The slogan ‘we’re in this together’ has featured heavily in the government’s rhetoric ever since it announced that major reductions were needed in public sector spending. The subsequent programme of retrenchment has, in some areas, been accompanied by plans for large-scale reform, including in health care. By appealing for togetherness during a time of hardship the coalition is, arguably, pursuing two underlying objectives: first, to encourage the view that although cuts to public spending will be painful, this pain is unavoidable and will be shared by all; and second, to suggest that future recovery will depend on a collective effort with everyone maintaining the same end goal.

In the NHS this means working together to deliver the outcomes described in the government’s White Paper ‘Equity and Excellence: Liberating the NHS’. However, the road to policy implementation has been rocky and the growing disquiet over the government’s approach – including its apparent reversal of a vow not to reorganise the NHS – threatens to undermine its stated commitment to a consensual approach. Indeed, the coalition itself has become something of a test case for the principle of putting aside one’s differences for the greater good and the NHS reforms have become the crucible in which many of the tensions within and between the two parties are being played out. Whilst the imperative to pull together will be strengthened by a unified governing coalition, the opposite is also true; the claim that we are ‘in it together’ will sound hollow if the government itself becomes increasingly fractured.

Elsewhere in the system, the collaborative agenda has shifted. The previous government’s commitment to partnership working has failed to bear the expected fruit and has proven both difficult and expensive to implement. In a climate of austerity, this casts doubt over the sustainability of large scale integration across health and other sectors. The focus going forward appears to be on a more targeted approach in which clinical partnerships and vertical integration – the alignment of primary and secondary care – predominate. The increasing role of the voluntary and private sectors in health care also presents new challenges and opportunities by putting the NHS into the hands of a greater number of people, including NHS staff and communities.

In this newsletter, HSMC considers the ongoing aspiration to joint-working and collaborative effort in this transformed health and social care landscape. Featured articles consider issues such as: the relationship between clinical and management roles; the changing place of social enterprise; joint approaches to promoting health and wellbeing; and the potential for joined-up rationing of health and social care resources. As always, these are supplemented by updates on the many projects, programmes and initiatives underway within the department.

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Health and well-being

Jon Glasby

As concerns mounted about aspects of the Liberating the NHS reforms, a critical report from the House of Commons Health Committee (2011) added further impetus and undoubtedly contributed to the subsequent ‘pause’. However, one recommendation in particular caught the attention of local government colleagues: the suggestion that with representation of a local councillor and a professional social care representative on the boards of commissioning authorities, there would now no longer be a need for the proposed Health and Well-being Boards. Despite promising to pause and to listen, the government have been clear that greater local government involvement in health is crucial, and something like Health and Well-being Boards (and certainly the principles behind them) seem set to stay. This is an important statement, as some 132 local authorities have already volunteered to be early implementers of Health and Well-being Boards and there is a clear appetite for closer joint working.

This newsletter focuses on the theme of ‘all in this together’ – and nowhere is this more true than the relationship between health and local government. Whatever happens next with the Health and Social Care Bill, there will need to be a strategic space in the system for these two key partners to try to make sense of the policy context together. Both the NHS and local government face significant financial challenges, and they will have to find ways of viewing the money available as more of a shared pot of scarce public resource to spend on behalf of local people, rather than separate budgets potentially in tension with each other. Joint Strategic Needs Assessment also seems an important part of this process, allowing health and local government leaders to be clear about what they need to know and then providing a single set of data to inform decisions about the future. While some of this is described by the Select Committee as “unnecessarily bureaucratic” (para.47), these mechanisms could be more about jointly understanding the world together and deciding a way forward, about seeing the bigger picture and about driving forward strategic change – all things that will be needed in a new system that could become even more fragmented than at present.

