, which was an added value to this topic in most compared curricula. Edinburgh Napier University felt best placed in terms of expertise to develop such a module. The resulting decision was that the first module would be on *Human Resource Management and Knowledge Management*.

Agreement on the second module had much to do with the focus group outcomes concerning the role of common values in management related to values in quality of direct care (Huotari, Havrdova, 2016). Quality management, as data has shown, represented a really important aspect of culture and values specifically in the social and health care fields, as was expected. The choice of *Quality Management* was also supported by the curriculum and competency analysis process. This highlighted that such an area was not addressed equally across all the curricula and for most universities it was added value to develop such an important educational module. The University of Evora was identified as the university with the highest degree of expertise in developing this topic so far and so became the lead for this second module.

The third topic, *Intercultural management*, was identified as a quite innovative topic of education, which emerged from the process and data from focus groups (Havrdová, Huotari, 2014), and was deeply related to the ideal of Europeanisation and internalisation. No participating university previously had such a specific educational module as part of its curricula. To support during education evolving intercultural sensitivity by future managers has been considered an important added value to the internationalisation of health and social care management education. As shown in the scientific literature about management generally (Hofstede, 2001, Schwartz, 2004 etc.) and during the focus groups in social and health care management specifically, the socio-cultural (country level) differences have an impact on attitudes and behaviour of employees and also management students. Inter-cultural reflection in groups supports the development of intercultural sensitivity of students, which can have an impact on management strategies and decision making, particularly as a part of HRM. This is related to sensitivity to organisational culture, which is an important issue in the contemporary education of managers. The need to extend this to international focus was clear and Charles University took on the lead role in developing this module.

Chapter 3 Process of Educational Module Design and Delivery

Manuel Agostinho, Janyne Afseth, Zuzana Havrdová

The outcome of the inductive decision-making process of the leading project management group (PMG) was the proposal to develop three modules, *Human Resource Management and Knowledge Management, Quality Management and Intercultural management,* each for 10 ECTS credits.

As a result of the theoretical and organisational framework and analytical phase of the project, four strategies informed the development and implementation of the modules:

1. Collaboration as a principle stemming from EU collaborative policy and receiving it's expression on all implementation levels (designing the modules, modes of learning, delivering the modules, evaluation process).
2. Building on the Bologna process masters level framework to assure appropriate academic level of outputs.
3. Development of value-based leadership of students through transformational learning in a cross-cultural setting and continual reflection of theory in practice.
4. Continual evaluation and feedback among teachers and students as a strategy to achieve a high quality programme.

In the first phase of designing the modules the collaborative strategy in particular was applied, as each module was led by one university, but members from all other universities participated in the discussions and development of the modules. The Bologna process masters level framework and related standards and guidelines informed the form and method of designing the modules.

Gehmlich (2005) suggested that a common structure should be prepared for all modules and that this should be reflected in a pro forma. A module pro forma and guidance notes were prepared and used for this project based on the Bologna process, ECTS User Guide and Tuning guidance, which details that the following information should be available. This includes the target group, ECTS level and any prerequisites; the learning outcomes of the module, the educational activities to meet the requirements of learning outcomes; types of assessments to meet the learning outcomes; and overall hours needed for the module (Gonzalez & Wagnaar, 2005). Some additional information based on the norms of the partners was also added, such as contact details for module teams and reading lists. The modules were jointly designed with a lead partner and then at least three partner institutions participated in the writing and preparing of readers, manuals and learning logs. Each module was hosted by one university but all modules were assessed by a common quality assurance process.

Within the design of the modules, principles of the student-centred learning were emphasised to help support the development of transformational learning and support the original theoretical underpinning of the development. The introduction of social and collaborative learning in a model of transformative learning can enhance the level of reflection through exposure to other norms and traditions of other professionals and cultures that challenge the beliefs and assumptions of both the teacher and the student. The motivation of students to take responsibility for their own learning leads to the development of value-based leadership of students. The cross-cultural setting and continual reflection of theory in practice strengthened their ability to develop intercultural sensitivity

and grasping of theoretical concepts in their meaning for practice. This was supported by continual evaluation and feedback among teachers and students.

While there were challenges around the exploration of differences in learning, teaching and delivery norms for each country, the agreed framework provided a platform for discussion and development of teaching and learning strategies across the three modules. Developing a joint approach to module development and approval ensured that the theoretical framework was represented as all partners had to review and adapt some of their teaching and learning practices to align with it. In the spirit of collaboration, each university took their turn at leading a module with the support of colleagues from the other universities. The agreement to adopt a universal module descriptor also ensured that there was consistency across the modules in terms of aims, objectives, learning, teaching and assessment strategies and references to appropriate literature. The use of the specially designed part of the online space Moodle/Reppu at Lahti UAS to frontload the module material also helped to provide consistency. Other considerations included active as opposed to passive didactic learning, a focus on a critical and analytical approach transferable to practice, increased emphasis on the autonomy and responsibility for the students to be active learners and incorporation of critical reflection to develop student learning as part of the overall transformational learning framework. Finally, assessment procedures were specifically designed towards application of theory to practice and the use of real practice issues.

It was agreed that for the pilot of the jointly developed modules the hosting university would issue the credits, which could be transferred based on the principles of credit mobility of ECTS for short-term study to other partners. There were differences, such as overall hours for 10 ECTS credits between the partners, but in acknowledgement of the Lisbon Recognition Framework, 1999, non-substantial differences in level, work load, quality, profile and learning outcomes should be considered flexibly.

One area that required further action was in relation to the fair treatment and transparency of grading structure for students, as this could have implications for jobs or further study. The partners undertook an agreement in advance of the equivalency of grades and transfer and credit of grades, which was shared with the students in line with ECTS guidance (see Table 6).

Table 6. The indicative equivalence of the grades between the five universities

ECTS Grade	Edinburgh Napier University Grade	Lahti UAS Grade	University of Evora Grade	HAMK Grade	Charles University Grade
A	D5–D4	5	A 18–20	5	1
A	D3–D1	4	A 18–20	4	1
B	P5	3	B – 17	3	2
B	P4	3	C – 15–16	3	2
C	P3	2	C – 15–16	2	2
D	P2	2	D – 12–14	2	3
E	P1	1	E – 10–11	1	3
FX	F1–F5 (F6)	Fail	F – 0–9	Fail	4

ECTS CREDITS
1 module = 10 ECTS credits.
1 module equates to 200 to 270 hours of student work within the CareMan modules

As previously mentioned there was a common quality assurance approval process in place (as well as the processes for the home university). In addition, specific monitoring and review of the modules based on feedback from the students, teachers and in the longer term prospective employers was planned in line with the European Association for Quality Assurance in Higher Education

(2009). In addition to that, some of the universities' routine external examination and external assessment of the pilot modules was integrated into the project.

The construction and delivery of the modules was supported by the shared expertise from both social care and health care and business and combined in order to identify and implement best practices. It had contributions from the five partner universities that developed them in co-operation. The best evidence and most up-to-date literature about the themes was used in each of the topics. In the pilot run of the joint modules it was decided to deliver one module each semester in the following order:

- Module 1, Human Resource and Knowledge Management, was delivered from April to June 2015 and Edinburgh Napier University (ENU) took the lead responsibility;
- Module 2, Quality Management and Assurance, from the 5th October to the 18th of December and was the responsibility of University of Évora (UoE);
- Module 3, Intercultural Management, was delivered from March 2016 to June 2016 and Charles University, Faculty of Humanities (CU) held the key responsibility for this module.

Each module will now be briefly described using a common structure of its purpose, process of its development, overall overview, content, assessment mode and how it was delivered.

3.1 Human Resources and Knowledge Management Module

Purpose

The purpose of this module was to develop the students' knowledge and understanding of the contribution of human resource management (HRM) and knowledge management within contemporary health and social care organisations and how these practices can facilitate organisational effectiveness and employee well-being.

Module Development

This module was the first to be delivered in the pilot and was built based on the previous experience of participating universities in a common ERASMUS programme. In addition, the scoping activities of the CareMan project identified key themes of HRM, performance management, knowledge management, learning organisation and leadership, with specific competencies within each.

Module Overview

This module gave an overview of the concepts and practices that underpin human resource management and knowledge management (HRKM) to help students build engagement with the dynamic and evolving nature of this topic area and its application to 21st century health and social care organisations. The emphasis of this module was to provide a critical reflection on research and approaches that underpin HRKM activities in contemporary organisations, to enable students to explore and evaluate their current practices and the debates surrounding them.

The module content, learning, teaching and assessment activities were formulated to allow students to:

- Critically explore contemporary research and debates in the fields of HRM and knowledge management and their application to leadership and management practice within health and social care organisations.
- Critically evaluate current organisational approaches and apply HRKM within health and/or social care organisations.
- Provide a management report on areas for improvement in the design, implementation and enhancement of HRM and knowledge management practices within a health or social care organisation.
- Propose strategies to implement strategic HRKM in social and health care management, which includes the critical evaluation of diversity management practices.

Content

Human resource management (HRM) within Western societies has evolved from its early roots in paternalistic welfare movements, through the psychological developments of the human relations movement, to become a focus of strategic importance within contemporary HRM (Chartered Institute of Personnel and Development, 2016). During the last few decades there has been increasing recognition by academics and practitioners that organisational goals such as competitive advantage, organisational effectiveness and sustainability are only achievable through the effective management of people (Dimitrios, 2012). Students were challenged to look at models of, and approaches to, HRM and in line with the theoretical framework, critically reflect on the impact of different approaches on the individual employees, as well as the organisation. For example, to evaluate a 'hard' approach that is very focused on business needs and an assumption that the staff will want the same thing vs. a soft approach such as the Harvard model, which involves more stakeholders and acknowledges a range of contextual factors – a pluralist perspective (Bratton & Gold, 2012). Softer forms have been explored with multiple approaches such as high commitment HRM, high involvement HRM and high performance work practices that are aligned to certain characteristics (Storey et al, 2010).

Organisations are increasingly recognising the value of knowledge-based human capital due to the increasingly complex problems of those organisations. There is a vital need to build on the knowledge and capabilities of the employees to sustain the most efficient and innovative workforce that is possible (Pemberton, Stonehouse, & Francis, 2002). This module guided students to consider "how" best HRM practices can influence performance and how knowledge management and organisational learning can positively impact organisational capability (Theriou & Chatzoglou, 2008).

The module content and approach recognised that managing people is a core competence for all professional staff and particularly those involved in service delivery within health and social care, with complexities of environment and conflicting agendas. In the delivery of this module there was the opportunity to explore this within a diverse cultural and multi-professional group to facilitate reflection on actions and learning to enhance development. Through both formative and summative assignments, as well as group interaction during the intensive week, students were given the opportunity to reflect upon their current competencies and practice and focus on areas of personal development.

Module Assessment

Formative assessment involved a number of interactive online activities such as identification of areas for development of competency in HRKM, asynchronistic discussions around 'hot' topics and informal assessment of knowledge of specific areas such as diversity management. The purpose of this was to engage the students in applying the knowledge of the module, but also to start to facilitate the peer interaction, which would help to challenge assumptions and consider new approaches to this subject in practice.

The formal assessments required each student to develop a learning portfolio that focused on reflection on a specific HRKM area from their work and/or the evidence base for this topic, including a reflection of their learning, feedback and HRKM competence. This was complemented by a group presentation on these topics that allowed the students to learn from each other in developing knowledge in this area. The second assessment was an in-depth essay to provide a critical analysis of an area of human resource and knowledge management that they have identified could be improved within a health or social care organisation of their choice. The use of practice-based assessments helped to facilitate a deep learning approach as students needed to research the theory and then look critically at this in relation to their practice.

Module Delivery

This module was successfully completed by 21 students, who were enrolled in home programmes with each of the partner universities represented. The module was taught in a blended format (online and face to face). During the module the online content was supported with asynchronistic discussion forums, learning content, self-guided reading activities and other interactive activities (such as self-assessments). The teaching methodologies during the intensive week included lectures, visits to health and social care organisations, group activities and peer presentations. The evaluation was positive, with the interaction with peers and academics from other cultures being identified as highly beneficial. This module had a great deal of self-directed learning activities and some of the students highlighted this as being quite onerous. In future modules additional support and guidance for students, particularly those with English as an additional language would be beneficial for the online content.

3.2 Quality Management Module

Purpose

The purpose of this Module was to enable registered health/social care practitioners to assume a clinical/professional leadership role in quality management in the health/social care sector. Most students were employed in this area, but in completing this module they will strengthen their effectiveness of management and in improving quality in health/social care services.

Module Development

This module was the second module delivered and was based on previous work that confirmed its importance and defined key competences for it. The team built this module descriptor and undertook the responsibility to deliver it through an intended structure that facilitated the students' improvement of their quality management competencies, allowing better practice after the course.

Module Overview

This Module provided a synthesis of the concepts and practices applied in quality management, so the students could understand the main steps, practices and tools applied in the field. This area is one that all professionals working in management at any level of health and social care organisations must master in terms of critically understanding or doing or participating in its management at any level. The module aimed to enable students to explore and evaluate the current practices and the debates surrounding them. They must be able to understand the research approaches already in use, but also that research is needed to develop new knowledge and to improve practices.

The module content, learning, teaching and assessment activities were formulated to allow students to:

- Critically appraise good quality of care at an organizational level;
- Critically reflect on care quality standards and criteria;
- Justify relevant techniques to plan quality assurance and improvement of processes;
- Engage in critical dialogue that demonstrates a holistic understanding of the social and health care system to develop continuous, customer--oriented services;
- Recommend strategies for implementing quality improvement within a health care or social care organisation.

The module was divided into three topics, which had to be completed in a 15-week timescale. This allowed five weeks for each topic. This was delivered in an e-learning environment using the Moodle platform and other tools such as introductory lectures, videos and texts to support the introduction to the module as whole and to each of the topics.

To develop depth in the module with respect to the three topics defined, we planned activities to fulfil and to ensure that the reading material was understood. Each of the topics has at least four activities to allow the teacher follow and support students' evolution and needs. This was not an assessment, but a strategy to engage the students in the content of the module.

Content

Quality in health and social care services is a long-standing issue that is evident within the industrial environment, where it is widely used, and is gaining a prominent place within the health and social care system. So quality of health and social care share with industrial production and services management concerns, organisation purpose and overall objectives. This specifically comes from the fact that "Patients play four roles in health care systems that must be reflected when defining and measuring quality in these settings: patient as supplier, patient as product, patient as participant, and patient as recipient" (Lengnick-Hall, 1995, p. 25). This can equally be applied to social services and the interactive nature of responses used by care providers; and the context of professional group actions in which it is part of the system (Revez & Silva, 2010).

The topics developed here were the same as other areas but applied to health and social care reality: Quality management and policies in social and health care; Quality assurance in social and health care; and Continuous quality improvement in social and health care.

Assessment

The formal assessments employed a learning portfolio that consisted of three reflections related to the three topics of the module. The portfolio was based on learning material and the students' own experience and reflections on quality

management and quality of care in social and/or health care organisations. The second assessment was a Case Study where the student used their organisation or an organisation they were familiar with to develop a case study analysis (drawing on relevant academic theory). The use of practice-based material for assessment facilitates a deep learning method to apply the theory and then look critically at the reality of their practice.

Module Delivery

This module had 16 students enrolled, but only nine students completed it with success. The teaching methodologies, content and evaluation process were considered very good. The material produced for the module was very good for most of the students but we must have more regular support and motivating activities. The module in the future would benefit from having more interactive activities and interactive material, to facilitate the exchange of ideas and to engage the students.

3.3 Intercultural Management Module

Purpose

The purpose of this module was to develop the students' knowledge, understanding and sensitivity to intercultural management issues within contemporary health and social care organisations. This should enable students to assume a culturally sensitive leadership role in the health/social care sector within a culturally diverse environment in Europe.

Development

Intercultural theories of Hofstede (2001) and Schwartz (2004) and contemporary principles of health care management (World Health Organisation, 2011) formed the theoretical background of a research study in the scoping phase of CareMan. This study acknowledged the effect of cultural values and background on a student's perception of managerial behaviour and actions in the social and health care sector (Havrdova, Huotari, 2014). The theory and findings of this research and the first-hand experience from intercultural collaboration during the CareMan project supported the development of content and learning methods in this module. Under the responsibility of Charles University, Faculty of Humanities, a module team comprising four members from the partner universities was established and through email and Skype communication a module descriptor and learning materials and methods were developed.

Module Overview

The module is designed to provide students with underpinning knowledge, understanding and debates surrounding contemporary issues and practices in the area of intercultural management. The module will be organised into core units that will enable students to critically analyse each topic area and reflect upon practice, including that of organisations within the health and social care sphere. Students will be encouraged to contribute to online discussions and share knowledge through scheduled tutor-led discussions at key points. The implementation will focus on three areas:

- Part 1: Theoretical knowledge of Intercultural Management;
- Part 2: Intercultural Dimensions in Social and Health Care Management;
- Part 3: Intercultural Management in Practice in Social and Health Care Organisations

Module Delivery

The module was delivered over 13 weeks in the spring of 2016. It consisted of three periods. The first period was dedicated to the core unit 1 and had a distant learning format. Participants were guided by instructions to complete eight tasks in a learning logbook, which was placed in Moodle. A forum space in Moodle was provided where students could share their perspectives. As a result, each student prepared a short presentation of their own learning outcomes that was presented in the second phase of the module.

The second period of the module consisted of an intensive week in Prague. This week was composed of theoretical presentations and group learning activities on core units 2 and 3. These activities enabled students to apply their knowledge and to gain sensitivity to intercultural issues to their organisations and management tasks and to their individual assignments. The work on individual assignments formed the third learning period of the module.

Assessment

The formal assessments involved a learning logbook assessment with prescribed tasks fulfilled and an essay, which consisted of a theoretical and practical analysis of a Case Study. In the Case Study students used their organisation or an organisation they were familiar with to develop an analysis of intercultural issues. Clear criteria for assessment were part of the learning logbook.

Chapter 4 Evaluation

Gerri Matthews-Smith, Janyne Afseth

Evaluation of the project was conducted on both an internal and external basis. In this chapter we focus on the internal evaluation process which was conducted in two phases. Phase 1 was an evaluation of the three modules and phase two a self-evaluation of the project management group. Here we describe the nature of the study and address methodological features including the theoretical underpinning, longitudinal nature of the study (continual feedback strategy), the data collection and analysis techniques employed, including the process of researcher–led and collaborative review of the transcripts. At the end of this chapter an account of the project management group's own evaluation is provided.

Ghedin and Aquario (2008) advocate a multidimensional approach to evaluation of teaching in higher education due to the multifaceted and complexity of this process with detailed input from teaching staff and students essential in this process. Traditionally modules are evaluated by survey data to provide a mechanism for quality improvement and this approach was undertaken this with project with surveys for all the teaching staff and students on each of the modules. However, as this was the first joint module within the EU development of this project we felt that this would not capture the complexity of the issues and learning to allow a continuous development process.