Whatever happens next, there is an exciting opportunity to promote more effective joint working via a more place-based approach. While NHS managers tend to move organisations, GPs are often based in the same local area for a significant period of time – perhaps even living in the area where they work. It’s still not uncommon for an individual GP to have known the same family over many years, treating a number of different generations. This commitment to ‘place’ seems similar to that of local government and of local councillors, with a range of local services (children’s centres, Sure Start, regeneration and so on) increasingly based on a local community or ward. In social care, there have previously been ‘patch-based’ and community development approaches that focus on similar local levels, and there could even be potential to link more fully to other local services (whether local extended schools or local police units).

In the longer-term, we have argued that the NHS and local government need each other now more than ever (Glasby et al., 2006, 2010). Local government is tasked with being a ‘place-shaper’ and with promoting the well-being of an area – and hence needs significant influence over local health services (as these are so important to local people). However, the NHS is having to make fundamental decisions (for example, about expensive cancer drugs or acute care reconfiguration) and needs to learn from the best of local government in order to take local people with it. This isn’t just about making the ‘right’ decision, but about making it in the ‘right way’. Thus, it is primarily about issues of place, identity and legitimacy and not just about technical data and decisions.

If this is the case, we have argued that there is an urgent need to more fundamentally rethink the nature of the relationship between the NHS and local government, and our previous work (Glasby et al., 2006, 2010) reviews different policy options in more detail. Ultimately, our preferred option is to develop a local government-led approach, integrating health and social care commissioning into the local authority. This would meet all the requirements of current policy around separating commissioning and provision, integrating care and promoting health – but would do so based within locally democratic and accountable services rather than in a system accountable upwards to the Secretary of State. It would also be consistent with previous policies around local authority scrutiny of health services, longstanding responsibilities for promoting well-being and anticipated new responsibilities for public health. Delivery could still take place on a neighbourhood basis via groups of GP practices and GP-attached social workers – but this would see GPs (and other members of the primary health care team) as the best people to pioneer new forms of service delivery rather than necessarily as commissioners.

While the Coalition pauses to listen, it will be interesting to see if there is scope for really radical options such as this to emerge – or whether we emerge with only slightly different versions of the same underlying policies.

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How viable is joint health and social care rationing?  
Iestyn William, Helen Dickinson, and Suzanne Robinson

One of the benefits often attributed to collaboration is the more efficient use of public resources, and it has often been assumed that co-ordination of services can help to avoid duplication, waste and over-supply in the delivery of care. Furthermore, we might hypothesise that the effectiveness of services – a major driver of wider system efficiency – is best served when fragmentation is minimised. All of which suggests that the aspiration to joint working might be strengthened rather than invalidated by the current austerity agenda. However, the argument becomes more complicated when we consider how this is to be achieved. Certainly reorganisations, mergers and takeovers are expensive to implement and often fail to bring about the expected increases in service impact. In the current climate, it therefore makes sense to consider less resource-intensive strategies for aligning health and social care, within a wider context of resource scarcity.

The need to control spending has been a feature of health and social care sectors, both in England and elsewhere, for many years. Resource scarcity is therefore an issue of long-term sustainability rather than just a result of recent government spending policies. It is perhaps surprising therefore that priority setting – explicit approaches to the allocation of limited resources – has not featured more heavily in the joint commissioning agenda. If we agree that collaboration remains important and that tough spending decisions need to be made, it seems logical that these concerns would be addressed in tandem via joined-up models of rationing. However, the traditional responses to financial pressures are very different in health and social care. The following are just a selection of the possible barriers to collaboration.

Structure and finance: despite undergoing some decentralisation in recent years, the NHS remains subject to considerable government command and control (not to mention guidance from bodies such as the National Institute for Health and Clinical Excellence). In comparison, priority setting in social care is much more decentralised, and local councils retain a high degree of autonomy in planning service responses to the needs of individuals and local populations. These differences are reflected in the generation and flow of resources, which also differs markedly across the two sectors.