Given the strategy of collaboration on all implementation levels of the project (see chapter 3), the same strategy continued into the evaluation. Collaborative inquiry sits in the evolving paradigm of human inquiry that values adult education, participation, democracy and transformative learning; characteristics that are essential for meaningful systematic inquiry into dilemmas, questions and problems that are part of human experience (Bray, Lee, Smith & Yorks, 2000). The approach is underpinned by the combination of critical theory and the concept of life-world (Habermas, 1979); the action orientated approach to learning from experience (Mezirow, 1991) and humanistic psychology of person-centered practice (Rogers, 1967). It arises from the work of Heron (1996) who claims that certain aspects of human experience cannot be understood from conducting experiments and collecting data from other people. Rather, collaborative inquiry is an innovative and holistic way to improve practice and develop new knowledge by building a community and exploring human experience. The process draws on the practical use of language used in a shared experiential context (Guba & Lincoln 2005) and develops living knowledge that is useful to the participants in their everyday working lives.

Whilst the internal evaluation used collaboration as a method, in analysing both phases of the data generated in the internal evaluation, the team were cognisant of the key objectives of the project and explored if there was evidence that the EU policy of cooperation was implemented and if so how this was achieved. It was also concerned with identifying the impact of collaborative educational provision and the benefits of collaboration in learning. In both stages of the analysis we considered how far the programme of education had contributed to cultural and value driven leadership development of the participants. Consequently, some recommendations may be made from the outcomes for future intercultural management programmes.

A longitudinal approach was applied to the internal evaluation process. In phase 1 data collection took the form of focus group discussions, employing a number of practical components from open space technique, module evalu-

ation questionnaires and testimonials from managers of the participants were sought to determine any changes in practice following the module delivery. Key questions relating to the overall experience of learning on the modules formed the basis of the discussions with both students and staff. Teacher experience of being part of the process was also explored particularly in relation to the blended learning nature of the programme and delivery in English. In phase two a single focus was conducted with the project management team, which explored if there was evidence that the EU policy of cooperation was implemented and if so how this was achieved. Both stages of data collection were concerned with identifying the impact of collaborative educational provision and the benefits of collaboration in learning.

Ethical Approval

Securing formal ethical and management approval is an integral component in any research study. The governance mechanisms for us involved a number of applications to the Edinburgh Napier University Ethics and Governance Committee at different stages throughout the development and evaluation of the modules. Ethical approval was granted at each point.

Phase 1 Overall Aim of the Internal Module Evaluation:

To evaluate three collaborative pilot masters' modules in health and social care management delivered in partnership across four European countries.

Internal Module Evaluation Research Questions

1. What are the key challenges for students and teachers undertaking a collaborative, cross-cultural module in health and social care management?
2. How does the delivery of the curriculum in English impact on the learning experience of a multi linguistic audience?
3. How can the on line learning environment be constructed to enhance social learning among students and staff?
4. What are the benefits of collaborative inter-professional education in the context of European education in health and social care management?

For the purpose of this part of the evaluation the process began with significant questions about the quality of experience of the learning journey throughout the programme from the perspectives of both the students and staff involved in a collaborative cross-cultural development and evaluation process. Participation and action makes research contextual and through interaction between the researcher and the researched there is a development of mutual knowledge (Swantz, 2008). This process of self–inquiry and learning engages participants in creative development and raises critical consciousness enabling the group to develop the confidence and capability to find answers to questions and to discover living knowledge or theory that is useful to them (Lykes & Mallona, 2008). The new knowledge is created individually and collectively and tested against the critiques of others in the team. The social purpose of this approach is to develop understanding of the lived experience of both students and teaching staff on the programme as well as the actions, developments and learning that take place in the process. The process of collaboration and involvement of key stakeholders along with the facilitation of reflection and learning in action

can transform attitudes and behaviours and enhance experience (Bray, Lee, Smith & Yorks, 2000).

Process of Conducting the Focus Groups with Students

At the end of face-to-face delivery of the first and third modules students and staff were asked to participate in a focus group. Seven students agreed to be a part of the first group. The diversity of background and culture in both groups was evident with students coming from Ghana, Kenya, Finland, Portugal, UK, the Czech Republic and the USA. This very diverse group gave some insight into the ways in which the students were interacting with the material on the module, cultural differences and how they might apply the knowledge in practice. In the second module three students provided comprehensive online feedback. The participants were limited (n=3). The final focus group was conducted following the third module and 16 students participated in the discussion group and a further five students completed a comprehensive questionnaire.

Once another explanation of the remit of the group was provided and consent forms were signed the groups commenced. Following introductions, the first of the four questions was put to each group. In the face-to-face focus groups (n=2) each member took time to think about the key areas of their answer and when ready wrote the result on a notelet and placed it on the noticeboard. The convenor then collected the notelets and used the points made as the basis for discussion. It was not possible to use this technique in the on-line feedback (n=1).

In each group session the discussion covered four key areas and students were facilitated to share their views on: The experience of learning/teaching on the module; Working with students/staff from other countries/cultures; Delivery in English the module content, module delivery and finally, what were the biggest challenges, best bits, what could be done better. The focus groups lasted about one hour and were recorded and transcribed for analysis. The second module feedback was conducted virtually, limited in size and feedback was minimal. The third and final focus group for module 3 had a very good response and those who could not attend provided additional questionnaires.

Process of Conducting the Focus Groups with Teachers

The focus groups with the teachers took the same format as those described above with the students. The agenda questions were also the same in order to be able to compare the perceptions of both groups. The first focus group with the teachers lasted about two hours and all discussion was tape recorded and later transcribed for analysis. Unlike the student response in module two the teacher focus group (conducted on WebEx) was attended by all the teachers involved in delivery of the module and the discussion was open, insightful and aspirational. The third and final focus group took place with seven members of the teaching team and representation from all the collaborating universities.

In a longitudinal study there is by definition a narrative component to the analysis. Green & Thorogood (2009) highlight that for most qualitative research studies the aims are to reflect the complexity of the phenomena studies and present the underlying structures that make sense of that complexity. As such, the role of the researcher is twofold, to tell the story but also unpack the story in such a way that the broader meaning can be extracted.

One of the most commonly used methods of analysing qualitative data is thematic analysis. Howitt & Cramer (2008) emphasise the importance of becoming immersed in the data through careful reading and re-reading of the transcripts. They suggest that theme development normally involves a set of steps: immersion in the data by repeatedly reading the transcripts; generating

tentative themes; and finally applying and developing the themes. Analysis of the data included both research-led and collaborative review of the transcripts and took place in two stages. In stage one the core researchers used an inductive approach to identify groupings and refine themes from the raw data. Once the main themes were identified the raw data and suggested themes were shared with two other members of the team to ensure that the themes suggested were agreed.

Phase 2 Process of Conducting the Self-Evaluation of the Project Management Group

In addition to the formal evaluation of each module, the Project Management Group (PMG) for CareMan also undertook a self-evaluation in relation to the overall management of the project to produce the three joint modules. In this phase of the evaluation the questions also looked for evidence of how the EU policy of collaboration had been implemented and achieved and the benefits of collaborative cross-cultural inter-professional education in the context of European education in health and social care management.

The PMG produced a quality assurance protocol to help ensure quality standards were adhered to throughout all stages of the project and this included a self-evaluation process, which was completed at the end. This was guided by a number of European guidance documents which included *Practical guidelines for joint programmes on the consortium agreement* (European Consortium for Accreditation, 2014), *EMQA – Erasmus Mundus quality assessment 2012; Handbook of Excellence – Master Programmes* (Erasmus Mundus, 2012) and *Standards and Guidelines from European Association for Quality Assurance in Higher Education* (European Association for Quality Assurance in Higher Education, 2005). Although some of this guidance was specific to joint degrees, many of the principles were relevant to projects that focused on joint modules.

Process

The PMG had agreed the use of a checklist from the Erasmus Mundus Quality Assessment which provided guidance and rating to assess various aspects of course preparation, delivery and evaluation which had a four-point rating scale (with a rating of 4 representing the most comprehensive actions) (Erasmus Mundus, 2012). This provided a reflective framework for that aspect, which the PMG used to help guide the self-evaluation. As the project was initially focused on a full joint degree, rather than joint modules, which was the eventual outcome, some were not relevant or fully completed due to this variance. The PMG members completed this during the final conference with discussion undertaken on each point until consensus was agreed. A description of the reflective self-evaluation is in the following paragraphs and is structured around themes of evaluation.

Outcomes of Stage 1 Student Focus Groups for Modules Benefits of Cross-Cultural Learning Experience

In the main the experience of doing the module was well evaluated with students benefiting from the interaction with students from other geographical areas. It was interesting to see how the groups formed and it was refreshing to see students from across the participating universities work and socialise together throughout the intensive weeks. While students acknowledged the culturally

diversity within their groups they were also able to identify with a number of the shared challenges that they face in their day-to day working life. For most this was considered a really good learning environment in terms of gaining from the experience of others on how they had overcome the challenges.

> *Actually listening to other people who are working in a similar area is a good learning experience for me. I always like to compare the differences and similarities between states. I got a sense from the group that it was very diverse even though we were all from universities, we had many nationalities, cultures and personalities –and with all of that it was impossible not to learn, not to take good experience from it and to create new output. (Focus group 1.)*

> *One of the most valuable elements I took from this experience was that we all shared similar problems and we worked as a group to try and find solutions to them. I think that even if we are from another culture or country we all have the same problems and we can help each other deal with it and solve the problem. We are dealing with the same issues, which is why I think we can help each other to deal with them. (Focus group 1).*

> *This was a challenging but good learning experience, in this type of situation you learn to tolerate different kinds of people and managing under pressure. I learned a lot about different cultures, how to be flexible, it helped a lot to understand the dilemma of management and the issues appear the same despite the country being reported. (Focus group 3).*

Through the discussions it became evident that the students had developed their ability to use a set of group skills to critically reflect on similar practice issues and together share new techniques that had proved to be useful elsewhere. The comment on reflection below, also demonstrate the development of transformational skills within the group, which supports the theoretical underpinning of the development. The students were able to recognise the similarity of the challenges in their areas of work despite the cultural and geographical differences. The realisation that the problems that they faced were universal increased their confidence in shared problem solving. There was also a sense of relief about being able to open up about real problems. Below is evidence of how this type of communication later became a part of the reflective process for some of the students.

> *It's what I wrote in my critical reflection. It was kind of learning from each other. I had to check my point of view again and think can I learn something and do it better. We all had opportunities to speak out our views related to different topics the teachers promoted and environment that enabled us to share our problems I believe this is one of the critical factors that makes this work. (Focus group 1).*

> *In general, we all feel comfortable talking in front of each other. That's not a thing that is common in everyday lessons and classes so I think it was really great for that. There was a sense of being anonymous when there are so many different universities and cultures. It was actually a relief to be so open and honest about issues without having fear of reprisal. The learning environment was very warm and people were very happy. (Focus group 3).*

Challenges of Doing the Module

The student diversity in terms of situated learning, practical experience, problem solving skills and experience of on line learning all needs to be considered and

supported in any educational provision for such groups. There were four key areas where the students felt challenged in terms of their ability to complete the module. These were navigating the REPPU online learning environment, reading and writing in English, specifically on REPPU; making use of the presentation material, the oral presentation to their peers and finally, the assessment. Students found some of the articles were hard to comprehend. They expressed their concern that they would be assessed on their ability to use the English language perfectly rather than understand the content of the module. Some students found they needed to print the material and write on it to help to make sense of its content. For module 2 which was conducted completely on line, the challenge of writing in English was substantial and as can be seen below many of the students had to print out the material to be able to interact with it at the level required.

REPPU the Virtual Learning Environment

One of the key areas that emerged was the importance of preparation and early access to the virtual learning environment to help students make sense of, expectations of the module and the some of the materials with which they were expected to interact. As the module was delivered in English and the virtual environment was also presented in English there were some challenges for the students to overcome. The development of a clear roadmap with obvious signposting to module information, expectations, learning materials and assessment is key to early interaction from any student group. The students on the first and third modules had access to the virtual learning environment a few weeks before the intensive programme. For students on module 2 this was the main mode of communication with both teachers and peers. There was information on REPPU in relation to the content, expectations and assessment of the module but there was variability in understanding and ability to access. We were interested in understanding how the students had prepared for the module and how they had navigated the online REPPU system. The quotes below illustrate some of the students concerns in terms of preparation. For local students the REPPU system and instructions was familiar, but even they recognised that the system was hard to use in the beginning while other students commented on the difficulties in navigating the REPPU system.

> *I have used REPPU and for me it was very clear that there was these assignments and articles to be addressed. But if you have not used REPPU before it's hard to find the information. It took me four years to understand REPPU. (Focus group 1).*

> *I think it was confusing when it comes to assignments. I was not sure which ones were to be done before [coming to the intensive week] and which to be completed after – I didn't know if it was compulsory or not. (Questionnaire group 2).*

However, whilst recognising some of the difficulties and reporting on the confusion and frustration it caused the students also presented a number of useful suggestions as to how the on line material could be improved to ease passage through for future student groups.

> *Maybe some kind of summary at the beginning of REPPU should be addressed on the main page so we have the topics and assessments before and the articles are linked by their numbers. (Focus group 1).*

It might be better next time to provide an instruction in REPPU for example that we need to prepare something like that or that it is expected of us that we have this kind of presentation. (Questionnaire group 2).

Clearer instructions in one place, and a list of what to do and when. All the articles for reading should be in one folder. Maybe if articles were in one folder with numbers relating to the sessions and how the articles related to the assessment. (Focus group 3).

Working in English

All module material, including all preparatory material, learning materials material employed on the module and on REPPU were delivered in English. For a student group with a majority using English as a second or third language this was a tough challenge. The students reported a number of anxieties in relation to how they would be assessed on their use of English grammar and potential errors made during presentations. This was particularly the case when English had to be presented in a written format and was presented as a rationale by the groups as to why they found writing on the discussion boards particularly challenging.

It's easy to speak but to write it on paper is much harder for us because English is not our first language. We were concerned that if we wrote it on the discussion board it was there for all to see including the mistakes we had made. Maybe some reassurance at the beginning of the course that this is not a language course so you will not be expecting perfect English. (Questionnaire group 2)

I think REPPU is easy to use but when I am reading an article I still print it out and scribble all over it – no I can't read articles online. (Focus group 1).

The most stressful part was the presentation but it was also a good experience because I think about what I can do better next time, how I can change my performance and so yes stressful. But a great experience! (Focus group 3).

Students also reflected on how they made sense of the module material. Apart from the need to print article out on paper in order to interact with them, they used techniques like highlighting and writing notes to make sense of the material. Others reported using Google translate as a support prior to putting up posts on REPPU. Students were also clear that they had preferences in terms of the way they learned. Preparation was essential because there was also issues with having to travel to attend the intensive week. Students had some concerns for other students who were doing the module fully on line and did not have the chance to attend the intensive week.

I print the article, then when I am reading it I highlight the bits that are important for me, but I think I learned more from working with colleagues from other countries and in the discussion groups because you can see that we need to know the same things, so we talk about what the articles were saying and then think about how we might use the information in our workplace. (Focus group 3).

First I wrote my information for the discussion board then I put it into Google translate to check my English (Focus group1).

Lecture Format and Presentations

Throughout the intensive weeks in module 1 and 3 a number of different teaching and learning strategies were employed by the team to try and address all learning styles. For most of the students they were happy with the different presentation styles. However, there were key aspects to the presentations that students noted as being really useful. In our section on practice we acknowledge the role of practitioners and the value they offered to the groups, however structure and timing of input was also acknowledged, as was the ability to present the material in a clear and audible format. Students also enjoyed sessions where the presenters were enthusiastic about their subject area. The comments from module 2 relate only to the on line content of the material

> *The input was very good. I liked some of the sessions where the teacher was really enthusiastic about her subject. It was not too demanding because the Monday we attended the conference and on Wednesday we had visits to practice areas. It might have been very different if we had been in classes all week! I liked the way the teaching sessions were organised, we did not do any one activity in a class the activity was always mixed so we were not just sitting listening all the time. (Focus group 3).*

> *The classes were a challenge but mostly in a good way. We had to listen for a while but then we did group work as well, so there was no time to get bored. It was hard sometimes to understand some of the teachers. I liked the structure to most of the sessions. It was a relaxed atmosphere and positive support and we stayed on schedule. (Focus group 1).*

Preparing for and Doing the Presentations

Module 1 and 3 required the students to work together in small groups (3–4 students per group) on a specific project over the intensive week and to present the project on a face-to-face basis to their peers on the last day of the week. This particular task was part of the assessment process and the students were awarded marks towards their final grade as an outcome. In module 1 the groups were formed on day one of the module whereas in module 3 in response to feedback students were already designated to a specific group and had introduced themselves on line prior to the intensive week. A large number of the students commented on the improvement in their use of English and management terminology as an outcome of the group work.

> *It was hard and challenging to prepare for a presentation with people you had only met a few days earlier. But this was also good because we discussed our culture and we learned about other cultures. I also think this helped me to improve my use of English*. (Focus group 1)

> *At first the preparation for the group presentations was quite challenging but I had spoken to my group on line so I felt I knew them a little bit. During the week the words were easier to find in my head. I learned a lot of management terminology and I think this will help me with my final assessment* (Focus group 3).

It was important that the presentations were acknowledged by the staff and a structured feedback session was provided after the final presentation. The student really appreciated the feedback given by the teaching group and saw this as a good learning experience. A full feedback was provided to the student groups

on their presentation by a panel of teachers from the participating universities. Students appreciated the feedback and valued the learning which came from it.

I liked the way we were given a report on how we had presented our group work. The comments were useful and helped me to think about how I might do some things differently in the future. (Focus group 1).

It was good to have a feedback session after we did our presentations. I was a little worried about what would be said but the comments were fair and we get marks towards our final assessment so that ok. (Focus group 3).

Preparing for the Final Assessment

In preparation for the final assessment the students were given opportunities in the modules to work together on a group presentation which was similar in nature to the final assessment. The rationale was that this activity would not only add some credits towards their final overall assessment grade it would also help them to develop techniques to address the task on an individual basis. However, despite this input and support students still expressed some concerns about the final assessment and how they might approach it. Reassurance about the support that was available on REPPU was not evident in module 1. Later in the delivery of modules 2 and 3 the students appeared more confident in the approach required. The teaching team also ensured that there was a discussion group formed on the REPPU where students could compare what they were doing together or seek further advice and reassurance from the teaching team.

I am still a bit anxious about doing the final assessment. I know we did some work in the week but when I go home I will be on my own and I am concerned I won't get it right (Focus group 1).

I like the fact that we have a discussion group on REPPU where we can put up information on our case study and get feedback from other students and staff on the module. I am still concerned that it will be a lot of work but at least I know I can get help if I need it. (Focus group 3).

Practical Application of New Knowledge – a Common Professional Interest Across Cultures

Despite the cultural diversity, the similar professional background meant that it was possible to share common problems to be solved. Through the discussions it became evident that the students had developed their ability to use a set of group skills to critically reflect on similar practice issues and together share new techniques that had proved to be useful elsewhere. Learning from the practice environment was acknowledged by the student groups and they really enjoyed sessions where the individual was working in a specific area and was able to discuss with them how what they were doing in their academic module was applied in working environments were particularly welcome. In fact, as is evident in one of the quotes below some requested more of this type of input in future modules.

Because he was like hitting the nail on the head, trying to show how this or whatever we are doing in the academic part of it is applied to working. To the kinds of challenges we might have in the fields. So I wish we had more of those kind of professionals. (Focus group 1).

I would have liked to have people with more practical knowledge to come and speak to us – they should be working in human resources. (Focus group 3).

Study Visit

In modules 1 and 3 during the intensive weeks, a number of health and social care practice placement visits were planned for the groups. There were mixed views in terms of the value of the visits. For some of the groups this was to do with the areas visited and they felt the personal contact with the place was very enriching. For others it was the time issue and they expressed need to use the time more efficiently.

The visits were not always useful I don't think I learned much from them to apply to my own practice. (Focus group 1).

Maybe we could be more efficient in terms of time, when we go out to the placements it takes a morning or afternoon of our time, having speakers come in and if they can use a video to show their place of work that would help us to understand and to use less time. (Focus group 3).

Key Challenges

There were mixed views in terms of what the most stressful components of the module were. We have already reported on the on line REPPU system which was perceived as a challenge at the start of the modules because it was considered to be difficult to navigate or access. However, throughout the modules the views on REPPU improved as the teaching group's implemented changed recommended by the student groups. A second key challenge was the presentations and working in groups with different nationalities. However, for many this was a challenge they overcame and once the presentation was completed they reported this a key learning area. Lack of time was also identified, despite the intensive week the students felt they could do with more time to make sense of all the learning material and complete the assignments. Finally, a constant challenge raised by the students was their perceived lack of time

At first the presentation was a major challenge and I did not want to do it. Presentations are not my thing and having to present in English made it even more difficult. However, once I did it I realised that I could do it and my use of the English improved greatly. (Focus group 1).

I think the biggest challenge was time, time to read, time to understand, time to do the assessment and time to enjoy the country we are in. (Focus group 3).

The Best Parts of the Learning Experience – Benefits of Intercultural Social Interactions

Module 1 and 3 had an intensive week built in and students had the opportunity to meet face-to-face. In the delivery of the first module the format of the intensive programme was such that most of the first day was spent on introductions and ice breaking activities. Some of the students commented on the fact that this was too much time spent on this, however for others the social aspect led to the development of more permanent friendships and working links. This may have influenced the level of social learning that occurred. In the final module the students developed a Facebook page and uploaded all information on social activities to

ensure all were informed and free to participate. The final question posed to the student groups was to identify where the module team had got it right and what parts of the module they enjoyed the most. There were a variety of responses to this including learning new theory and how they might apply it, learning about different cultures, visiting different cities, working in groups and getting to know new people. Well-organised module delivery was already acknowledged as a good thing.

> *It was great meeting students from other countries, the introductions helped us to get to know each other better. We learned so much not just in the classroom but also in social activities outside. I liked it a lot, it was a wonderful experience and I made some new friends and people I can contact to discuss work issues in the future. (Focus group 1).*

> *I think there were a number of really good bits in the module. I liked meeting people from other countries and talking to them about their practice areas. Some of the seminars and visits were really useful. Learning new theory and then applying it to real life situations was great for me. On a personal level I loved seeing the cities and the accommodation was great. (Focus group 3).*

For students on module 2 there was a real sense of not feeling part of the module or a group. Some explained this was because they never really felt they got to know each other and the outcome of this was reflected in the amount of group activity completed. The challenge of having discussions on line limited interactions and for some of the student group was a frustration particularly when others did not engage and they were not able to initiate the type of discussion they wanted to support their learning.

> *I was upset because not all the students made the effort to use the discussion boards, so sometime it was only me and a few others who made comments on what was going on. I missed not seeing the other students. (Questionnaire group 2).*

> *There was no discussion or feedback from the other students so I was not really able to learn from their experiences. (Questionnaire group 2).*

Summary of Student Evaluations

Overall there was more positive than negative feedback from the students across the three modules. However, there are some key learning points that should be considered in terms of future delivery of the modules. The intensive weeks were an essential component to developing the intercultural learning processes within the student groups. It was clear that learning took place both formally in the classroom and teaching environments. However, the social activities planned and unplanned for the student group developed in many cases long term friendships and professional links. Students set up Facebook sites to share not just social but also professional information. In some cases, they acted as guides for the new groups who were attending and ensured that these groups made the best of the opportunity.

The key learning challenges outlined above are important if we want to provide cross cultural learning experiences that have meaning, introduce new theory and ensure that is applied in the practice environment. The feedback from each focus group and the questionnaires was shared with the teaching team so that they could react to student feedback in a timely manner. As a consequence, a number of new initiatives were added to modules 2 and 3. For example, more introductions at the early part of the module, clearer instructions on module assessment and pre and post module requirements, more online support and

reassurance that students would not be downgraded for minor errors in grammar in their presentation or on REPPU discussions.

Stage 1 Outcomes of the Staff Focus Groups

It was interesting that the focus groups with the teachers started with a common agenda similar to that of the student group. In the focus groups following modules 1 and 2 the discussion was very much related to the key areas of module delivery. However, by the time we had reached module 3 the team had been working together for some years and there was a stronger bond between the groups. Although it did not set out to be, focus group 3 was much more evaluative in terms of how we had worked together as a cross-cultural team. As a consequence, a number of recommendations were made as to how we could improve the process and the roles we might develop were we to do the project again. So in presenting the key themes in the teacher focus groups the early sections will be more concerned with focus groups 1 and 2 and this section will finish with the key recommendations made in focus group 3.

Learning to Work Together in Cross-Cultural Learning and Teaching Development

Roles and Responsibilities

The exercise in curriculum and skills analysis and the additional data provided by the focus groups conducted with practitioners meant that the staff in the project had already established a working relationship prior to the development, delivery and assessment of the three modules**.** A number of communication systems were already in place including project meetings, skype discussions and face-to face meetings. The outcome of work package 3 was an agreed framework for the modules, a set of core competencies to be considered and key areas of practice interest to be addressed. Three of the universities took responsibility for one of the modules. However, as with any new development there were some early communication problems that needed to be addressed. In the focus groups there were concerns raised about the module descriptors. Not all the partners had used this form of descriptor in the past and it took some time to get used to them.

To support the discussion some suggestions were made as to how to move forward with using the descriptors. It was agreed that the descriptors need to be consistent across all three modules but that the content and the modes of delivery could and needed to be different.

> *There was a problem in communication and what was missing was whether I was expected to be involved in the delivery and /or the planning of the module or indeed whether I was expected to discuss the structure of the assessment. In the early module development nobody seemed to want to take responsibility for saying how the module should be delivered. I was not sure what was going to be there and I would have liked some idea of what I was expected to do. (Focus group 1 teachers).*

> *While the module descriptors were interesting and informative, they were very new to us and we were still discussing the format as we are not fully clear but we needed to be because the module was due to start and we did not really know who was doing what. We needed a clear timetable of events for the intensive week and that was really only decided about two weeks before the module started. (Focus group 1 teachers).*

Challenges of Collaborative Leadership

There were additional concerns in terms of leadership roles in the teams. The question as to who should be involved in module planning and delivery was raised and there appeared to be some confusion as to this this process should work. The teachers were unclear what their role was in the preparation and delivery of each of the modules particularly when the module was the responsibility of another institution. There was also confusion as to how involved each module team member should be in contributing to the planning and delivery of the module. What was evident as the focus groups progressed was clear ideas of how these issues would be addressed. There was a clear understanding that working with the module descriptors was a key way of maintaining quality across the three modules.

> *The university who is delivering the module needed to take full responsibility for organising the content. The module leader from that institution then needed to communicate and delegate across the team as to who is doing what and when. They should also be involved in providing regular updates to the module team so that we all know what is going on. (Focus group 2, teachers).*

> *It's interesting because we were learning by doing. We were trying to teach intercultural management and we were an intercultural team and sometimes there was conflict and we did not always deal with them well in the early delivery of the modules but I think we got better. What we needed to do was ensure the modules were strongly driven and that we worked to each other's strengths. In the early modules I sometimes felt my suggestions were ignored but we need to take into account that we are communicating in another language and that might explain why we did not always get it right. (Focus group 3 teachers).*

> *We were bad on timing, sometimes one person would react but the others didn't and then another reacted later so we did not focus together at one time and this had an effect on how we delivered the material. I think another problem was that we all had different approaches to teamwork so we should have had more meeting together to make decisions. We had never delivered a full online module before so for us this was really a challenge and not having an intensive week (Focus group 2 teachers).*

Delivery of the Module in English

The challenge to deliver, understand questions from students and respond was the main part of the discussion. Given that the majority of the teaching team were using English as a second or third language this was an important consideration. The delivery of the module in English formed the first part of the discussion with the teaching team and we returned to this question throughout the three interviews to examine any changes or developments. Teachers reported that it was challenging to speak with non-native English speakers whilst others reported that it was a learning opportunity. Like the student group the teachers found it difficult to understand some of the students because of the way they expressed themselves in English. Interestingly in focus group 1 it became apparent that the teachers were less concerned with the possibility of making mistakes when they delivered in English. It was also interesting to note that working in intercultural projects was 'learning by doing'.

I don't care if I make a mistake I am not afraid of them and I notice I am being understood so I can practice my teaching with the students. We have surpassed the phase where we pay attention to mistakes that we do we are quite self-assured in that sense So we do it in our way and maybe it's because we do it all the time I use English every day. (Focus group 1, teachers).

I agree we make mistakes in English and it's our first language we told the students this and they asked what about grammar and we explained we get mistakes from our students also. (Focus group 2 teachers).

It's about having confidence you know in the lecture. When you are in the classroom you have to speak, we are learning by doing. We are trying to teach intercultural management and actually we are an intercultural team and as such we have to face many challenges. But it's also cultural differences which we just have to accept. We can learn so much if we can do that (Focus group 3 teachers).

Along with a strong will to support the students to learn in English and to accept the difficulties that come with that there was also a feeling of comradery with the students and a willingness on the part of the teachers to acknowledge that it was ok to make mistakes and that that was a key way to learn. However, there was a clear indication that delivering the curriculum in English over a period of several days was exhausting and some of the teachers explained about having to really listen to hear what was being said. The level of concentration was high and maintaining this over several days was quite a commitment on their part. Consequently, a number of the participants appreciated the inclusion of native English speakers in the classroom who would share the delivery. They saw this as a supportive technique but also a learning opportunity for their own development.

We all make mistakes and maybe reassuring the students at the very beginning that we are all in this together and we will all make mistakes might increase confidence. But also to reassure them its fine we need you to speak to us. The current group were very scared about this they explained that speaking in English is hard but writing in English where there are mistakes is even worse. (Focus group 2 teachers).

At first it feels like you haven't done it for ages so it's really hard and then somewhere in between you get really tired and need a rest and then somewhere along the path you feel like I could do this all day and its different phase's really. (Focus group 1 teachers)

*As teachers we get very tired translating even though I am not translating it all the time in m y head its quite tiring because we are really concentrating – **we are really listening to hear** So if we need to help people we can or that we can understand folk and make them feel part of what is going on – so although it's been exciting for us this week it has also been very tiring so you do really listen. To try and hear what is there. So I think it is a major commitment – but it's great for us that we have native speakers because I listen to you very carefully – I listen to the sentences and it's a learning opportunity for me. (Focus group 3 teachers).*

REPPU – Developing Material for On Line Learning and Maintaining Interaction with the Student Groups

One of the key differences in the delivery of module 2 was that it was a completely on line module and there was no intensive week in which both students and staff

had the opportunity to meet and to develop strong working links. This placed additional stress of the module team in terms of how they would ensure good communication and cohesion with the student group. The university who had chosen to lead this development had a strong subject expertise in terms of the module content but were not as experienced in terms of delivery of modules online.

> *It was difficult for us as a group because we were not used to doing our teaching all on line. It was a very technical presentation and relied on the Moodle platform. There was a stronger expectation on the students to write more on the Moodle boards and this was difficult for them but also for us. (Focus group 2 teachers).*

> *I think some of the students found it very hard because we had the discussion section on REPPU and they said it took a very long time to do this because they have to really think about what to write and how to write it. I was thinking that maybe they need longer next time just to get to know REPPU – to get the sections right and to understand the whole system it took much more time that it would in their own language. The speed of reading was less and they found this a challenge. The students wanted more face to face discussion and less writing. We all agree that a blended module where there is opportunity to meet face-to-face with the students in an intensive week is a much better way to deliver the module all on line.it is not good for the students, there is much less cooperation and cohesion among the groups. (Focus group 3 teachers).*

Despite the difficulties for the students in terms of learning in another language the suggestion of some of the material being delivered in the students' own language was not considered a useful option. However, there was a consensus that student should be advised that there was a commitment period of preparation prior to starting the module. There was agreement that the demand on the student was twofold in that they were learning about a new topic but having to do this through the medium of another language.

> *I am wondering what kind of pre instruction that we give them and how can this be filtered through to all of the different countries – the key things the students need to know. The kind of things they need to think about. We are demanding of the students in terms of cognitive demand you know we are saying not only are you wanting to learn something new but you are also going to do this in English. (Focus group 1 teachers).*

> *Students who enroll on the module. We have a short session we explain the language and what is going to happen. I think there are three kinds of learners those who learn new content in a foreign language, those who learn something they already know but in a foreign language and those they can learn something new in a foreign language and they can even apply it even in their own language backwards. So there are different kinds of learners. (Focus group 1 teachers).*

The discussion went on to consider the student suggestion that some of the instruction could be provided in their own language. This particular idea was not considered in a positive light with most of the participants saying that the development of English skills was essential for the student group. Indeed, it was also suggested that the same principles must be applied to teachers in that they must be able to describe and explain the process of the module competently in English.

It's really a necessary competency for the teacher to speak and write English very well because we have to be able to say the same things or say things in another way to help them understand. You also have to understand them, where they are coming from, and help them to understand the message in English. (Focus group 1 teachers).

Learning from Working Together

As the group worked together each became more aware of specific aspects of practice in both the classroom setting, on line and in the format of feedback. The final focus group provide opportunity for reflection on the development, delivery and assessment of the modules. Some suggestions were made in terms of the way in which certain aspects of the modules were difficult to develop or deliver. However, there was also a real sense of enjoyment and learning from working together across the three modules. Some very honest observations were made in the spirit of improving working in the future. Here I have chosen to include more quotes as they really convey the sense of team cohesion that had developed at this point in the project.

For me it was like a tension between fulfilling the task and getting the time and space for understanding and creating some team solutions. There was kind of a tension and I think next time I would plan to have much more time to work as groups in developing the materials. We were not careful enough at the time of planning. So for me I think one of the problems with deadlines in the first module. For me the bits I enjoyed most was actually teaching the students but also having other teachers from other regions in the room who were commenting on their perspectives. As a teacher this made me think differently and there are things I can look at more critically now. You know you don't often get the chance to observe other people's approaches in a teaching and learning sense and I found some of the experiences really helpful to focus on areas to do with my own development. You are so much focused on feedback and I saw this last time, you really know how to handle the cases the students present and this is something I have learned and developed as part of the modules. (Focus group 3 teachers).

I think when we did get together, we did some great work and we generally worked as part of a team but I think there should have been much more communication and management meetings, maybe someone should have had that as one of the roles in the project. I was very satisfied with us working together as a team. I think we know so much more now about how we all work. For example, we were having a meeting yesterday and it could have gone on for hours because we were exploring really important differences. In some ways I wish this had happened in the first module because we used the time so well we were exploring some real differences and really trying to make this as robust as possible within a limited timeframe so we were really focused, it was good. And part of that is now we have done three modules together. (Focus group 3 teachers).

I think we could do some things better. It would be good to have an identified tutor on each site to meet the students before they start the module and certainly before the intensive programme so they can prepare the students and answer any questions they might have before they leave. We should have considered a short evaluation meeting after each of the modules to identify the problems and strengths of the module. Perhaps we should have appointed one individual within the project team as the module coordinator. From a management point of view this would make sense as they could

ensure the communication was taking place and that it was a smooth process, sometime this was not a clear responsibility in my experience. (Focus group 3 teachers).

The content of the project was very ambitious and maybe it was a little too ambitious in terms of our capacity. We were not careful enough in time planning and for me some of the problems were caused simply because our deadlines were too short. There was not enough time to really develop things properly. It's a fine line between being ambitious and having the capacity to fulfil our obligations. Maybe being clear about the strengths each partner brought to the project would also have been a good exercise at the beginning of the programme. (Focus group 3 teachers)

It was not unexpected that after working together on the project and developing and delivering three modules that the teachers felt much more comfortable working together. There was a strong sense that in the third module we really worked very well together and had become a team in the approach that we took. In the third focus group there was a much clearer insight into how we might have organised some of the roles within the team to give specific responsibility to individuals. There was a sense of being a part of a team and a realisation that some decisions should really have been made earlier in the project. Despite making a decision early on in the project about using transformational learning as an underpinning for the educational development, delivery and assessment there was a sense that there had been a lack of pedagogical leadership in terms of the learning process.

During this week I think we worked very well as a team. We were clear on what we were doing, the purpose of the sessions and we were student orientated. The students were also very clear on what was expected of them and they cooperated with us and interacted on all levels. (Focus group 3 teachers).

I think now that we should have considered specific responsibilities for the team from the management point of view and that someone should have taken on the role of like a module coordinator to ensure the smoot running of the modules and that the people who are managing the modules are working to time and are informed about the outcomes of previous modules, like what worked well, what we might need to change. Like almost having a programme leader who oversees the module leaders. (Focus group 3 teachers).

We also need to plan carefully about articles and reports and to assign responsibility early on in the project as to who will be responsible for writing and publications, or who will proof read that material and organise the publications. I think that within any project aiming for four or five articles might be lot. But I think we missed out on opportunities to record data because we did not think it was important at the time. Maybe next time we should have a clear publication strategy. (Focus group 3 teachers).

I use English on a daily basis and have been involved in a number of international projects. And I think there has been some lack of pedagogical leadership. I think there should have been a pedagogical leader who was following the process of learning throughout the three modules, not so much the results but more on how we worked together as a team and how we enhanced the learning environment. (Focus group 3 teachers).

Overall the teacher data from the three focus groups was positive and a number of the issues of diversity and cross-cultural work practices were to be expected. What is reassuring is that although there were tensions and some problems

they were addressed and the feedback into the group allowed for them to be rectified for the next module occurrence. The reflective element at the end of focus group 3 provided some good ideas on how teams in the future might want to consider specific management roles early on in the project development. Like the students, the teachers have developed strong intercultural friendships and professional links which may well lead to future collaborations.

Stage 2 Self Evaluation Of The Project Management Group

Outcomes
Developing a Comprehensive Course Vision

This part of the evaluation focused on identifying the need and 'unique selling proposition' to run this project and included indicators such as performing programme needs analysis, detailing who will receive value from these modules and building a viable sustainability strategy. Due to the extensive work undertaken in mapping the situation in health and social care management, the focus groups, the curriculum analysis, in combination with the lack of another competence definition at the start of the project, the group felt that in general this aspect was very comprehensive. As stakeholders had been widely consulted and a clear need for this project was clearly articulated. Sustainability had been considered, but the group recognised that there might be challenges in relation this. For example, while there are plans to continue the modules, as there is integration of the modules within the home programmes of each university, financial support for students for attendance at the intensive weeks may be problematic. While the individual universities supporting this aspect of funding for the pilot of the modules (rather than project funding), and this is planned for the continuity, university priorities may change and it is difficult to be completely assured this will be available in the future.