Understanding need: in social care, priority setting is largely embedded in needs assessment criteria, and rationing takes place by applying funding thresholds to these needs-based categories of eligibility. The picture is very different in the NHS, where the expectation (if not the reality) is that no patient with legitimate health care needs will be denied care, irrespective of condition severity. The ways in which need is conceptualised and measured is also markedly different in each context. In the NHS, this reflects the traditional medical model and the more recent emergence of quantitative tools for information synthesis and decision support (such as health technology assessment and quantitative needs assessment). By contrast, successful interventions in social care are linked to notions such as lived experience, adaptation and empowerment, which are more difficult to codify and measure.

Political realities: as well as being administered by national government, the NHS - and by implication the priority setters operating within it - is subject to intense interest group lobbying over the availability of expensive treatments and it is politically risky to explicitly withhold treatments and/or close down services. By contrast, social care is subject to relatively little routine interference from ministers. Furthermore, the public profile of social care is generally more negative than that of the NHS. Indeed, it has been argued that public pressure is more likely to be for reductions in expenditure on social care than for increases (Bergmark, 1996). For these reasons, one might hypothesise that decisions to ration care are politically more acceptable, albeit still controversial, in a social care setting than they are in the NHS.

Whist it may be difficult to fully overcome these areas of divergence, the work of HSMC suggests that a number of factors may help to reduce some of the asymmetries that have developed (Williams et al., 2011). These include:

Embedding joined-up priority setting: to be worthwhile, we believe priority setting needs to take a central role in joint commissioning. Furthermore, collective decision making needs to be accompanied by effective governance and performance management structures to ensure implementation. Greater alignment of funding models will help in this process; in the NHS this might mean greater use of individualised budgets and, perhaps more controversially, co-payments for selected interventions.

Increasing dialogue: distrust between health and social care reflects differences in ethical codes and belief systems, and whilst a single model of health and social care may not be attainable, we would argue that both parties would benefit from greater dialogue. In relation to decision making, for example, there is scope for social care to better analyse population needs, and for health care to develop less narrowly-defined measures of service outcomes.

Negotiating political contexts: in relation to political contexts, both health and social care agencies are required to address the key governmental, public and stakeholder groups whose support is required if priority setting is to be deemed legitimate. Despite differences of profile, perception and expectation, priority setting in both environments is more than simply a technical exercise. Rather, it is a complex process that requires the engagement of a range of stakeholders in the pursuit of political legitimacy.

These strategies suggest the need to go beyond technical solutions when implementing priority setting processes, and HSMC is engaged in developing research, theory and practice in this area. For more information on HSMC’s priority setting work see page 8.

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Social enterprise in the NHS: a partnership with the ‘Big Society’?

Ross Millar and Robin Miller

Over the past decade or so, social enterprise has struck a chord with national policy makers on the basis of its potential ability to act as a vehicle to empower, improve quality and deliver innovative approaches for dealing with complex social needs. New Labour’s policy programme promoted the organisational form in the NHS based on its ability to unleash public sector entrepreneurship. Various initiatives ensued that included a Social Enterprise Investment Fund to support the development of social enterprise entry into health and social care (Millar et al., 2010); a social enterprise Pathfinder Programme (DH 2010); and a ‘Right to Request’ policy to encourage ‘spin outs’ in the delivery of primary and community services (Miller and Millar, 2010).

The Coalition Government’s aim of developing the NHS into the ‘largest social enterprise sector in the world’ has continued and arguably accelerated the social enterprise approach to service delivery. This clearly resonates with the Big Society agenda to put more power and opportunity into the hands of staff and communities. The ‘Right to Provide’ policy will ensure that (in the short term at least) NHS (and Local Authority) staff will have a mechanism for ‘spinning out’ publically funded services to ‘innovate and lead rather than follow’ (DH, 2011: 10). This is particularly relevant in relation to the Government’s commitment to give patients more choice and control over their care and treatment through ‘Any Qualified Provider’ (AQP).