Understanding the Value of the Shared Academic and Administrative Cultures, the Quality of All Partners and the Participating Students

The partners had undertaken a formal assessment and review of the academic quality processes of each university for approvals as part of the work packages for module preparation. In all stages of the project the quality protocol defined roles, responsibilities and quality indicators for each step of the process to maximise the involvement and quality input of each partner. Differences were explored at length to take forward the modules in a format acceptable to all partners to allow student participation from each institution. Extensive preparation and support of cultural differences within the project group were taken which was supported through the risk assessment strategy and clear delineation of responsibility with structures and leadership to address this.

Students were supported by a named contact in each university on administrative issues, which included guidance on enrolment, participation and articulation of the module onto the 'home' Masters programme.

Providing an Integrated and Consortium-Wide Learning, Teaching and Staff Development Strategy

In the common module descriptors the learning, teaching and assessment strategies were detailed to provide a clear overview for students. All modules where supported a common virtual learning platform (REPPU) which provided multiple tools to support a variety of approaches for online learning. Staff in some instances also undertook additional training to further develop their pedagogical approach in supporting blended learning. In addition, many of the staff were expert in intercultural management which also supported the effective teaching of a culturally diverse group of students. With the underpinning theory of transformative learning, the PMG felt the modules had an overarching cohesive pedagogical perspective focused on application of theory to practice. Learning outcomes guided the formation of module descriptors included the learning, teaching and assessment approach, and while some of the guidance asserted that these should be detailed according to knowledge and understanding, skills and abilities, attitudes – this applied more specifically to whole programme aims rather than modules. Partners decided collectively on teaching balances on the basis of the project proposal and funding, the objectives of each module, institutional and national constraints, and teachers' career perspectives and development

Significant efforts were made to support students to understand any variations in the learning, teaching and assessment strategies in relation to their home university. Workload of the students was discussed at length as the hours attributed for 10 ECTS credits varied across the partner from 200–260 hours. The university with the lowest level was the university with English-speaking students and it would have been likely this was balanced through self-study time needed for those students with English as additional language. There was also a consortium-wide tables mark, conversion tables and mechanisms such as joint- and double- marking by different partners and marking criteria to ensure that students are coherently assessed. In addition, there was provision of tailor-made local learning tools and facilities and a functional e-learning platform at consortium level.

A comprehensive consortium-wide internal course review and evaluation process was undertaken as previously discussion that supported a continual quality improvement. External evaluation was also integrated into the programme as the end of CareMan pilot, however it was recognised some input after each module might have also been beneficial.

While the pedagogical approach was a significant focus throughout – there were areas of practice in relation to sharing good practice, guidance for students and teacher and module delivery which were identified for improvements in the pilot which resonated with the module evaluations and featured in the recommendations for future running of this and other similar courses.

Developing a Realistic Management, Financial and Institutional Strategy

Non-academic human resources such as administrative support, quality personnel and financial management support were in place for the project within the institutions. This was funded within the CareMan project in which resources and finances were carefully planned which included annual consideration of budgets, regular monitoring and a risk assessment. The project was supported as a pilot, however longer terms support will be required for the extension of the modules, but as these modules articulate onto the home programmes of the universities the resources will be comparable for activities such as quality activities and student registrations. A structured intranet was set up to communicate both the basic information on the programmes for, staff and administrators to ensure

access to all activities and documents, which included aspects such as financial reporting guidance.

The project had a clear and unique focus of the curriculum with diversity and intercultural management key subject areas, which explicitly supported an international and cross-cultural curriculum. All staff had significant international experience with many involved in other transnational programmes with most teaching regularly out with their country. Each PMG member also ensured linkage with university-wide internationalization strategies to maximise the support and exposure of the pilot within each partner university.

Recruit Excellent Students, Deliver Value to Them, and Engage Alumni

Marketing for students was primarily institution led as for the pilot this was only for students already on existing and relevant master programmes from each partner university. Individual partners actively recruited and selected students on the basis of a portfolio approach such as academic credentials, language skills, motivation and attitude, however this was set within each university. Key information on all academic aspects such as course requirements and expectations, as well as non-academic aspects for the intensive weeks, were sent to all students. This included support of the students socially, culturally and academically through a range of planned activities, for the full online module this was mainly through student support and mentoring, but the intensive programmes also provided a full range of social and cultural events such a visits to relevant organisations in that country and cultural events such as historic tours.

In relation to learning opportunities the partners ensured that local resources such as library access were available to help achieve learning outcomes. Student learning was maximised with a named contact in each university to ensure available resources such as additional academic opportunities were signposted or any relevant career development. Employability was one of the indicators considered and achieved to some extent through ensuring that practitioners contributed to the programme delivery as well as visits to relevant organisations, however other aspects such as internships and monitoring of jobs post-graduation were not undertaken as most participants were already in employment.

Throughout the modules – application of theory and linkages to health and social care organisations. Students also set up social networks to maintain linkages beyond their participation in the module. In addition, in the intensive programme and at the final seminar alumni of both these modules and the home health and social care management programmes were in attendance to help establish and build long-term alliances.

Conclusion of Self-Evaluation

This pilot provided a unique and valuable opportunity for diverse health and social care managers to undertake a programme focused on developing their intercultural management skills. The project provided valuable opportunities to develop their intercultural competence and management skill, particularly when an intensive programme was included. The quality protocol and quality improvement approach ensured that the project was delivered in the agreed timelines, but also ensured that improvements were made in subsequent modules. There are some risks to sustainability, such as sustainable funding, particularly for the extremely valuable intensive programmes, however the project team will continue to work beyond the life of the funded project to seek to offer this opportunity.

Chapter 5 Summary and Conclusion

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This monograph outlines the process and results of development of a common educational programme at masters level in health and social care management, which was supported by the Erasmus Life Long Education project CareMan (Culture and Care Management). The CareMan project brought together university partners actively involved in educating social and health care professionals in leadership and management at master's level in Europe. The five partners of the consortium were Lahti University of Applied Sciences – Lahti UAS (administrative and academic coordinator, Finland), Charles University – CU (the Czech Republic), Edinburgh Napier University – ENU (Scotland), Hammeline University of Applied Sciences – HAMK (Finland), and University of Évora – UoE (Portugal).

The objectives of the project were to achieve lower-level educational goals that included the development through education cultural and value-driven leadership, quality of care and quality management to effectively manage an integrated health and social care service. Through mapping the situation in the field and comparing curricula of all participating universities the overall aim was to develop a joint masters programme in social and healthcare management.

After the detailed understanding of national and institutional specifics of each of the individual academic entities it was recognised that, due to a number of regulation issues, the original aim was not achievable. Following subsequent analytical work, it was decided to develop a set of three master's level modules. At the end of the project it was intended that all created modules would be available virtually to the participating programmes and would contribute some added value to existing curricula. In the future these ready-to-use modules are intended to be taught in cooperation with the participating universities or as a separate module in each university.

The chosen theoretical framework of the project that underpinned the development, management and evaluation of the inter-cultural educational provision relied on the combination of two learning theories – 'cooperative collaborative and social learning' and 'transformational' (Mezirow, 2009). This theoretical framework helped to align with European collaborative policy and its application on all levels of implementation of the project.

Developing educational modules required initial analytical work to be conducted by the team. Because the project was to be implemented in collaboration between educational institutions, the collaboration had to be based on methodological approach of the analyses, which mainly relied on comparisons.

The analytical process was conducted in three stages: focus groups with graduate students who were also practitioners to identify key learning requirements; curriculum comparison based on framework analysis adapted from the European Tuning Project; and identification of a cross-sectional skills matrix that would underpin the development of the learning outcomes for module development.

The analytical work in mapping the situation and curriculum comparison brought data and findings that further supported and even better specified the lower-level objectives and helped to formulate content goals. An inductive process of the project management group led to decisions on what content of the modules might be most efficient and also feasible within the available time

and resources to achieve the overall educational objectives. The outcome of the inductive decision-making process of the project management group (PMG) was the proposal to develop three modules: *Human Resource Management and Knowledge Management, Quality Management and Intercultural management,* each for 10 ECTS credits.

As a result of the theoretical and organisational framework and analytical phase of the project, four strategies informed the development and implementation of the modules:

i. Collaboration as a principle stemming from EU collaborative policy and receiving it's expression on all implementation levels (designing the modules, modes of learning, delivering the modules, evaluation process).
ii. Building on the Bologna process masters level framework to assure appropriate academic level of outputs.
iii. Development of value-based leadership of students through transformational learning in cross-cultural settings and continual reflection of theory in practice.
iv. Continual evaluation and feedback among teachers and students as a strategy to achieve a high quality programme.

All three modules were collaboratively designed and piloted during 2015 and 2016. Each module was led by one university, but members from all other universities participated in the development and delivery of the modules. The Bologna process masters level framework and related standards and guidelines informed the form and method of designing the modules.

A module proforma and guidance notes were prepared and used for this project based on the Bologna process, ECTS User Guide and Tuning guidance, which details that the following information should be available. This included the target group, ECTS level and all prerequisites; the learning outcomes of the module and the educational activities to meet the requirements of learning outcomes; and types of assessments to meet the learning outcomes and overall hours needed for the module (Gonzalez & Wagnaar, 2005). Each module was hosted by one university but all modules were assessed by a common quality assurance process. The agreement to adopt a universal module descriptor ensured that there was consistency across the modules in terms of aims, objectives, learning, teaching and assessment strategies and references to appropriate literature. The use of the specially designed part of the online space Moodle/Reppu at Lahti UAS also helped to provide consistency.

Finally, assessment procedures of the students' learning were specifically designed towards application of theory to practice and the use of real practice issues. The quality of the students' outcomes has become an important source of the evaluation of the efficiency of the programme. A continual feedback and long-lasting evaluation process also helped inform the teachers and project management group about the results of each phase of the project and enabled them to make changes in the following module design and delivery. Based on the findings from the analytical phase and evaluation of the modules and project management process, conclusions in the form of recommendations for future development of similar programmes will be formulated.

Recommendations

a) Intercultural Sensitivity Support

Findings

The sharing of culturally diverse experience in practice appears to be one of the main benefits of this programme. Although this benefit was mentioned in all modules, guided reflection and continual group work and discussion during intensive weeks was necessary for students to start to understand the specific intercultural aspects influencing everyday situations in practice.

Recommendation

The transformational design of education of future managers in interculturally mixed groups in combination with guided theoretically informed reflection led to higher focus on and sensitivity to intercultural issues. This leads to new approaches to analysis and problem-solving in social and health care human resource management and quality management. The cross-cultural setting during intensive weeks and continual reflection of theory in practice strengthen the ability to develop intercultural sensitivity and grasping of theoretical concepts in their meaning for practice. This should be supported by continual evaluation and feedback among teachers and students.

b) Realistic Planning in Intercultural Settings

Findings

Both students and teachers referred to difficulties and a higher level of stress in communication and collaboration with different cultural group members and using language that was not native to them. It required more time and energy to overcome the barrier of diversity and experience the benefits mentioned above.

Recommendation

The positive effect of intercultural communication and collaboration must be achieved by dedicating more time and securing more energy for meetings, discussion about concepts and diverse learning and teaching styles, etc. The understanding of country level differences and their impact on situations and common planning should not be underestimated in planning any project activity. Considerations could include timetabling or co-facilitation of sessions or other activities if requested, which help save energy of the teachers.

c) Special Care for Instruction in Intercultural and Online Spaces

Findings

Intercultural communication and collaboration challenges all kinds of preliminary understanding on which people build their learned behaviour and expectations from others. This was often a source of misunderstanding and conflicts among team members, followed by blame apportioned to a lack of rules and instructions and calls for more expressive and tighter leadership and guidance.

Recommendations

In intercultural settings, special care should be given to discussing and explaining all procedures and instructions, showing how to use online spaces and materials, repeating instructions in a number of innovative ways (written, video, pictures, Skype, etc.), and being available for questioning and searching for information, etc. Clear guidelines on what is expected of students in terms of pre-reading and assessment delivery in English should be available well in advance of starting the module. Additionally, online discussion groups could encourage more participation from students and provide opportunities to reflect and clarify the content of their written posts. Given the reported difficulty of understanding the written word, navigating REPPU, and facilitating different learning styles, it is recommended that verbal presentation of core information in all three modules is incorporated. This would include oversight of REPPU, REPPU learning materials, assessment strategy and an explanation of assessment criteria.

d) Clear Roles in Leadership Including Educational Project Leader

Findings

Teachers felt uncertain in several situations, regarding what their roles were and who was responsible for which task. This raises tension as individuals do not always ensure time for certain tasks when others might expect it. Although in each module a clear leader was appointed, it was felt during evaluation that a position of educational leader for all modules might help to reduce the level of uncertainty in such processes of responsibility.

Recommendation

There should be clear management roles identified in relation to module delivery, for example the role of a programme leader or module coordinator who takes responsibility for/oversees the overall smooth running of all the modules and is the key point of communication for those delivering the modules. Clear guidance should be provided for the role of the module leaders to support them in the development and delegation of module preparation and implementation.

e) Innovative Ways to Support Communication in English

Findings

The use of English by non-native speakers was often experienced as an obstacle to understanding, due to different accents and ways of using the language. This was often a source of misunderstanding, lower ability to provide feedback or to understand fully the process of communication. It also required a special extent of energy to listen and to strive to understand.

Recommendation

It is necessary to acknowledge that a certain level of knowledge of English language is a preliminary requirement for common communication and cooperation in a multicultural setting. Based on some tested level of knowledge, special care and innovative ways of support in communication to non-native speakers should be part of the projects. It is vital that staff interact competently with students in a way that builds confidence in their use of the English language and interacting

with peers. However, although a reasonable level of competence is required in written and spoken English by both the teachers and students, minor grammatical errors are common and acceptable.

Final remarks

The main objective of the joint programme, which finished with the development of three modules, aimed to address and "answer societal needs" (Resende da Silva et al, 2015, p. 587) common to European countries (mainly those involved in the project) and intended to produce at the end of the process a set of core common competencies needed in future, at European level that can be useful to health and social care leaders. For that we share different backgrounds, experiences, interests, core competencies, and cultures, trying to develop a coherent, multicultural and cross-cultural curriculum in Health Care Administration at a European level, maintaining the strong commitment of all involved, updated with recent knowledge and with the best evidence available.

It was considered that highly specialised knowledge was taught in the three developed modules, some of which was at the forefront of knowledge in the field of study and work and therefore could become the basis for original thinking and/or research. Conditions to enhance critical awareness of knowledge issues in the field and at the interface between different fields were created. It was hoped that students should be well prepared to take responsibility for contributing to professional knowledge and practice and/or for reviewing the strategic performance of teams. It was felt that with this programme a good base of experience and knowledge to develop other projects in the European area, approaching practices in health and social care, could be harmonised with the best evidence.

The project team believe that the modules have several elements with the potential to make an impact on social and health care services. It is hoped this will not only widen the knowledge base of the participants but also help cross-fertilise current approaches to lead to truly European and novel ways to tackle the pressing social and healthcare managerial challenges.

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Part II

Learning Material

I Human Resource Management: Health and Social Care Perspective

Päivi Huotari

Introduction

The health and social care sector is facing diverse and complex political, economic and social challenges, which lead to reorganisation processes like organisational mergers, health and social care integration and privatisation. Furthermore, the care sector is labour intensive. Under these circumstances it is important, even crucial to implement a successful human resource management (HRM) policy. HRM policies comprise systems and practices that ensure the effectiveness and productivity of human capital, the employees. This chapter will briefly present HRM as a phenomenon, and especially the HRM challenges that future public health and social care managers might encounter.

Learning outcomes

After reading this chapter, a student should be able to:

- Explain and understand the concept of HRM
- Define the main challenges for HRM in health and social care
- Define and understand the role of line and front-line managers in HRM
- Explain and understand the HRM outcomes of employee commitment and quality of care

Human Resource Management

HRM is an essential organisational process and part of all management jobs. It refers to a set of activities aimed at building up individual and workforce performance in organisations (Boxall & Purcell, 2011). The concept of HRM is relatively new and its use was established and expanded in the 1980s and 1990s (Beer, Spector, Lawrence, Mills & Walton, 1984; Storey, 2007). HRM aims to ensure that an organisation is able to achieve success through people. In other words, HRM aims to increase the capacity of an organisation to achieve its goals by making the best use of the resources available. It guides the workforce to focus on what is most pivotal for the organisation and its desired results (Boudreau & Rice, 2015; Armstrong, 2009). Furthermore, HRM ensures a socially legitimate system of labour management (Boxall, 2008). HRM is practiced as a fundamental part of business. Only the largest organisations tend to have an HR strategy (Boxall, 2008), and in small and medium-sized enterprises there is a lack of formalized and organisational level HR practices and policy (Atkinson & Lucas, 2013).

There are several different HRM approaches and models. Beer et al. (1984) provided one of the earliest and most well-known ones. Their model describes a broad causal mapping of the determinants and consequences of HRM policies (Figure 1). The final HRM policy is influenced by two determinants: situational factors (in the environment or within the organisation) and stakeholder interests. Situational factors constrain HRM policies while, conversely, HRM policies influence them. Future HRM policies are affected by the interests of various stakeholders, and it is the task of managers to comprehend and balance the different and even conflicting needs of these stakeholders. HRM policy choices

made by managers and based on situational factors and stakeholder interests further affect four main HR outcomes, referred to as the four Cs: the commitment of employees, the competence of employees, the degree of congruence between the goals of employees and those of the organisation, and the overall cost effectiveness of HRM practices. Furthermore, these four Cs lead to long--term consequences that are evaluated in terms of their benefits and costs at three levels: individual well-being, organisational effectiveness, and societal well-being. Organisational effectiveness is the capacity of the organisation to be responsive and adaptive to its environment. Further, the model illustrates the circularity of HRM policy, as the long-term consequences affect situational factors and stakeholder interests.

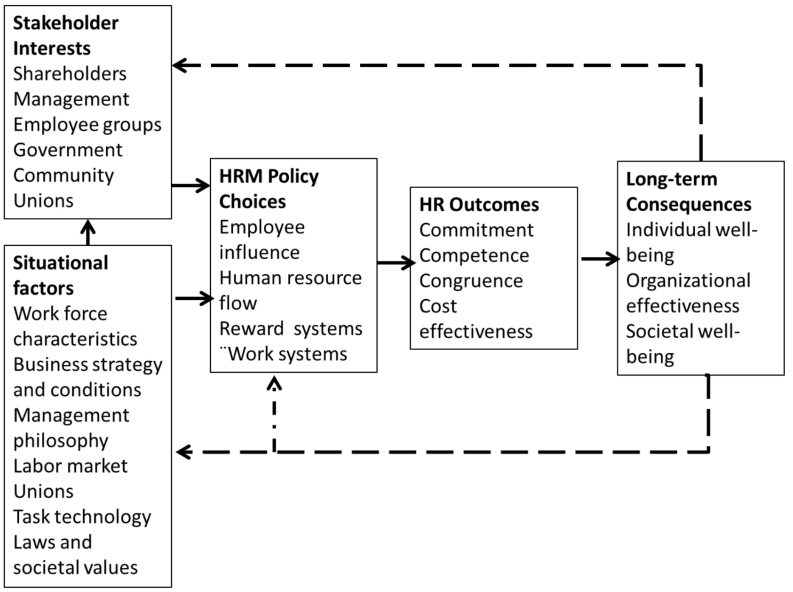

Figure 1. Map of the HR Territory (Beer et al., 1984)

HRM on the level of individual performance can be analysed with the employees' Ability, Motivation and Opportunity, the AMO model, initially proposed by Bailey (1993) and developed by Appelpaum et al. (2000) (Hutchinson, 2013). Boxall and Purcell (2011) also presented this model, where AMO refers to ability, motivation, and opportunity to perform. These three factors are all involved in creating employee performance, but the precise relationships among them are unknown. In addition, there are other factors that affect the AMO, not only HRM. According to Boxall and Purcell (2011, p. 5), individuals perform well when they have:

- "The ability (A) to perform (they can do the job because they possess the necessary knowledge, skills and aptitudes);
- The motivation (M) to perform (they will do the work because they feel adequately interested and incentivized); and
- The opportunity (O) to perform (their work structure and its environment provide the necessary support and avenues for expression)."