Despite the government’s enthusiasm for social enterprise, a number of challenges remain. This includes the potential challenges of creating such organisational forms, namely making the benefits clear to all stakeholders concerned, the potential loss of NHS branding, issues around pensions and the overly optimistic timescales to establish a social enterprise (DH, 2010). Furthermore, our own research in this area highlights a number of barriers to the vision of social enterprises in the NHS: including nurturing the skills and confidence to become an ‘entrepreneur’; having the available funding and capacity to develop business cases; and having the necessary internal and external support. These were key factors shaping the adoption and implementation of the ‘Right to Request’ policy (see Miller and Millar, 2010).

Despite a number of success stories, evidence about the effectiveness of social enterprise by existing public sector providers remains unclear (Heins et al., 2010). Furthermore, the message and implications about becoming a social enterprise remain unresolved. Some suggest that it has the potential to motivate staff; however, others draw attention to the potential dangers of the NHS falling into private hands. In the current climate aspiring social entrepreneurs are going to require the necessary desire and vision to make it happen, but they will also require support and assistance from the existing system.

It is too early to observe the effect of increasing numbers of social enterprises on the effectiveness of local partnership working. Bringing new organisations into healthcare economies will increase the complexity of inter-agency partnerships that have to be formed, and it has been argued that increased diversity of providers could pose a barrier to integrated pathways (Ham and Smith, 2010). Social enterprises could however provide an effective vehicle for increased engagement with local patients (and indeed staff) if they adopt a ‘mutual’ model as their organisational structure. Through their ‘membership’ of the Third Sector they will also potentially have relationships with organisations, such as local community groups, which could offer new opportunities for innovative partnerships. These may be of particular value to GP Commissioners as a means to connect with their local areas (Dickinson and Miller, 2011). Finally, social enterprises may also provide a new means to develop integrated health and social provision (Miller et al., 2011).


Clinical leadership

Iain Snelling

The original Liberating the NHS proposals clearly had GPs as the focus of structural reforms in the NHS. Now, following the NHS Future Forum report, and the Government response to it, there will need to be ‘arrangement for multi-professional involvement in the design and commissioning of services… at every level of the system’. (Field 2011:11) New clinical ‘senates’ will be established to provide advice.

There has been a long history of primary care commissioning in the UK and elsewhere, and accordingly there is a reasonable evidence base to inform policy on commissioning to drive service change. The evidence on collaboration and integration is perhaps a little more recent. The new arrangements, drawing clinicians together from a range of sectors and roles, may draw learning from both of these areas of evidence.

There has also been a long history of attempts to engage hospital clinicians in management. Changing structures to improve clinical leadership is also being attempted in hospitals. Monitor, the regulator of Foundation Trusts, has developed ‘Service Line Reporting’, which new Foundation Trust applicants and existing Foundation Trusts have been encouraged to adopt. Studies of the medical profession, exploring for example its changing demographic make-up, and the relationship with patients, also contribute to an understanding of the relationship between doctors and managers.

Two issues relating to clinical leadership – in commissioning and in provider organisations, particularly hospitals – seem relevant. The first is that although there is a wide literature on the relationship between managers and doctors, there doesn’t seem to be a similar understanding on the relationships between GPs and hospital clinicians as leaders. These will be key relationships in the future leadership in the NHS. How might leadership relationships build on clinical ones? The medical profession often seems to be regarded as a single entity.

Second, there seems to be an assumption in policy that leaders being clinicians (mainly doctors) will be enough to improve leadership. The literature on leadership has not been widely applied to clinical leadership. The NHS has developed a Medical Leadership Competency Framework (and a separate one for clinical leadership) which draws on ideas of shared leadership. These frameworks apply to the leadership role of doctors as doctors, and clinicians as clinicians, rather than in managerial or leadership roles – this builds on the idea of clinicians as leaders in the Darzi Review.

Many years of experience of clinically-led commissioning, and encouraging clinical leadership are coming to a head in the NHS reforms. Developing effective clinical leadership will be an ongoing challenge for the NHS, long after any structural changes have been completed.


Postgraduate programmes

HSMC looks forward to welcoming a new intake of students in September 2011. The department delivers a number of UK-based Masters programmes as well as contributing to a number of interdepartmental programmes. These include:

1. MSc in Health Care Policy and Management, with an option to specialise in:
   - Quality and service improvement, and
   - Commissioning
2. MSc in Leadership for Health Services Improvement
3. MSc in Public Service Commissioning (with the Institute of Local Government)
4. MSc in Managing Partnerships in Health and Social Care (with the Institute of Local Government)
5. MSc in Leading Public Service Change and Organisational Development

All of HSMC’s Masters programmes emphasise the application of theoretical perspectives to current policy and practice in the NHS and other health care systems, and are explicitly designed to support professional as well as academic development. The majority of our students study part-time (over 2 years) whilst working in the health service or a related field, although we do have a number of full-time students studying on our UK-based programmes, and completing their qualification within 12 months.

HSMC staff bring their wide knowledge of UK and international health systems (gained through research and consultancy activities, as well as their own professional experience) to their teaching and tutorial support for students. This emphasis is maintained throughout all of our programmes, from the choice of titles for assignments and the topics selected for dissertations, through the involvement of practitioners and policy makers in teaching activities. While some students choose to concentrate on theoretical dissertation topics, many students carry out empirical studies, often related to their own place of work or area of professional expertise.

Graduate Scheme tops Guardian UK 300 and makes top five in Times Top 100

The NHS Graduate Management Training Scheme, hosted by the NHS Institute for Innovation and Improvement, has taken first place in the 2011 Guardian UK 300 survey of the top graduate employers, and made it into the top five of The Times Top 100 graduate employers. HSMC has been involved in the NHS Management Training Scheme for over 10 years and have been awarded the contract for the fourth time in a row - the first time this has happened in the Scheme’s 55 year history. A partnership between HSMC and Manchester Business School has been awarded a new contract to run the education programme for the scheme which contains four specialty areas: General Management, HR, Finance, and Information.

Trainees work in a series of NHS management roles while undertaking postgraduate studies in their relevant field. The 60 General Management trainees will study towards a Masters degree in Leading Service Improvement which will be jointly awarded by the two universities. A new innovation this year is that all 150 trainees across the 4 specialty areas will study the first part of the General Management programme, as well as their specialism, to reflect the need for all NHS Managers to understand service improvement principles. This means we will be co-ordinating our efforts with 5 other educational providers.

Jon Glasby, professor of health and social care at HSMC said: “These are some of the most talented and creative managers in the UK, and it’s a pleasure to teach them early in their careers and then see them go on to hold very senior roles in the NHS in the future. We welcome the HR, Finance, and Information trainees to the first part of the programme: this is important in showing that service improvement is everybody’s business.”
HSMC also runs a number of MScs in Healthcare Commissioning for both clinicians and managers, including:

- A standalone MSc commissioned by NHS London, with an in-take per year (the third in-take is due in October 2011). Over time, this programme has included more and more participants who are GPs and/or from a primary care development background.
- A standalone MSc and additional modules commissioned by NHS West Midlands.
- A broader MSc in Public Service Commissioning run jointly with the Institute of Local Government Studies.

In the longer run, HSMC is also working with colleagues in public health and primary care to develop additional commissioning support for GP consortia.