HRM includes the management of individuals, but it also includes collective and organisational level activities: building work systems to coordinate individuals, building collaboration across organisational boundaries and networks, building workforce capabilities, and affecting the general climate of workforce attitudes (Boxall & Purcell, 2011).

Integration of the organisational strategy into human resource management is the core idea of HRM. The strategic approach takes into account the alignment of the organisational environment, the organisation's overall strategy and HRM

policy. In practice, this means that HRM takes a strategic approach towards employment management. As Beer et al. (1984) argued, general managers need to provide a strategic view or a central philosophy in order to achieve a coherent HRM policy. Storey's (2007, p. 7) definition of HRM underlined the strategic approach: 'Human resource management is a distinctive approach to employment management which seeks to achieve competitive advantage through the strategic deployment of a highly committed and capable workforce using an array of cultural, structural and personnel techniques'. The role of line managers is crucial in delivering HRM policy by, for example, communicating with employees, holding performance appraisal discussions, setting targets and encouraging involvement and engagement (Storey, 2007). The alignment of the organisational strategy and the HRM strategy means aiming for horizontal and vertical fit, or integration, with an emphasis on organisational culture and values (Hutchinson, 2013).

Boxall (2008) stated that the goals of HRM have fundamental managerial 'strategic tensions': the tensions between employer control and employee motivation, between short-run productivity and long-run adaptability, between corporate survival and employee security, and between managerial autonomy and social legitimacy. Storey (2007) explained that HRM has both 'hard' and 'soft' dimensions. The hard aspect refers to the business-focussed stress on the word 'resource' in a rational way like any other factor of production. The soft aspect relates to human relations, stressing the word 'human'. It emphasises communication, training and development, motivation, culture, values and involvement, and it has a longer-term focus on building and sustaining employee capability and commitment.

HRM in the Health and Social Care Context

The health and social care sectors have certain characteristics that frame and define HRM. Firstly, both sectors operate in an increasingly regulated environment (Cooke & Bartram, 2015). Secondly, health and social care operate with different stakeholders, including government, regional and municipal level institutions, political parties, private and third sectors, managers, employees, clinicians and professional associations, trade unions, education institutions and different client lobby groups (Bartram & Dowling, 2013). Direct and indirect political intervention in the public health and social care service sectors has no similar equivalent in the private sector (Bach & Kessler, 2008). In the public health and social care sector, political leaders and public administrators share the responsibility for strategic management (Lumijärvi & Leponiemi, 2014; Niiranen & Joensuu, 2014). Political and, on the other hand, administrative and professional decision-makers represent different institutional routines and procedures, and sometimes conflicting interests (Kalkan, Sandberg, & Garpenby, 2015). Political leaders are guided by the interest of citizens, the municipality as an entity, and the interests of their own political party. Public administrators base their decisions on administrative and legal perspectives (Niiranen & Joensuu, 2014).

Thirdly, the health and social care sector in most countries has been caught up in a continuous process of adapt-and-reform that has major consequences for HR practice. There is a need to restructure health and social care services in order to be able to face financial and other challenges (Ollila & Vartiainen, 2014). These changes cover reorganising service structures, organisational mergers and health and social care integration. Changes in the care administration system and organisational structures and cuts in funding have implications for and need support from HRM, for example, more intensive work practices and downsizing (Cooke & Bartram, 2015; Freire & Azevedo, 2014; Bach & Kessler, 2008). Still, in care system reforms, HRM issues are not always recognised (Leggat, Bartram, & Stanton, 2011).

Most of the research on HRM in care services has focused on health care. In the context of social care and social work, the research on HRM is quite limited. The starting point in this chapter is that HRM in health and social care is based on aligning the needs of the organisational environment, the strategic aims of the organisation and the HR strategy. In other words, HRM in health and social care aims towards strategic vertical and horizontal alignment that integrates the organisational environment and organisational aims with personnel management in order to achieve a high quality of care with qualified and committed staff. Vertical alignment means that organisational strategy is transferred into the work and competences of employees by line managers. Vertical alignment supports horizontal alignment by ensuring that the line managers at the same organisational level understand and implement organisational and HR strategy the same way. The environment of the organisation and strategy are contingency factors. McDermott, Fitzgerald, Van Gestel and Keating (2015) highlight the importance of continually identifying the context and the environment in which the organisation operates. This way, an organisation is able to respond to current and future challenges with organisational and field-specific HRM (Boudreau & Rice, 2015; Cappelli, 2015). In other words, HR practice must fit the context in which it is enacted. It must reflect the influence of numerous forms of regulation that influence training, qualifications and performance reviews (Atkinson & Lucas, 2013). In this section we look more closely at health and social care HRM and the role of line managers, employee commitment, and performance and quality of care.

Line Managers Putting HRM into Practice

In health and social care, as well as in other organisations, line managers are responsible for putting HRM strategies into practice. Line managers ensure that the aims of employees are consistent with the organisation's overall priorities and objectives. Line managers also willingly undertake responsibility for HRM, particularly when it has service-related implications (McDermott et al., 2015). Nevertheless, the role of line managers in HRM is not always understood or adequately supported (Shipton, Sanders, Atkinson, & Frenkel, 2016; Huotari, 2009). A strong HRM system requires a high level of leadership. In addition, managers at all levels of the organisation need to be provided with the relevant knowledge and skills, and to have the same relevant, consistent and valid message on HRM across the organisation (Stanton, Young, Bartram, & Leggat, 2010).

The role that line managers, and especially front-line managers, play in implementing HRM strategies needs to be emphasised (Kakuma et al., 2011; Huotari, 2009; Ott & Dijk, 2005). The involvement of front-line managers in implementing HRM policy can enhance their role as people managers and, in turn, can transmit important knowledge from the front line back to the top management level of an organisation (Stanton et al., 2010; Huotari, 2009). Researchers stress the importance of the leadership style of the line manager. In particular, the development of supportive and transparent leadership and a fair leadership style on the part of first-line managers can effectively improve employee satisfaction (Armstrong-Stassen, Freeman, Cameron, & Rajacich, 2015; Ott & van Dijk, 2005).

Top management also has a crucial role in HRM and its visibility across the organisation. According to Stanton et al. (2010), the role of top management can give HRM its legitimacy, provide leadership, commit resources, and provide the links between organisational and HR strategy. The top-level management group needs to have a consistent message on HRM, as well as informing, engaging and empowering managers at all levels of the organisation. Gilbert, DeWinne and Sels (2015) stressed that with clear, consistent and agreed-upon HRM processes, line managers are better able to understand the HR policy and their role in it.

Besides HRM, line managers have several other roles and responsibilities with different, sometimes incompatible, expectations, leading to role conflicts.

McCann, Granter, Hassard and Hyde (2015) state that the more traditional concepts of management and, on the other hand, the emphasis on professional norms may create different approaches: tasks are evaluated in terms of care, professionalism and compassion rather than on metrics and efficiency. Professional norms can remain active, and to a large extent, organisationally and culturally legitimate, even though HR systems and targets try to constrict and control them. Cooke and Bartram (2015) further argue that the care sector would benefit from a broader HRM approach that is interdisciplinary, multilevel and multi-stakeholder. This approach would help overcome structural silos between professions, providing shared support that would enable a coordinated approach to addressing HR in a service- and problem-oriented manner (McDermott et al., 2015).

Employee Commitment as an HRM Outcome

The future success of care depends on how the care sector attracts talented, creative staff and develops and supports them. In a time of growing market pressure and quality service focus it is important that HRM policies aim to develop and create working environments that sustain and enhance the emotional attachment of employees who are committed to their jobs (Rubery et al., 2011; Boselie, 2010). In other words, HR policies must contribute to increasing the organisational commitment of care professionals (Freire & Azevedo, 2014), which has a further impact on quality of care (Shipton et al., 2016).

Human resource management is not the most important activator of commitment, since HRM in isolation may even lead employees to attribute neglect of their interests to managers. In HRM discussions, employees should not be defined solely as a resource to be effectively employed, but instead should be considered as people with specific concerns that need to be addressed. Engaging in roles that simultaneously show respect and understanding of employee groups together with a commitment to put the client first is likely to promote value alignment and correspondingly higher commitment (Shipton et al., 2016.) When line managers have a central role in HRM, it is likely to have a positive impact on care employee commitment (Ott & van Dijk, 2005). Line managers create meaning for employees by 'framing' issues and themes that they see as important. This means in practice that the line manager spends time listening to employees, sharing insights that employees perceive as important, communicating HRM policies, and demonstrating support for employees and willingness to address their concerns. It is important for the line managers to provide pertinent information. HR-oriented line managers can help the organisation achieve its strategic goals by encouraging high employee commitment as a precondition for successful individual and organisational performance. To accomplish this, line managers need resources, skills assessment and training (Shipton et al., 2016). To enhance the effective commitment level, management and supervisors can implement various HRM practices, including career and skill development, job promotion, formative performance management and fair reward systems. By implementing such practices, care institutions can demonstrate that they value the contributions of staff and care for their well-being. Furthermore, fair management and supervision procedures – such as employee participation in decision making, transparent performance appraisal and opportunities for training and career development – can enhance the perception of procedural justice (Sharma & Dhar, 2016).

There are certain HR practices that enhance employee commitment. For example, improving pay strategies has value for care workers in reducing staff turnover, as care workers feel that their pay is unfair for the work they do. As there are limits to increases in payment, other factors, such as work autonomy, training possibilities and good practices in managing working time are likely to

improve employee commitment. For example, opportunities for training make employees feel valued by their employer, and because of this care, workers feel committed to their employer. Commitment relates to the nature of the work and, in particular, the opportunities to help people (Rubery et al., 2011).

Performance and Quality of Care as HRM Outcomes

There is a clear link between effective HRM practices and employee performance, but there is no certain way for HRM to improve performance, as performance depends on a number of things, including specific organisational goals and, especially, context. HR practices are most effective when they are analysed as systems of practices that have synergistic effects beyond the individual practices (Sánchez, Marin & Morales, 2015). Performance reviews are practiced and valued among care providers. Managers see performance reviews as effective mechanisms for monitoring progress and communicating, identifying and supporting training needs and reviewing overall performance based on achieving the previous year's key objectives. Employees also value performance reviews as well as training and opportunities to upgrade their qualifications (Atkinson & Lucas, 2013.) Relevant HR outcomes influencing organisational performance are work environment, financial and non-financial rewards and working conditions (Sharma & Dhar, 2016). Boselie (2010) also includes employee commitment, employee absence, level of stress, employee satisfaction, motivation, trust and perceived organisational justice. Client satisfaction, together with efficiency and professional quality are some of the main performance indicators (Ott & van Dijk, 2005). In addition, intrinsic factors and rewards like autonomy and job content are highly valued among care workers (Clarke, 2015; Rubery et al., 2011).

Quality of care is an important indicator of the performance of a care organisation (Cooke & Bartram, 2015; Rubery et al., 2011), and HR practices are important in ensuring that the staff achieve a high quality of care (Atkinson & Lucas, 2013; Leggat et al., 2011; Ekholm, 2012). Improving a range of HR outcomes (e.g. job satisfaction, engagement, retention and knowledge sharing) will positively affect the quality of care that an organisation's workforce provides (Cooke & Bartram, 2015). For example, employee commitment and engagement are seen as prerequisites for high performance and quality of care (Sharma & Dhar, 2016; Shipton et al., 2016). Designing and implementing HR practices in ways that are perceived positively by employees is necessary for promoting the interpersonal aspects and quality of care, like treating patients with courtesy, dignity and respect (Baluch, Salge & Piening, 2013). In health care, the functioning of relevant HRM systems should be improved as one important means for achieving good quality of care (West, Guthrie, Dawson, Borrill & Carter, 2006).

HRM processes have an effect on the continuity of quality patient care (Townsend, Lawrence & Wilkinson, 2013). One important HR process to achieve the desired level of performance and quality of care is the development of personnel. Skills training, general training, and task enrichment and employee participation are important HR practices for creating a high performance work climate (Boselie, 2010). Training and competence development are widely practiced in the care services (Atkinson & Lucas, 2013). According to Freire and Azevedo (2014), managers should invest in employee training, value and recognise employee experience and expertise, share information openly and honestly, and create autonomous work units. Also, reward systems should value knowledge and expertise. In HRM, it is of crucial importance to provide open and honest access to information about organisational policies.

Discussion

High-quality care, continuity of care and controlling labour costs at the same time are crucial challenges for HRM in the care sector (Cooke & Bartram, 2015; Townsend et al., 2013). The key HR issues in the health and social care sector chosen for this article were the role of line managers, employee commitment, and employee performance and quality of care. As HRM practices can create a high performance work climate (Boselie, 2010), it is important that future managers have studied HRM theory and practice in order to understand the impact of human resources. Line managers are responsible for putting HRM policies into practice and for ensuring that employees have the knowledge, competence and skills needed to perform their jobs, are committed and motivated and feel safe and secure. The main goal of HRM is the same as the overall goal of management: to support the organisation's viability, effectiveness and productivity. In other words, the clients receive the care they need with good quality, and the services have positive effects on their health and social well-being. In addition, with good HRM policies and practices, the care sector will attract new employees to social and health care.

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II Knowledge Management and its Application in Health and Social Care Organisations

Mikko Mäntyneva and Päivi Huotari

Introduction

Managing organisational knowledge and developing competence is a constant theme of health and social care organisations. Health and social care organisations are typically extremely knowledge intensive, requiring highly qualified professionals from a range of professions. These professionals must both act independently and work together with others. The main challenge is for the health or social care organisation to provide excellence of care and services to its patients or clients. Knowledge management emphasises both a leadership and management perspective. Both these approaches support the other in achieving better outcomes through the management of knowledge and the development of competence within an organisation. This article covers the background to the management of knowledge and competence and their application in improving the effectiveness and efficiency of health and social care organisations.

Learning outcomes

Having read this chapter, a student should be able to:

- Explain and understand the concepts of knowledge management and competence development.
- Define and understand knowledge management as a process.
- Define the main challenges to knowledge management in health and social care.
- Explain and understand the link between knowledge and competence development.

Knowledge management – an introduction

Knowledge is central to the value-generating activities of professional services such as health and social care. Sanches (2003) implies that one of the main purposes of knowledge management is to make it possible to share knowledge between organisational units and individuals within an organisation. Knowledge exists within the individual members of an organisation or within the organisation itself as a collection of knowledge (Nonaka, 1994). Knowledge management deals with organising knowledge and making it available where it is most needed. Awad and Ghaziri (2004, p. 27) say that the following themes are typical to the practice of knowledge management:

– Knowledge is accessed and used from outside sources.
– Knowledge is embedded in operational processes and services.
– Knowledge is represented in databases and documents.
– The organisational culture promotes and supports knowledge creation.

– Knowledge is shared and transferred throughout an organisation.
– Knowledge assets are valued on a regular basis.

Davenport and Prusak (1998) define knowledge as personalised information in an organisational setting, which is related to facts, processes, procedures, concepts, ideas, interpretations, observations and judgments. Knowledge is organised, collected and embedded in the context of application, and this differentiates it from information.

Nonaka (1994) defines knowledge as justified belief that increases an individual's or group's capacity for effective action. In addition, it is based on the truthfulness of the concept. This means knowledge is based on trust, which relates to the source of the knowledge. Knowledge is often divided into two categories, explicit and tacit. Awad and Ghaziri (2004) define explicit knowledge as a codified form of information that can be printed or digitised in documents, books, sheets, memos, training materials, etc. Tacit knowledge is highly personal by nature. This makes it difficult to formalise and communicate to others. From the perspective of operational knowledge management, it is assumed that explicit knowledge is easier to store, retrieve and distribute than tacit knowledge.

In order to manage knowledge efficiently, it is beneficial to have it in a format that can be utilised in operations. Botha (2008) suggests that this is achieved through such activities as classification, mapping, indexing and categorising, so that it can be stored, navigated and retrieved. Knowledge management within organisations is described as a cyclic process (Dalkir, 2005). This cycle consists of three main phases: 1) knowledge creation, 2) knowledge sharing, and 3) knowledge application.

Knowledge creation

The organization needs to identify existing knowledge, which may be generated from various sources. Knowledge that is considered valuable from an operational or even strategic perspective should be prioritised in allocating resources for codifying that knowledge. In practice, this means that within an organisation it is not necessary to codify or transfer all existing knowledge. The main reason for knowledge sharing is that it improves the performance of both the organisation and the individual. If the knowledge sharing process is not successful, it is likely to have harmful effects on performance.

Knowledge sharing

Organisational knowledge is a critical resource for creating value. Davenport and Prusak (1998) emphasise that organisations ought to organise their knowledge-related resources effectively, thereby making it possible to capitalise them. This means that it is not enough that issues related to personnel training and staffing are in order. Knowledge contained within organisations will increase in value when shared (Dalkir, 2005).

Zawawi et al. (2014) define knowledge sharing as social interaction involving the exchange of knowledge, experience and skills. Abu-Shanab, Haddad, and Knight (2014) state that the sharing of knowledge involves various organisational actors who have the intention of exchanging knowledge and experience and wish to be influenced by the knowledge and experience of others. This is in line with the interpretation of Allameh, Abedini, Pool and Kazemi (2012), who suggest that the principal goal of knowledge sharing within organisations is to transform individual knowledge and experience into organisational knowledge resources. This is expected to increase organisational effectiveness. Cabrera and Cabrera (2005) consider knowledge sharing to be an essential strategic capacity, which makes it possible to capitalise on knowledge-based resources.

In an international setting, knowledge management may prove more difficult in some cultures than in others. Glisby and Holden (2003) emphasise that cultural differences may affect knowledge transfer. This mainly has to do with how knowledge is socialised within an organisation. Organisations in countries with a high level of collectivism are usually more successful at knowledge transfer. Awad and Ghaziri (2004, p. 250) emphasise three things to take into account when transferring knowledge: 1) the origin of the knowledge, 2) the tools for transferring the knowledge, and 3) the destination of the knowledge.