HSMC student comments:

James Taylor commenced his post-graduate studies with HSMC in 2001, as an NHS General Management Trainee. Having worked initially in general management within an acute hospital setting after graduating from the scheme, James decided to experience life as a clinician, and joined the Tees, East & North Yorkshire Ambulance Service NHS Trust in 2005. In 2007, James returned to HSMC to complete his research dissertation, and was subsequently awarded his MSc in Health Care Management with distinction in 2008. Always keen to strike a balance between personal and professional challenges, James took time out last year from working as a Paramedic, to sail the Atlantic as a member of a yacht crew, returning home to start training for this year’s London Marathon, which he completed successfully. Of his time at HSMC, James says:

‘My studies at HSMC, both during my time on the NHS General Management Training Scheme, and then in completing my MSc in 2007/2008 have been absolutely critical in my personal, professional and academic development. I have very fond memories of the time I spent at HSMC, which provided me with a fantastic environment within which to learn, and develop my research skills. The support provided by staff at the centre was excellent, and the facilities second to none.’

Other student comments:

‘Very enlightening, it has opened my eyes to areas that I had previously dismissed in terms of importance. I have found it very useful in identifying new ways of approaching difficult situations or tasks’

‘Enjoyable, challenging theories which will contribute towards my management approach to change’

‘It made me think more critically about my personal approach to quality issues and want to take time to reflect on which techniques may help me to try and drive some real changes’

Where are they now?

HSMC would like to hear from former students about their experiences and career progression since completing their studies. If you studied with us please get in touch with your stories by contacting Kate Vos on c.j.vos@bham.ac.uk

One of HSMC’s International MSc students, Abdullah Meshal Mubarak Al-Abdullah Al-Ahmad Al-Sabah, was recently received by His Highness the Amir of Kuwait Sheikh Sabah Al-Ahmad Al-Jaber Al-Sabah at Al-Seif Palace.

Abdullah presented His Highness the Amir with his Master’s dissertation entitled Public views on the healthcare system in Kuwait. Abdullah, a doctor in the Kuwaiti army, then met with the Crown Prince and Minister of Defence to discuss healthcare provision.

Abdullah was awarded his MSc in Health Care Policy and Management (Quality Specialism) at the December 2010 Degree Congregation and since returning to Kuwait has been closely involved with the preparations for the national celebrations for the 50th anniversary of Kuwait independence, and the 20th anniversary of Kuwait liberation.
Projects Update

HSMC’s Priority setting work stream

The priority setting work stream has had a number of publication outputs and research successes over the last few months. These include the completion of a study of PCT priority setting in England funded by the Nuffield Trust (see below). We are also collaborators on a University of British Columbia (UBC) research project focussing on disinvestment in health care, funded by the Canadian Institute for Health Research. This project is currently in the set-up phase. The department has also secured funding for a PhD studentship on rationing and disinvestment. The PhD will be a joint award between the University of Birmingham and UBC. HSMC will be recruiting to this post very shortly.

A number of academic papers have recently been published on topics such as the challenges of disinvestment in health (Public Money and Management), joined up rationing in health and social care (Journal of Integrated Care), and the importance of leadership in priority setting and rationing (Public Money and Management - forthcoming). A book on the theory and practice of rationing, published by The Policy Press will be available from October 2012.

Conference presentations and organised panel sessions have been accepted by the Annual Conference of the European Health Management Association (EHMA) held in Finland, International Health Economics Association (iHEA) conference held in Toronto Canada, the European Health Management Conference (EHMA) held in Portugal and the Healthcare Collaboration Conference, held in Austria. Themes covered in these events include joint rationing in health and social care and disinvestment.

For further details of our priority setting work contact Suzanne Robinson s.m.robinson@bham.ac.uk or Iestyn Williams i.p.williams@bham.ac.uk