The origins of organisational knowledge can include lessons learned from previous activities; written documentation in the form of books, articles and documents; and various types of databases. In order to make the lessons learned more transferable, they ought to be codified. The tools used to transfer knowledge include the internet, video- and tele- conferences, training sessions and meetings. The target group for the transferred knowledge should also be considered: it matters whether it is an experienced professional or an apprentice who will receive the transferred knowledge. Furthermore, potential external target groups, such as customers and other stakeholders, require a cleaner and more finalised form of the relevant knowledge. For internal target groups it may be somewhat rougher. It is important that the organisational culture supports and encourages knowledge sharing. In order to be successful, knowledge management activities must include knowledge sharing. The direction of knowledge sharing may be either pull or push. The pull option takes place, for example, when an individual within an organisation actively seeks knowledge through asking or through an information query. The push option in knowledge sharing may be illustrated by existing knowledge being pushed towards users through the intranet homepage, an organisational newsletter or by other relevant means (Dalkir, 2005).

Knowledge application

An organisation's ability to both create and apply new knowledge is important for a successful knowledge management process. Information, which is a codified form of knowledge, is essential to successful knowledge management. However, the greatest managerial challenge remains how to transform information into effective decision-making and operational processes. Information technology provides a logical approach to storing data and transforms it into information. However, from the perspective of knowledge management, information technology and its possibilities are often underutilised. Knowledge management should be a vital support process in every organisation. However, it is important that the person who acts as process owner, responsible for knowledge management, strongly emphasises the application of that knowledge. Without application, the potential investment in capturing, codifying, storing and sharing knowledge is not worth the effort (Dalkir, 2005).

Knowledge Management in Health and Social Care

In this section, we outline some relevant research findings and literature that can provide an understanding of knowledge management in health and social care. Under the concept of knowledge management, we include knowledge and competencies and their management and development. We focus on three overlapping themes: a strategic approach to knowledge management, knowledge and competence management, and the manager's role in knowledge management.

Change and reorganisation will inevitably require a greater emphasis on knowledge management in the future. As Williams (2012) states, moving towards a more coherent and integrated health and social care system creates challenges that relate to knowledge management. The process of integration provides occasions for learning, and with colleagues, the opportunity to pool

knowledge. However, there may not be a planned, coherent or purposeful strategy for knowledge management despite the fact that it is fundamental to reform. Knowledge management requires a strategic context and a shared purpose, managing across organisational and professional boundaries, improving communication and understanding between different cultures, clarifying roles and responsibilities and searching for a common purpose through new models of service (Williams, 2012).

Most studies on knowledge management have focussed on health care, and there is limited research into knowledge management in social care. Leung (2014) argues that knowledge management in social services is a new management area. Knowledge management in the context of health and social care can be defined in various ways. Laihonen and Sillanpää (2014) define knowledge management as managing information and information processes, which includes the gathering, combining and using of performance information. Tzortzaki and Mihiotis (2014) define knowledge management as a social process, in which the focus is on encouraging the creation of new knowledge through the voluntary sharing of knowledge within organisations, between organisations and with external partners. Sibbald, Wathen and Kothari (2016) highlight the importance of the internal and external context, and of knowledge seeking, synthesis, sharing and organisation.

Knowledge management is part of strategic human resource management. This management process enables an organisation to respond to its environment and to reflect overall strategy. Employees' knowledge and competencies are human capital and must be managed. Research findings on knowledge and competence management emphasise the strategic approach (Sánchez et al., 2015; Ollila & Vartiainen, 2014; Huotari, 2009; Kivinen, 2008). Strategic knowledge and competence management include mastering strategic wholeness, so that line managers are able to operationalize core ideas by utilising the knowledge and competencies of employees (Huotari, 2009). To move an organisation towards strategic goals, knowledge management requires a culture of overarching guidance and supportive leadership (Sibbald & Kostari, 2015). Strategy indicates which competencies are strategically important to recruit and retain (Lammintakanen, Kivinen & Kinnunen, 2008). The strategic goals at national, regional and organisational levels need to be considered as factors that direct knowledge management activities.

Research findings show that challenges are experienced in differing areas of knowledge and competence development in care services. Ollila and Vartiainen (2014) argue that everyone needs to take responsibility for the development of at least some of his or her own professional and cognitive skills and competencies. The responsibility does not lie only with the managers. Collaboration within and across organisations is key in knowledge creation and sharing (Tzortzaki & Mihiotis, 2014), since some aspects of knowledge can only be shared and learned through people-to-people interactions (Leung, 2014). Informal group level practices, such as discussions with colleagues, are widely used especially inside units (Kivinen, 2008; Lammintakanen et al., 2008), but knowledge sharing and transfer between units and other organisations is insufficient. The creation of knowledge and personnel development often focus on individual level practices and on the needs and interests of particular individuals or professions (Kivinen, 2008; Lammintakanen et al., 2008); this means that individual knowledge is not well capitalised at the organisational level (Kivinen, 2008). Augustsson, Törnquist and Hasson (2013) argue that even extensive workplace learning initiatives can be inefficient in advancing individual learning to become organisational learning. Currie, Burgess and Hayton (2015) suggest that putting members of different professional groups together, as in multidisciplinary teams, would enhance and motivate knowledge sharing in health care. Leadership needs to create environments supportive of social interactions, which would be conducive to knowledge capturing and sharing, especially between departments and across organisational structures (Sibbald & Kostari, 2015).

A considerable amount of knowledge sharing and learning occurs between colleagues on an entirely informal basis. Professionals share their own and colleagues' experiences, and they share in interactions with other professionals, leaders and patients. They largely use sources of tacit knowledge, and tend to use knowledge drawn from practice (Williams, 2012; Gabbay & May, 2004). Experiential, informal learning, such as the transferring of tacit knowledge between different professional groups, is important in health and social care, for example through shadowing and allowing staff to observe practice in action. Knowledge sharing can be facilitated by a co-location of services, which expose different professionals to one another on a regular and face-to-face basis (Williams, 2012).

According to Lammintakanen and Kivinen (2012), health care organisations offer many opportunities for continuing professional development. From their research findings, they state that nurses do not use these opportunities in a systematic way. Managers need to discuss professional development with staff members; for the younger employees, particularly, this can convey a positive signal of being valued. Because the number of nurses is diminishing, there is a need for better utilization of competencies and skills, and nurse managers need to systematically collect information about their staff's competencies and to identify management tools (Lammintakanen & Kivinen, 2012). Sibbald and Kostari (2015) add that another challenge to knowledge sharing is the constraint on resources, which frequently serves as a barrier to exploring avenues for making tacit knowledge available. Knowledge seeking and knowledge synthesis are often done in an ad hoc manner; this makes capturing and organising the outcomes for knowledge use a challenge. Sibbald and Kostari (2015) recommend that knowledge sharing should be more formalised.

As knowledge and competency management is partly based on the needs and interests of the individuals or professions involved, strategic organisational needs may be underestimated. Organisational issues are not easily resolved through knowledge sharing or through learning organisational systems. However, organisational culture, leadership and resources are instrumental in supporting the knowledge management process (Sibbald et al., 2016). Managers need to regard staff learning, the implementation of learning activities and new ways of working as central to caring work (Augustsson et al., 2013). Managers can lead through example, behaving in ways that convey both tacit and explicit knowledge (Shipton et al., 2016) by investing in employees' training and valuing and recognising their experience (Freire et al., 2015). The starting point for improving knowledge sharing and knowledge creation is that managers and staff need a common vision for workplace learning. In addition, managers and employees all need to take ownership and responsibility for knowledge transfer (Augustsson et al. 2013), and thereby create a more collective and strategic learning and knowledge sharing culture rather than a profession-based working culture (Lee, Kim & Kim, 2014; Lammintakanen et al., 2008). This means developing an organisational climate that embodies trust, openness and diversity of opinions, and promotes knowledge sharing and the creation of new organisational knowledge (Kivinen, 2008). The value of trust and inter-personal relationships is highlighted especially in relation to tacit knowledge exchange (Williams, 2012). Managers find it is more effective to motivate subordinates to transfer their experience and talent voluntarily to the organization. Concerning human capital, through good management, knowledge organisations can improve the communication and synergy between key employees, such as knowledge workers, and ensure their retention. Knowledge management can enable organisations to focus on their core business and on critical company knowledge (Tzortzaki & Mihiotis, 2014). Participation in organisational learning initiatives creates feelings of recognition, pride and autonomy. In addition, it is time saving, reduces stress at work, standardises practices, provides continuous support to employees and encourages reflection (Gagnon et al., 2015).

Managerial implications of knowledge management

In order to improve knowledge management in organisations, the following should be encouraged:

1) New knowledge must be created internally within the organization;
2) Both formal and informal flows of knowledge among teams and individuals need to be endorsed;
3) Knowledge should be codified, as this supports transfer, sharing and learning;
4) New external sources of knowledge should be accessed.

Health and social care operations often cross organisational boundaries. Organisations frequently work through networking, and thus access each other's knowledge resources. This means that knowledge management initiatives do not have to depend on the knowledge existing within one organisation only. Botha (2008) suggests that knowledge management within a networked setting mainly involves providing relevant information, based on internal knowledge resources, and encouraging knowledge integration and sharing with other organisations.

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III Quality Management

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Introduction

The purpose of this chapter is to enable registered health and social care practitioners to assume a clinical and/or a professional leadership role in quality management in the health and social care sectors. The contents in this chapter will strengthen the management competences of practitioners working in these sectors, including critical thinking, critical reflection, problem solving and decision-making, thus improving the quality in health and social care services.

Learning Outcomes

Having studied this chapter, the student should be able to:

- Define the quality in social and health organizations;
- Define the planning process to implement quality of care at the organizational level;
- Understand the tools available for quality assurance;
- Understand continuous quality improvement processes;
- Analyse quality systems in social and health care organizations.

There is recognition of the importance of those leading health and social care organisations "to raise the quality of services and to improve the health and social wellbeing of the people" (Department of Health, Social Services and Public Safety, 2006, p. 2). However, the concept of quality has different meanings for different individuals, depending on what one considers and/or expects to get or achieve. Quality emerges as an inseparable requirement of health and social care systems (Martin, Henderson & Charlesworth, 2010). This inseparable requirement, in our view, is related to the relevant social, political and economic impacts of the health and social care sector and has therefore received increasing attention from the responsible entities.

This chapter incorporates an examination of key quality management practices within the context of health and social care organisations focusing on quality planning, quality assurance and continuous quality improvement in social and health care.

Quality and Quality Planning

Quality definition and quality planning are justified because all professionals should understand the cause and effect relationships between their organisation's actions and the results achieved. Because quality has an impact on the outcomes delivered by health and social systems, it is imperative that decision-makers, planners and professionals at all organizational levels have knowledge on how to make informed strategic and scientific choices for quality improvement. All organizations should provide high quality care for everyone, however, quality might have many meanings, for example: a degree of excellence; conformity with

requirements; fitness to use; fitness for purpose; customer's satisfaction; and the totality of characteristics of an entity that bear on its ability to satisfy stated or implied needs (Hoyle, 2011).

All stakeholders involved in the delivery of health and social care services are important to attain good quality. Quality may be divided into two main dimensions that are conceptually different: quality of products and quality of services (Hoyle, 2012). The importance of product characteristics used in care delivery cannot be neglected. Nevertheless, this work will focus only on the quality of services. The most common characteristics of service quality are: accessibility; accuracy; courtesy; comfort; competence; credibility, dependability; efficiency, effectiveness; flexibility; integrity; responsiveness; reliability and security (European Commission, 2014).

To provide quality services or *to do the right things in the right way*, it is imperative to understand the purpose. The International Organization for Standardization (ISO, in Hoyle 2011) defines purpose as a comprehensive and fundamental rule or belief for leading and operating an organization to success that must respect at least eight quality management principles: customer focus, leadership, involvement of people, process approach, system approach, continual improvement, factual approach to decision making and mutually beneficial supplier relationships (ISO, 2012). In management science, to plan is the first step that drives all organizations. Without a good plan, good performance or results cannot be assured. The steps for good quality planning are: the establishing of goals; identifying who is impacted by these goals; determining the needs of the stakeholders; developing products or services to fulfil the needs of those stakeholders; developing processes able to produce, promote and distribute the product features; and establishing process controls, as well as transferring the plans to the operation forces (Hoyle, 2011).

To plan quality management, it is necessary to work within a good framework that provides the guidelines to understand and manage its complexity and include all the necessary requirements for quality. One of the most common frameworks applied to health and social care is the Excellence Model of the European Foundation for Quality Management (EFQM). The designed EFQM Excellence Model "allows people to understand the cause and effect relationships between what their organisation does and the results it achieves" (EFQM, 2013, p. 2).

Many other factors have contributions to quality at macro, meso, micro and nano levels, and many disciplines – not only scientific and technological knowledge but also new organizational conceptions and communications strategies and tools – make their contributions.

Quality Assurance

Quality assurance, to the ISO, is about providing confidence that quality requirements will be fulfilled (Hoyle, 2011, p. 60), or is "the measurement of the actual level of the service provided plus the efforts to modify, when necessary, the provision of these services in the light of these results of the measurement" (Williamson, 1979, in Sale, 2005, p. 1). To understand the main quality activities that drive quality assurance the following subjects were selected: effectiveness and efficiency; risk management and safety; standards and measurement.

Effectiveness is one of the main aspects of quality assurance and can be defined as the degree to which the organization ensures that the best practice, based on evidence, is used in the organization and that interventions do what they are intended to do (Sale, 2005). Social and health care delivery must be clinically and cost-effective (efficiency) because the costs of care are increasing every day. Clinical guidelines can be used to assist practitioners and the customer to make the best decision in a specific situation and are developed mostly by scientific societies and professional organizations, but also by government insti-

tutes such as NICE (National Institute for Health and Care Excellence – https://www.nice.org.uk/). Evidence can also come from: clinical experience, patients, clients, carers, local context and environment.

Risk management in healthcare is the systematic identification, assessment and reduction of risks to patients and staff through: a) the provision of appropriate, effective and efficient levels of patient care; b) the prevention and avoidance of untoward incidents and events; c) the adoption of the lessons learned and the changing of behaviour or practices as a result of near-miss incidents and adverse outcomes; d) the communication and documentation of care in a comprehensive, objective, consistent and accurate way (Sale, 2005).

Clinical risk management can be seen as having three component parts: a) identifying risk; b) analysing risk; and c) controlling risk. The identification of risk is achieved through the analysis of data collected about accidents, near-miss incidents and the results of systematic service reviews. The three components of clinical risk management can be developed into a risk management cycle similar to the quality assurance cycle and the audit cycle (Sale, 2005). In addition, the leadership team should ensure that there are sufficient resources to meet the requirements of the organisation and systems to effectively mitigate, control and manage all risks, and that attention is focused on the core business of the organisation – to care for and treat consumers / patients in a safe and high quality clinical environment (ACHS, 2013).

Another important aspect of quality assurance is *standard definition.* According to the UK's Department of Health, Social Services and Public Safety (2006), "A standard is a level of quality against which performance can be measured. It can be described as 'essential'– the absolute minimum to ensure safe and effective practice, or 'developmental' – designed to encourage and support a move to better practice." (p. 2). The importance of standards is to:

> "Give Health and Personal Social Services (HPSS) and other organisations a measure against which they can assess themselves and demonstrate improvement, thereby raising the quality of their services and reducing unacceptable variations in the quality of services and service provision; enable service users and carers to understand what quality of service they are entitled to and provide the opportunity for them to help define and shape the quality of services provided by the HPSS and others; provide a focus for members of the public and their elected representatives to assess whether their money is being spent on efficient and effective services, and delivered to recognised standards; help to ensure implementation of the duty the HPSS has in respect of human rights and equality of opportunity for the people of Northern Ireland; and promote compliance, and underpin the regulation and monitoring of services to determine their quality and safety and to gauge their continuous improvement." (Department of Health, Social Services and Public Safety, 2006, p. 3).

The accomplishment of the standards of the chosen system can give the organization a quality certification. The National Institute of Standards and Technology (2015_2016) defined seven key areas of the organization: leadership; strategic planning; customer and market focus; information and analysis; human resources; process management; and business results.

Quality control is the oldest quality concept. It refers to the detection and elimination of components or final products that are not up to standard. It is an after-the-event process concerned with detecting and rejecting defective items. As a method of ensuring quality it may involve a considerable amount of waste, scrap and reworking. Quality controllers or inspectors usually carry out quality control. Inspection and testing are the most common methods of quality control, and are widely used in health and social services, education, and so on, to determine whether the standards are being met.

There are seven basic tools of quality control, first emphasized by Kaoru Ishikawa, a professor of engineering at Tokyo University and the father of "quality circles" (Tague, 2004):

- *Cause-and-effect diagram* (also called 'Ishikawa' or 'fishbone' chart): Identifies many possible causes for an effect or problem and sorts ideas into useful categories;
- *Check sheet*: A structured, prepared form for collecting and analysing data; a generic tool that can be adapted for a wide variety of purposes;
- *Control charts*: Graphs used to study how a process changes over time;
- *Histogram:* The most commonly used graph for showing frequency distributions, or how often each different value in a set of data occurs;
- *Pareto chart*: Shows on a bar graph which factors are more significant;
- *Scatter diagram:* Graphs pairs of numerical data, one variable on each axis, to look for a relationship;
- *Stratification:* A technique that separates data gathered from a variety of sources so that patterns can be seen (some lists replace 'stratification' with 'flowchart' or 'run chart').

These tools can be used to gauge performance against standards and also provide comparable measures over time.

Continuous Quality Improvement

Quality improvement has a long history in organisational thinking and practice and many changes related to quality improvement have occurred in recent years in European countries (the development of the Service Excellence Frameworks, the Quality Standards, and the accreditation systems). Despite all these systems, the quality of services is not something implied, given or fixed. As such it is mandatory to ensure that organisations systematically and intentionally improve services and increase positive outcomes. Continuous quality improvement (CQI) is a systematic approach, a "*management philosophy and a management method*" (McLaughlin, McLaughlin & Kaluzny, 2004, p. 8) that may be used to describe, assess, evaluate and improve an existing service, practice or product (Radawski, 1999).

Quality Improvement is also defined as "a structured, organized organizational process for involving personnel in planning and executing a continuous flow of improvements to provide quality care that meets or exceeds expectations" (McLaughlin et al., 2004, p. 8). In this definition all the basic assumptions of CQI are present. The principal ones relate to people, who are at the core of CQI. CQI recognises internal and external "customers" (Graham, 1995). While external customers include clients or patients and their families, but also the local community or external contractors; internal customers include all professionals. On one side, the CQI has a substantive requirement to involve the staff in the process of quality improvement (and thus build an organisational commitment to quality through the quality activities: the description of the processes, their monitoring and the application of the changes). As such, while the process is managed from the top, the changes are implemented from the bottom. On the other side, instead of the individual, CQI emphasises the organisation, systems and processes when considering improvement opportunities (Graham, 1995). The staff are not primarily seen as the source of problems or mistakes; CQI assumes that most of the problems in organisations lie in processes, not in people (Graham, 1995).

CQI is also a flow – an endless, cyclical process based on the experimentation or variation testing of proposed changes on the level of everyday processes. For affirmation that changes really bring improvement, objective information is mandatory in CQI; the data are gathered to analyse and improve processes (Graham,

1995). CQI is a method of management that uses a scientific methodology; it is management by fact (Goldstone, 1998).