Setting priorities in health: a study of English Primary Care Trusts

HSMC and the Nuffield Trust have just completed a project which explored priority setting activity across English Primary Care Trusts. This work is funded by the Nuffield Trust as part of their New Frontiers in NHS Efficiency Programme. The findings from this project are to be disseminated in a report published by the Nuffield Trust in Summer 2011. The main findings from this work suggest that many PCT commissioners have made notable strides in their priority setting practices. However, the overall ‘map’ of PCT priority setting remains patchy and there is much variation in the scale, aims and methodologies of priority setting functions that currently exist. Many priority setting challenges have only been partly addressed. In particular, there remain questions over how technical approaches to decision making can be incorporated into broader strategies of governance, implementation and legitimisation. Many of the difficulties experienced by PCTs are likely to be faced by whichever commissioning group is given primary responsibility for priority setting in the reformed NHS in England. For example, issues of complexity, plurality, process and ethics will need to be resolved by GP commissioners making population level resource allocation decisions. Although GP commissioners may suffer less than PCTs in terms of legitimacy deficits, they will have to overcome a shortage in the priority setting skills, resource and experience that PCTs have built up in recent years. The forthcoming report also makes a number of recommendations on how to take this learning forward under the new NHS structure.

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Personalisation and welfare reform

Following a national think tank entitled ‘A Beveridge report for the C21st’, HSMC have been working with the Centre for Welfare Reform to publish a series of policy papers on the implications of the personalisation agenda for health care, children’s services, criminal justice and the tax and benefit system www.hsmc.bham.ac.uk. HSMC have also been asked to produce a discussion paper for the Joseph Rowntree Foundation on risk and regulation in an era of personalisation.

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Stoke Association Evaluation

HSMC have been commissioned to undertake a three year evaluation of the ‘Long Term Support Model’ in Gloucestershire. This Stoke Association project is seeking to develop a number of support groups across the county for people who have survived strokes.

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Royal College of Nursing (RCN) Executive Coaching

We have just completed the second commission of coaching support for new Council members, which took us to Devon, Wales, London, the West Midlands, the North West, the North East and the midlands of Scotland! An evaluation of both coachees’ and coaches’ experiences is nearly completed.

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Older people’s experiences of transitions in care

An SDo-funded project, across HSMC and the University’s social work department, has been exploring older people’s experiences of care transitions. The first phase of in-depth interviews is reaching completion, and has looked at people’s experiences of going into and leaving hospital and of receiving services for dementia for the first time. The research is being jointly carried out by a team that includes several academic researchers and 22 older service users and carer ‘co-researchers’, including older people who have dementia and older people from black and minority ethnic communities. In the next phase of the project, the research findings will be fed back to the local areas where the research is taking place and support will be provided to help providers and commissioners implement these into practice. This implementation phase will run until the end of October 2011, when the project is completed.

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Next Steps Reforms

This study aimed to examine the ‘Next Steps Reforms’ which were set out by the Department of Health in 2005. The reforms comprised a ‘coherent and mutually supporting’ set of four reform streams (demand, supply, transactional and system management) that together would lead to better patient experiences and better value for money.

The study was based on ‘realistic evaluation’ that aimed to uncover ‘programme theory’. It examined across three different tracer conditions across six local health economies (PCTs) in different contexts (eg urban and rural). Data was gathered using a mix of methods including: documentary analysis; two rounds of qualitative data collection resulting in over 200 face-to-face and telephone interviews with key informants; and quantitative data analysis.

The different stages of the research led to the following results. High-level policy interviews with key policy makers suggested some elements of ‘programme theory’ were not fully clear at national level. Local respondents suggested that different reform levers were more in evidence in some areas and some tracer conditions. Respondents were broadly clear across sites and tracers that transactional reforms and system management and regulation were stronger than demand and supply reforms. There were also some ‘dogs that did not bark’, with little mention of outcomes such as health gain and prevention. Few respondents were clear about how the reform streams fitted together to produce a coherent and mutually supportive set of levers.

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INTERLINKS – modelling long-term care systems

HSMC continues its contribution as one of 15 international partners in the Framework 7 European collaboration project - INTERLINKS. The research focuses on the interfaces and links between prevention and rehabilitation, informal care and quality. HSMC have led on a governance and finance European overview report which was presented to a sounding board of representatives from key European organisations this May at the Dutch Ministry of Health, Welfare and Sport. The sounding board will also start a validation process of the general model and web-based tool created by the consortium. This model draws on international examples to highlight possibilities for planning and delivering long-term care.