CQI, as a management philosophy, also assumes that most things can be improved through small incremental steps and that opportunity for improvement exists in every process. It requires an organisational culture where mistakes are seen as opportunities and where improvement is a natural part of the everyday work. With this assumption, CQI is a very proactive (not reactive) approach, supposing that incidents and problems can be prevented and that it is better to monitor and improve services than wait for something to go wrong and then fix it (Maher & Penny, 2005).

Plan-Do-Study-Act (PDSA) Cycle

A number of methods, often represented by a cycle or diagram, can be used to apply CQI. The best-known method of CQI is the four-step PDCA/PDSA cycle, also called the Deming circle, the Deming wheel, control circle or cycle, or plan–do–study–act cycle. Originally used in business, but applicable in all types of organisations (Moen & Norman, 2006), in recent decades it is the most commonly used approach for rapid cyclical improvement in healthcare (Varkey, Reller, & Resar, 2007). The concept of PDCA (Plan, Do, Check, Act) was published by W. E. Deming in the 1950s. Later, Deming modified PDCA to PDSA – Plan, Do, Study, Act – because he thought that "C" for "check" emphasised inspection rather than analysis (Moen & Norman, 2006). This method is characterised by a testing, sample approach in which the improvement, an examined solution, new approach or new practice is tested on a small scale before any changes are applied to the whole system (Berwick, 1998; Langley et al., 2009). The PDSA cycle has four phases (Figure 1).

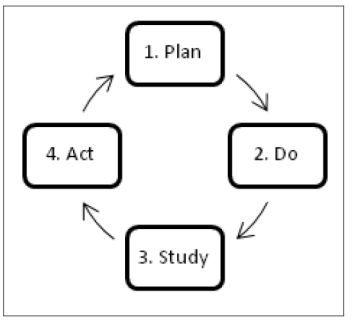

Figure 1. Phases of the PDSA cycle (Moen & Norman, 2006)

The first phase – "Plan" – means the planning of improvement. At the beginning it is necessary to understand how ***the process (***treatment, care, support process) works at present and identify exactly the problem to be addressed. Then a potential solution can be developed and formulated. For this solution, the changes to be made and the goal of the improvement must be defined, and then a plan for the implementation of the change has to be prepared. The second phase – "Do" – means realising the change, implementing the potential solution. In this phase the solution will not be fully implemented – the changes are to be tested on a small scale. During the implementation phase, monitoring, gathering of data and documenting of both the process and the outcomes is mandatory (Maher & Penny, 2005). In the third phase – "Study" – the results of the testing phase will be considered. The data is analysed and the results are compared with the original goals or the predicted outcomes with the actual ones

(Maher & Penny, 2005), in order to draw a conclusion and decide if the expected benefits were achieved. Depending on the success of the pilot project and the number of areas that needed improvement, a decision on implementation or redefinition of the solution – by incorporating other improvements and repeating the testing – should be made. The fourth and final phase – "Act" – means adopting the change, fully implementing the solution into the whole system if the pilot test succeeded, or abandoning it otherwise. This phase is crucial for maintaining the change in practice. It is necessary to establish the systems and support them through the integration of the change in the organisational culture (Maher & Penny, 2005).

By repeating this cyclical testing of improving solutions, a better quality of healthcare or social services may be achieved. This strategy minimises the risk of the implementation of an inappropriate solution to the whole organisation. Furthermore, the PDSA procedure supports acceptance of the change by the staff because they have been involved in the process, because of the time they have to understand the goals of the change and because of the procedures to increase the credibility of the change through testing and improving of solutions in the real practice of the organisation. Therefore, the PDSA cycle may serve as a method eventually adaptable to the conditions and specificities of the organisation, thus developing the quality management strategy to fulfil the requirements and take advantage of the CQI approach.

Findings in Social and Health Care Context

As a means to justify the value of Quality Management we tried to identify studies that relate any of the different components and find whether effectiveness in health and/or social care has been proven, regardless of the models implemented. As a reference we can refer to the work 'Deepening our Understanding of Quality Improvement in Europe project (DUQuE)' by Sunol et al. (2015, p. 2) where the authors found that "there are significant gaps between recommended standards of care and clinical practice in a large sample of hospitals". Moreover, implementations of department-level quality strategies are significantly associated with good clinical practice. In the same project, Groene et al. (2015, p. 2) found an "absence of, and wide variations in, the institutionalization of strategies to engage patients in quality management or implement strategies to improve patient-centeredness of care… suggests that patient-centred care is not yet sufficiently integrated in quality management".

Despite this assertion, it was found that many hospitals of the DUQuE project have now obtained the ISO 9001 certification and have launched policy management initiatives and improvements at the organizational level. Subsequently, some management indexes have been improved, as has health care quality (Munechika, Sano, Jin, & Kajihara, 2014). Another study that compares evaluations made by care standards inspectors, based on the experience of residential care, concluded that "national minimum standards and modernization of inspection methods recently announced by the Department of Health and the Commission for Social Care Inspection are timely and appropriate" (Beadle-Brown, Hutchinson, & Mansell, 2008, p. 210).

It was found that different methods of training for quality assurance (QA) effectiveness can decrease the cost/care process significantly (Cánovas, Hernández, & Botella, 2009). As such, "Internal QA programmes should be incorporated into the professional culture of health institutions and routine activities in the health teams daily work should be encouraged and given incentives by the system, as they may have an improvement effect on the care provided to patients" (Cánovas, et al., 2009, p 818).

Another important aspect of quality management is patient safety. Indeed, positive correlations exist between total quality management and patient

safety management, as well as between patient safety and service quality (Tsai & Wu, 2013).

These studies justify the investment in quality management programmes in health and social care organisations in its different aspects, as it improves the quality of the service and greatly benefits all the involved agents, especially customers.

Discussion

Quality management is a continuous process of planning, implementation and evaluation of quality assurance structures, systems, procedures and activities, focused on human factors and assuring the deployment of motivational and quality culture. The success depends on the commitment of everyone and this will increase with training, safety and worker involvement in product and services development (Sallis, 2002; Coote, 1993; Donabedian, 1988; Setbon, 2000; Mezomo, 2001).

To transfer quality of care as a scientific process to health and social care structures requires a major reorganization of the entire system's procedures. The quality of health and social care is not restricted to observance, development and application of technical factors. In fact, it also involves other problematic areas of modern and developed societies, such as: extending the quality of care to other dimensions beyond the technical one; the use of quality concepts and standards to regulate the "distribution" of health and social services; and, last but not least, the value of professional groups in the evolution of quality of health and social care (Amar, 2000; Revez & Silva, 2010; Malley & Fernández, 2010), which has proven difficult to assess.

In the coming years, tighter public budgets – due to greater pressure to cut costs and the challenge upon governments to prove to taxpayers that they can do more with the available resources – will encourage further development of quality measures (Malley & Fernández, 2010).

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IV Intercultural Management

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Introduction

Globalization has increasingly brought permanent contact with people whose cultural background is different from what many would consider their 'own' culture. The area of intercultural management is of critical interest due to the impact of increased European and global migration, which has required health and social care leaders and managers to develop competency to respond to the diversity and changing needs of their workforce and service users. The communities within the European Union are now often characterised by significant diversity whether at cultural, social, or psychological levels. The purpose of this chapter is to enable health and social care practitioners to assume a clinical/professional leadership role in quality intercultural management in the health and social care sector.

This chapter will focus on developing health and social care practitioners' knowledge and understanding in the area of intercultural management within contemporary health and social care organisations. It will focus on the critical application of knowledge to practice through the provision of underpinning knowledge, understanding and debates surrounding contemporary issues and practices in the areas of intercultural management. Many practitioners accessing this information may already work in the heath/social sector and this critical focus on intercultural and diversity management has the potential to improve the quality in health and social care services through the critical application to practice.

Learning Outcomes

This chapter will focus on providing information to allow the reader to meet the following learning outcomes:

- Describe and explore the theoretical and research-based knowledge on intercultural dimensions in health and social care management;
- Analyse the influence of socio-cultural dimensions on organisational culture and practice;
- Produce and evaluate good communication and information in multicultural settings in health and social care management;
- Critically reflect on intercultural management practice and its role in meeting strategic, organisational and professional objectives;
- Demonstrate commitment and respect to difference in multicultural teamwork.

This chapter will be organised into core units that will enable readers to critically analyse each topic area and reflect upon practice, including that of organisations within the health and social care sectors.

Part 1: The theoretical background to diversity and intercultural management
Part 2: Intercultural communication
Part 3: Implementing intercultural management in practice

Intercultural, cross-cultural, multi-cultural and transcultural management in Health and Social Care

Theoretical Background

This section will focus on the relevant underlying theories, which have been researched and conceptualised by several authors. One of the most well-known is Hofstede (1983, 1984). His research on cultural differences began in the late 1960's and his research on cultural differences has continued for more than 40 years. According to him, culture is "the collective mental programming of the mind, which distinguishes the members of one group from another" (Hofstede, 1983).

Hofstede's initial research was carried out in more than 50 countries and initially found four dimensions in which cultures distinguish: (1) power distance, which was defined as "the extent to which the less powerful person in a society accepts inequality in power and considers it as normal" (Hofstede, 1984, p. 390); (2) uncertainty avoidance, described as "the extent to which people within a culture are made nervous by situations that they consider to be unstructured, unclear or unpredictable and the extent to which they try to avoid such situations by adopting strict codes of behaviour and a belief in absolute truths" (Hofstede, 1984, p. 390); (3) masculinity, which was defined as "masculine cultures use the biological existence of two sexes to define very different social roles for men and women. (…) Feminine cultures, on the other hand, define relatively overlapping social roles for the sexes" (Hofstede, 1984, p. 390); (4) individualism, which was defined as "individualist cultures assume individuals look primarily after their own interests and the interests of their immediate family (…). Collectivist cultures assume that individuals (…) belong to one or more close 'in-groups', from which they cannot detach themselves" (Hofstede, 1984, p. 390).

Afterwards, when Hofstede extended his research to Asian countries, a fifth dimension was added: (5) long-term orientation vs. short-term orientation (Minkov & Hofstede, 2012). These two poles of the fifth dimension are proposed to express the focus on 'virtue' on one hand and the focus on 'truth' on the other hand. The words synthetic and analytical seem to be representative of these two sides. Within cultures where long-term orientation is higher "what works is more important than what is right" (Hofstede & Minkov, 2010, p. 497).

Finally, a sixth dimension was added to the model as it was not covered by those previously mentioned: indulgence, which means the culture emphasizes human drives to enjoy life, as opposed to restraint, meaning "suppression and regulation of human drives" (Hofstede, 2016, p. 174).

Utilising this model, culture is conceptualized with four levels of expression, with the deepest level expressed as values and the content changing very slowly over time. The six dimensions previously described, as culture values, have implications for practices within cultures. The second level expresses rituals, corresponding to the way certain actions are carried out within a culture; for example, having a medical consultation. The third level corresponds to heroes: Who are the people admired by those belonging to a specific culture? Finally, the outermost level of culture corresponds to symbols that are used and have specific meanings within a culture (Hofstede, Neuijen, Ohayv, & Sanders, 1990).

When approaching management in health and social care organisations through Hofstede's Model there are new ways that may emerge of looking at what happens in daily life inside and outside the organization. We will present a summary of results found in three studies, which have approached relevant intercultural concepts and examined their impact for health and social care management. The first one focused cultural characteristics of medical consultations

in a cross-cultural comparison. Following this we present the contribution of Hofstede's Model for having insightful perspectives on the quality of life concept. The third study explores the way cultures have an impact on antibiotics use.

Meeuwesen, van den Brink-Muinen and Hofstede (2009) have researched cultural characteristics of medical consultation, approaching this subject through Hofstede's Model. They tried to contribute to the prevention of intercultural miscommunication at a micro-level, inferring the importance of doing the same at a macro-level when pursuing integration of European health care policies. They found higher power distance was related to less unexpected information exchange in doctor-patient interaction. Likewise, high power distance countries seem to have shorter time for consultations, with roles being clear and fixed. Where there is higher uncertainty avoidance, less attention is put on rapport building. Additionally, 'masculine' countries have less instrumental communication.

Another concept, which is relevant for health and social care, is *quality of life*. In individualistic societies this is related to "individual success, achievement, self-actualization and self–respect" (Hofstede, 1984, p. 394). Emphasis is put on self-interest. On the other hand, in collectivist societies quality of life is more related to family and groups of belonging. For people in these societies, work recognition is more important than a job well done. Respect from relevant groups (avoiding shame) is more important than self-respect (avoiding guilt), contrasting with individualistic societies. It also contrasts the order of tasks and relationships: in individualistic societies, tasks precede relationships, and in collectivist ones the order is the opposite.

In relation to power distance, quality of life also depends on the specific culture score in this dimension. High power distance societies would prefer to have clearer rules than low power distance societies. Low power distance societies would prefer to have a voice and individuals feel uncomfortable if they have no chance to express opinion, even when their contribution may be irrelevant. We can also distinguish between countries where uncertainty avoidance is high from those where it is low. Quality of life is accordingly more related to security needs or to challenging situations. Likewise, people from cultures high in masculinity would prefer clear directions in contrast to those who are from cultures high in femininity, in which they value harmony instead (Hofstede, 1984).

Deschepper et al. (2008) have undertaken research on the use of antibiotics that has shown that in cultures where power distance is high, hierarchical differences are expressed in stronger doctors' autonomy. Patients expect greater expertise from doctors and don't participate in therapeutic decisions. This contrasts with cultures low in power distance in which doctors are part of a team and other professionals express their opinion regarding prescriptions. Accordingly, this cultural dimension affects the doctor-patient relationship, as well as the relations between professionals.

The research summarised here provides examples of cultural influences on health and social care matters. Hofstede is one of the most popular researchers on cultural diversity, but he is only one among many researchers carrying out studies on cultural issues. In social sciences four key words synthesize the different approaches to cultural subjects: cross-cultural, multicultural, intercultural and transcultural.

In spite of some divergences that exist among authors, the meanings of these words (cross-cultural, multicultural, intercultural and transcultural) will be defined in the present chapter as follows:

- 'Cross-cultural' is related to comparison between different cultures. Sometimes this expression describes the process of seeking equivalent meanings, experiences or concepts between cultures (e.g., Beaton, Bombardier, Guillemin & Ferraz, 2000). It can also be used regarding cultural differences (e.g., Gierlach, Belsher & Beutler, 2010).
- Multicultural means a specific context where there are various cultural backgrounds but the original cultures keep their specificities. Strategies

to cope with cultural differences are mostly focused in literature on multicultural issues. This may be the case when health managers or professionals have to relate to colleagues from cultural backgrounds different from what they belong to (Jäger & Raixh, 2011). Since it is hard to think of an organization where diverse cultural backgrounds are joined together and keep their original character, the meaning of *multicultural* is confusingly similar to that of *intercultural*.

- Actually, the *intercultural* concept focuses on what happens when different cultures join together, and relate to each other. This concept is in the core meaning of intercultural sensitivity (Chen & Starosta, 2000).
- Finally, when professionals deal within intercultural contexts in a competent way providing culturally relevant care, we talk about transcultural care. Therefore, transcultural care is related to what is cross-culturally valid (Brink, 1999). This concept also means a new way of relating, where a new cultural complexity is reached and subjects have multiple and complex anchors that ground them in a global culture, or a trans--cultural way in which individuals relate to each other in an integrative way.

Overview of Intercultural Literature in Health and Social Care

The huge interest in studying cross, multi, inter and transcultural issues is expressed in academic databases. There were around 40,000 articles published in academic journals with these words in the title. Specifically, when searching the 'intercultural' word more than 8,000 results appear having it in the title. The word 'transcultural" produced more than 2,000 results; the word 'cross-cultural' produced more than 25,000 results; and the word 'multicultural' produced more than 4,000 results. These searches were made in March 2016.

The importance of cultural issues (whether multi, inter, cross or trans) is also witnessed through the growing number of academic journals having these expressions in the name of the publication. Currently at least 17 were found to include in their name any of the words 'multicultural', 'cross-cultural', 'intercultural' or 'transcultural'. However, through the restriction of the search to English language publications a significant number of academic journals and articles are excluded from our review, which is a significant limitation that needs to be highlighted.

In spite of the interest in this subject raised in the academic realm, restricting the search to a management (or leadership) approach in the health or social care field resulted in a massive reduction in the number of published pieces of academic work found (only 27 articles were found). As the area of interest was in checking evidence-based management and leadership strategies aiming at dealing with cultural issues, the results were categorised as (1) theoretical essay; (2) empirical research; and (3) literature reviews. Table 2 shows that most of pieces analysed were theoretical essays.

Table 2. Type of publication

Theoretical / Essay	Empirical Research	Literature review
Andrews (2008); Bojakowski (2010); DeLellis (2006); Dolan (2013); Dreachslin (1998); Dreachslin (2007); Gathers (2003); Kerfoot (1990); Loewenthal (2007); Luna, & Miller (2008); Muller & Haase (1994); Nkansah, Youmans, Agness, & Assemi, (2009); Robb, & Douglas (2004); Sagar (2015); Shapiro, Miller & White (2006); Sohmen, & Razzaque (2010); Vinz, & Dören (2007);	Holtbrügge, & Schillo (2008); Hunt (2007); Jäger & Raich (2011); Kavanagh (1998); Lyberg, Viken, Haruna, & Severinsson (2012); Myers & Wooten (2009); Trapp (2010); Wall (2013); Wallace Jr & Ermer (1996);	Peck, Kleiner, & Kleiner (2011);

Despite the huge interest by the scientific community regarding cultural issues, Table 2 suggests research on this subject in health and social care is not yet consolidated. Seventeen out of 27 articles publish personal reflections, advice and recommendations; nine report empirical research and one is a literature review.

In general, theoretical articles recognized the importance of offering culturally relevant care. Recommendations go from universal aspects of human being to the specificities of each culture. Cross-cultural similarities and differences are related to the concept of transcultural care. Both directions seem to be relevant: paying attention to the commonalities among cultures as well as specificities of each culture. These two orientations can contribute to delivering culturally relevant care.

DeLellis (2006) focused on similarities instead of differences for approaching culture, which presents a perspective of aspects of organizational culture (and subcultures) that can be taken into account for delivering respectful and professional services. Accordingly, Sagar (2015) presents Transcultural Nursing and the Transcultural Nursing Society (and the Scholars Group), briefly describing the movement since its origin by Leininger in the 1950's. Andrews (2008) presents a short history of transcultural nursing since the early beginning in the 1950's. Luna and Miller (2008) also pointed out some landmarks of transcultural nursing. Finally, Sohmen, and Razzaque (2010) propose a transcultural e-governance model for the health care sector.

Other articles are more focused on diversity and respect for cultural differences. Shapiro, Miller and White (2006) linked cultural diversity and health care disparities. Robb and Douglas (2004) suggest three exercises for helping in diversity management. Loewenthal (2007) examines the professional regulation of psychotherapy and highlights the danger to be avoided of what he calls cultural imperialism. Similarly, Dolan (2013) promotes equality of care and the need of multicultural leaders and cultural competence. Dreachslin (2007) also advocates for cultural competence. According to this author, two perspectives can be put in discussion: (1) diversity has value, differences strengthen societies – which leads to customisation; (2) emphasis should be put on similarities between people – which emphasizes homogenisation. Managing diversity in healthcare implies the requirement to cope with client diversity as well as human resources diversity. Awareness of the categorisation process is a first step in

managing biases. The authors then advise to manage diversity through cultural competence development.

Other articles emphasize the value of diversity. Kerfoot (1990) gives directions on the way health care must cope with an increasingly diverse workforce. This article advocates for more than peaceful coexistence: sensitivity to others, respect for their values, recognition and celebrating diversity are the main suggestions. Nkansah, Youmans, Agness, and Assemi (2009) approach diversity as an aim, with consideration of how this can enhance an organisation. Taking this into account, diversity should be pursued and not just coped with. They describe nine best practices regarding the promotion of diversity in organisations: (1) leadership commitment shown in communication and demonstration; (2) diversity is integrated in the mission and vision; (3) diversity is linked to recruitment; (4) diversity is linked to retention; (5) diversity-related training; (6) diversity linked to performance; (7) accountability; (8) assessment; and (9) diversity integrated into a strategic plan.

Gathers (2003) presents disparities regarding the balance between men and women in leadership positions in health care organisations, as well as considering other categories such as ethnic minorities. The stereotype of what a manager is promotes an imbalance in relation to minorities. Steps to help solve the problem are proposed. Although the advantages of diversity are highlighted, emphasis is put on the pursuit of balance, and equality as a value of its own. Dreachslin (1998) discusses and provides advice on the use of focus groups by health care organisations for dealing with patient diversity. The author presents the requirements for effective diversity management. Muller and Haase (1994) also present recommendations suitable for health care managers to adopt in dealing with heterogeneous workforces. Bojakowski (2010) discusses the variations in health care policy in UK, claiming that some variations can be justified, among other reasons, by diversity between groups, but other variations seem to be unwarranted. Finally, Vinz, and Dören (2007) theorize about the implications of a diversity framework concerning health research and the care system.

In short, differences between cultures are approached: (1) in characterizing them; (2) as an asset for the social system; (3) as a condition that social and health care managers (and other professionals) have to deal with. The concept of culturally relevant care is emphasized, whether looking at the common aspects across cultures or the differences between them.

Regarding empirical research, the nine bibliographic pieces retained for analysis comprise three case studies, two focus group researches, three correlational studies and one qualitative research (see Table 3).

Table 3. Research design /Method

Case study	Focus group	Correlational	Qualitative
Holtbrügge, & Schillo (2008); Kavanagh (1998); Myers & Wooten (2009);	Hunt (2007); Lyberg, Viken, Haruna, & Severinsson (2012);	Trapp (2010); Jäger & Raich (2011); Wallace Jr & Ermer (1996);	Wall (2013);

Lyberg, Viken, Haruna, and Severinsson (2012) used an interpretative qualitative content analysis of data gathered through multi-stage focus group. These authors aimed "to illuminate" midwives' and public health nurses' perceptions of managing and supporting prenatal and postnatal migrant women in Norway. They found Norwegian maternity care needs improvements, as it does not fit migrant women's needs.

Kavanagh (1998) describes a training program (field school experience mostly attended by nursing students) aiming at development of cultural com-

petence. The author ends by proposing 'concernful practices' after testing and adapting them.

Trapp (2010), in a survey on ethics in organisations carried out in several countries, found differences between countries but also agreement that corporate identity, values, and reputation are important motivators for ethical behaviour. Myers and Wooten (2009) present a case study on diversity management (in USA) concerning a health care organization that uses diversity management for improving operations and through that contributes to organizational goals.

Wall (2013) has examined how cross-cultural management impacts global competitiveness in healthcare organisations and what area of cross-cultural management contributes the most to the enhancement of competitiveness. The author carried out qualitative research, interviewing 50 participants and using grounded theory as method. The main results were: cross-cultural management impacts healthcare organizations; comfort, confidence, sensitivity, accuracy of diagnosis and treatment, respect, and awareness are reported as gains; and cross-cultural management seems to have an effect on global competitiveness.

Hunt (2007) presents some practical strategies that managers can adopt for supporting nurses in multicultural contexts and for managing cultural diversity among health workers. Her focus was on overseas trained nurses. The article is a synthesis of a 25-participant workshop. Results highlight four subjects managers can pay attention to: (1) assumptions and expectations of all staff; (2) education and training for cultural sensitivity, equality and human rights in daily work management; (3) performance management of all staff; (4) transparency in HRM processes.

Wallace and Ermer (1996) studied how diversity management is perceived and implemented by hospital executives in the USA. They consider diversity as an asset that has to be managed and surprisingly found that 68% consider they have a diverse workforce, while only 30% have a diversity management program implemented in their hospitals. Holtbrügge and Schillo (2008) presented a case study and suggest to virtual delegates (who live and interact with one culture but work together with people from other cultures) to support intercultural training.

A diverse workforce in the health sector is a consequence of insufficient local workers in several countries and due to this Jäger and Raich (2011) have verified that in retirement homes multicultural teams are a new reality managers have to deal with. They found where there is high commitment to the team, higher levels of diversity are related to lower levels of commitment. In addition, higher team diversity corresponds to higher levels of process and delegation conflict. In terms of relationship conflict, higher team diversity is related to higher relationship conflict. Finally, where communication effectiveness is high, more diversity relates negatively to the overall communication outcome.

Regarding the literature review (see Table 2), Peck, Kleiner and Kleiner (2011) sought articles on generational diversity. They found each generation has specificities in its world vision that impacts on its vision of what a health care organization is. At the same time similarities between generations regarding both quality of care and personal drivers led the authors to recommend managers keep a generationally diverse workforce.

Most of the research on intercultural management has focused on health care, rather than social care. While some findings may be transferable, the organisational cultures – as well as norms and cultures of professions – vary, which will have implications for the findings across sectors.

In general, the results presented here suggest that diversity is a growing situation that health and social care managers have to handle in their organisations, regardless of whether they view this as a benefit or detriment. Diversity seems to have the potential to become an asset, but that doesn't happen on its own. It requires competent leadership management, which is a challenge for leaders and managers of health and social care organisations. With competent diversity management, culturally relevant care can be provided that is in accordance with

the culturally diverse society present within the European Union. Communication is a core competence area in which managers and leaders must develop in intercultural management and this will be discussed in the next chapter.

Intercultural Communication

Communication is the act of transmitting messages, including information about the nature of the relationship, to another person who interprets these messages and gives them meaning (Berlo, 1960). Both the sender and the receiver of the message play an active role in the communication process. Successful communication requires not only that message is transmitted but also that the meaning of the message is understood. For this understanding to occur, the sender and receiver must share a vast amount of common information called grounding. This is based on each individual's field of previous experience but is updated moment by moment during the communication process (Thomas & Peterson, 2015).

Intercultural communication is significantly more demanding than communicating in a single culture, because culturally different individuals have less common information. They have less grounding in common due to their differences in their fields of expertise. Cultural field refers to elements of a person's background (education, values, and attitudes) that influence communication (Thomas & Peterson, 2015). When the sender / receiver do not share the same culture, the particular filters through which the messages pass can lead not just to incomprehension of the messages, but also to their distortion and misunderstanding (Browaeys & Price, 2015). When barriers to communication exist there is potential for inaccurate and incomplete information and even a total disruption of communication. These situations can lead parties in a situation to misunderstand the goals and interest of each other (Aycan, Kanungo & Mendonca, 2014).

The communication process involves the meaning that is to be transmitted, the sender of the message, a channel through which the message is transmitted and the receiver of the message. All of these elements are embedded in their respective cultural fields. The message is encoded (converted to symbolic form) and sent by some means (channel) to the receiver who then interprets (decodes) the message. The effectiveness of the communication depends on minimizing the distortion that can occur at all the stages of the communication process (Thomas & Peterson, 2015).

The meaning of the message, being grounded in the personal field of experience of the sender, can affect how it is encoded. It can thus be affected by the communication skills and knowledge of the sender and by the associated cultural field. Therefore, we cannot communicate what we do not know and our ability to encode accurately is determined by our skill in the chosen channel (e.g., speaking, writing). Also, the symbols a person uses to express an idea vary with the cultural field. The language varies, but so too do aspects of communication that transcend language such as communication style, conventions and practices. Thirdly, all of the factors that affect the sender also influence the receiver. The symbols must be decoded into a form that can be understood by the receiver. As in any intercultural interaction, the ability of receivers to accurately perceive the communication behaviour is influenced by their cultural field. In addition, the extent to which the cultural fields of individuals overlap affects the opportunity for distortion in the communication process. The more each party understands the other's situation, perspectives and culture, the easier it is to use symbols that will be encoded and decoded similarly (Thomas & Peterson, 2015).

Verbal communication consists of language itself and its pragmatics. Communication styles also belong to verbal communication. The language being used forms the most obvious consideration in intercultural communication. It is the symbolic code of communication consisting of a set of sounds with understood meanings and a set of rules for constructing messages. In intercul-

tural encounters, the use of a second language has a number of implications for communication. Using a second language creates cognitive strain and is exhausting. Furthermore, the greater the fluency of second-language speakers, the more likely they are to be seen as competent in other respects. First-language speakers tend to respond to lower linguistic competency of their partner by modifying aspects of their speech, such as slowing their speech and reducing sentence complexity. This kind of speech accommodation can be perceived as patronizing and might not be well received. Sometimes second-language speakers pretend to understand in order to avoid embarrassment or appear competent, if the environment is not acceptable to check for understanding (Thomas & Peterson, 2015).

Communication styles present the logical extensions of the values and norms that people have from their respective cultures. Many of them are related to the key value orientation of individualism and collectivism. One way in which cultural norms about communication style vary is in the degree to which they use language itself to communicate a message. This can be characterized by a bipolar typology called high-context and low-context communication styles. A high-context communication is where most of the information is either the physical context or internalized in the person while very little is in the coded, explicit, transmitted part of the message. A good deal of the meaning is implicit and the words convey only a small part of the message. In a low-context communication the mass of the message is vested in the explicit code. The message there is conveyed largely by the words spoken. Countries can be classified according to whether they are primarily high or low context (Hofstede, 1980). The place on the continuum is connected to countries' location on Hofstede's individualism-collectivism index. Individuals with independent self-concepts are more likely to be low-context communicators whereas interdependent self-concepts (collectivists) are likely to be high-context communicators (Thomas & Peterson, 2015).

Directness of communication also indicates the low- or high-context communicate styles. It means the extent to which communicators wish to "get to the point". Do they cut straight to the perceived truth or do they imply, suggest or understate matters? Other questions in directness are if the other sees assertiveness as aggression, indirectness as being submissive (Browaeys & Price, 2015). Directness is associated with individualist culture and indirectness with collectivist cultures. The relationship to the social context is evident when evaluating motives for indirectness. In collectivist cultures, politeness and a desire to avoid embarrassment often conquer the truth, which is not absolute but depends on the social situation. Though making untrue statements to preserve harmony is probably universal, the extent of its use is higher in collectivist cultures (Thomas & Peterson, 2015).

There are also other language considerations in differences of cultures. Cultural difference also exists in how silence is used in communication. Silence might be thought of as an extreme form of high-context communication. It can also vary in low-context cultures. Another stylistic element that has a systematic relationship to culture is the use of praise and the response to praise. Differences exist in how frequently praise is used, what is praised and how people respond. Beyond the formal structure of the language there are language styles and registers that are important to understand in order to function effectively in intercultural communication. The ability to use slang and jargon of a particular group helps to define one's membership in that group. The knowledge of euphemisms – words that replace expressions not said publicly – helps to understand what topics can be referred to directly or not. Idioms are ways of combining particular words and can mean something totally different, e.g., "a little birdie told me". Proverbs are short sayings that are true in a particular culture and advise people how to behave (Browaeys & Price, 2015; Thomas & Peterson, 2015).

Just as important to communication as the verbal components are the nonverbal aspects of communication. Nonverbal communications convey important

messages and are produced more automatically than words. They include body movements and gestures, touching, facial expressions and facial gazing, tone of voice, space usage, eye contact and even scent of smell (Thomas & Peterson, 2015). For example, facial expressions give important signals in social interaction. They are linked to the context and differ whether the context is clear or ambiguous (Browaeys & Price, 2015).

There are three aspects in nonverbal communication that one should acknowledge in intercultural encounters. Firstly, most nonverbal behaviour is unconscious, so people are not aware of the pointers they are sending. Secondly, one should be aware of the impact of nonverbal communication on others, and thirdly, the meaning assigned to nonverbal expression differs per culture (Garten, 2015). As much as 70 percent of communication between people in the same language group is nonverbal. In intercultural communication it is possible that people rely even more heavily on the nonverbal component. This helps to regulate intercultural interaction by providing information about feelings and emotional state, adding meaning to verbal messages and governing the timing and sequencing of the interaction. Nonverbal behaviours have the same function across cultures; however, they have a significant amount of variation around the world. The same nonverbal behaviour can have very different meanings across cultures, or different nonverbal cues can be used in different cultures. Attempts to systematize nonverbal communication have included classifying nonverbal cues as conversational, topical or interactive. Functional approach to nonverbal communication means grouping by the outcomes achieved as opposed to the origin (hands, eyes, body and voice). People in intercultural encounters must rely largely on descriptions of the peculiarities of nonverbal communication in various cultures (Thomas & Peterson, 2015).

Approaches to Intercultural Management in Practice

There can be two conflicting viewpoints in relation to a diverse workforce that can contribute to divergent views and challenges for managers (Dreachslin, 2007). Supporters purport that a diverse workforce presents a valuable resource through the diversity of information and viewpoints that can provide a better service, with the potential to decrease health disparities of minority groups. Detractors highlight that a homogenous group functions more harmoniously and most conflict and challenges to teamwork stems from diversity. However, research on nursing teamwork has demonstrated that the most influential factor that mitigated conflict and facilitated team working was effective leadership, which can help to validate alternative viewpoints and appreciate different perspectives that strengthen the positive aspects of diversity (Dreachslin, Hunt & Sprainer, 2000). In this section an overview of how organisations and individuals can effectively implement intercultural management will be explored.

Implicit in this discussion is that all organisations – like individuals – have a culture. Organisational structures and systems are influenced by culture, which helps establish the norms of behaviour and action that guide managers and employees. For example, this can be a country perspective – Schneider, Stahl and Barsoux (2014) report that in France managers see their role as controlling staff in a hierarchical structure, whereas British managers see their role as coordination, with goals achieved through persuasion and negotiation. This diversity in approach may not be explicit, and while those who are native to the country or long-term employees of an organisation will understand these implicit 'rules', those who are new may struggle to see these unwritten 'rules of engagement'. The national view of culture as previously described by Hofstede (1983) can be useful as a starting point, as this can impact many aspects of organisations such as the hierarchy of management structures, decision making and approaches to risk. However, it is important to recognise that culture can be

influenced by many other factors such as family, religion, social group, gender, political alliance, etc. (Schneider, Stahl & Barsoux, 2014). Organisations may also have specific cultures, mission statements or codes of practice that can be explicit; however, most will have also have implicit or unspoken cultural norms that to outsiders are not clear, such as patterns of communication, which could cause isolation or exclusion.

Organisations often focus their explicit intercultural management practices within diversity HR programmes, which will typically be grouped into three types (Pitts, 2007). Often the initial focus is on the legal framework concerned with adherence to the rules surrounding anti-discrimination. The second type is those that focus on valuing diversity within the norms and values of organisations that help employees to learn about different cultures and focus on inclusion, tolerance and acceptance. The third type is pragmatic policies that are in place to help all employees succeed at work and can be integrated into the organizational strategy and mission such as seeking diverse representation of groups and ensuring managers are accountable for implementation and adherence. A multi-component diversity policy can engender a range of individual and group reactions within an organisation and some individuals who may have felt excluded from the mainstream of the organization because of their diversity can now see they are valued and see options for their future.

Research in the area of social care has demonstrated that policies that support inclusive organizational culture such as fairness, inclusion, stress management, and social support provide a sense of belonging, satisfaction, and commitment in employees; improving retention and loyalty to the organisation (Findler, Wind & Barak, 2007). Through the successful management of an employee relationship that builds loyalty and belonging, the organization may be more stable by keeping well-trained, experienced employees, instead of continually investing in training and recruitment (Moczydłowska & Widelska, 2014). While there are underlying moral and legal drivers to support diversity, an organization or leader/manager that has operationalized successful strategies can bring benefits to the organization (Arredondo, 1996).

Managers must work within the structure and policies of the organisation to implement diversity management, but they also require leadership, knowledge and skills to support and help multicultural teams navigate the norms of the organization. Jacob (2003) advocates that successful leaders require a frame of mind of being comfortable with diversity and the different approaches and viewpoints this may bring. Individual managers should have or develop cultural empathy and mental flexibility that allows them not only to accept diversity but to recognize this as an asset that may provide learning from other cultures and a platform for looking at different problem-solving strategies (Jacob, 2003). However, challenges can arise as interpreting social and emotional cues across cultures can be difficult both for individuals and managers. Emotional competence may be simpler in a single cultural environment as social and emotional cues can vary from culture to culture. For instance, employees who are naturally quieter and do not debate decisions may be seen as lacking original thoughts or leadership capabilities and this could impact advancement within the organization. Integration of staff from different cultures can be supported through existing staff of different cultures that may have skills to act as guides in the understanding of different interpretations of social and emotional cues (Borrego, 2011).

Dreachslin, Hunt and Sprainer (2000) found in their study of nursing and teamwork with diverse cultural nursing teams, the underlying triggers for conflict were different perspectives and 'realities; and three areas were identified that could further exacerbate conflict and dissatisfaction with communication. These were social isolation, selective perception and stereotypes. Managers who could appreciate the differences and help navigate difference to bridge new alliances were core to achieving goals with diverse teams and decreasing conflict and isolation. This core skill has been described as intercultural competence and

although there may be different terms to encompass this – such as cultural intelligence, intercultural communication competence or culture learning – there is agreement that this a description of the capacity to interact effectively and appropriately across cultures (Deardorff, 2009). Gallegos (2013) highlights some practices in intercultural management that leaders can undertake to support multicultural diversity such as: create conditions to help explore differences; model and communicate the understanding and value of cultural diversity; and define (and redefine) boundaries for behaviour that embrace acceptable practices in relation to cultural diversity.

The strategies, procedures and policies that managers, leaders and organisations can implement to promote inclusion through the bridging of cultural differences represent a complex, dynamic and multifaceted practice. Through ongoing and integrated activities at the level of the individual, manager, and organisation, good intercultural management practices can bring clear benefits to organisations; however, there is also an imperative that in our global society, human rights, dignity and emotional wellbeing are central to healthy businesses and society (Wheeler, 2013).

Conclusion

Those working in health and social care management face unprecedented challenges within the EU due to increasing needs and complexity, which includes an increasingly diverse population and workforce. Managing the diversity of the workforce can improve employee loyalty, inclusion and retention. Effective and competent intercultural management of those who lead organisations and teams can engender cohesive teams, which fosters innovation and diversity of views. Education and training that is interdisciplinary and intercultural can facilitate the development of health and social care professionals who are able to embrace the diversity to effectively support an intercultural workforce and client base (Bjegovic-Mikanovic et al., 2014).

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