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Feasibility of Transferring Budget and Commissioning Responsibility for Forensic Sexual Offences Examination Work from the Police to the NHS

Since the early 2000s, there have been a number of reports, commissioned by both the Department of Health and the Home Office, analysing and assessing the quality of the police and crown prosecution response to allegations of rape. This was due to the marked decline in the percentage of successful prosecutions for rape offences and continuing poor standards of service delivery. In 2002, a joint thematic inspection (HM Crown Prosecution Service Inspectorate/ HM Inspectorate of Constabulary 2002), found that the rate of conviction for rape, after trial, had decreased from one in three cases reported (33%) in 1977, to one in 13 (7.5%) in 1999. Furthermore, only one in five (20%) reported cases at that time was reaching trial stage.

One of the key issues raised in this and subsequent reports, concerned the quality of forensic examination services and healthcare support for victims of rape. The DH recognised that the development of effective and available services for victims of sexual assault also relies on competent healthcare, including forensic medical services, and clinical governance to drive service effectiveness, and will require a commensurate development of commissioning, quality service design and development of the specialist healthcare workforce, especially amongst forensic doctors and nurses.

The response to these problems was a strategic undertaking by the Department of Health and Home Office to examine the “feasibility of transferring budget and commissioning responsibility for forensic sexual offences examination work to the NHS at the earliest opportunity”. The Department of Health’s Violence and Social Exclusion Programme commissioned HSMC between September 2010 and February 2011 to undertake this feasibility study.

The study produced separate documents which have been submitted to the Department of Health:

Impact Assessment – considering costs and benefits of options for change, including status quo;

Evidence Base – that collated fieldwork, including:

Report of ‘Survey A’ Fieldwork on Service Provision - a questionnaire was sent to all service providers, (managers of Sexual Assault Referral Centres (SARCs) and police leads of services located in custody suites, ie non-SARC areas), collecting information on finance, workforce and activity;

Report of ‘Survey B’ Fieldwork on Commissioning and Quality Standards – the survey was sent to police leads;

Case Studies – 4 case study sites were visited, providing data about service structure and quality;

Status of professional education and a statement from the Faculty of Forensic and Legal Medicine (FFLM);

Equalities Impact Assessment – considering the relationship between forensic services for sexual assault and gender, disability, race and religion.

The important findings of the study (currently confidential), are being prepared for ministers (Health and Home Office) for a decision. Once this has been taken, the evidence base and executive summary will be available for distribution.

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Enhancing the Healing Environment (EHE) Evaluation

EHE is a national programme led by the Kings Fund which provides grants to health care providers to refurbish clinical areas. As well as the grant for the environmental work, the Kings Fund provide a leadership development programme for the multi-disciplinary team co-ordinating the local initiative. HSMC will be undertaking an evaluation of the impact of the EHE programme in a prison setting.

developing effective hospital Trust Board governance of safe care.
4. To assess the impact of external commissioning arrangements and incentives on hospital Trust Board oversight of patient safety.
5. On the basis of findings relating to points 1 to 4, to make evidence-informed recommendations for effective hospital Trust Board oversight and accountability, and Board member recruitment, induction, training and support.

The study team also involves colleagues from Dr Foster, the National Patient Safety Agency and the University of St Andrews.

Health and well-being

HSMC (and its sister Faculty the Institute of Local Government Studies) has been involved in the development of the new Health & Well-Being Boards in a number of local areas. This has for instance, included chairing preparations for Birmingham’s Health and Well-being Board, facilitating a series of six sessions with local GPs, councillors and senior officers. Topics have included what works in health and social care partnerships, values and culture and practical case studies around maternity services, children’s services and public health. In Sandwell, HSMC facilitated a stakeholder event to identify the role of the Board and how it can work differently to improve outcomes for local communities. HSMC and INLOGOV are now developing a joint programme to support Boards as they move towards the planned date for assuming statutory responsibilities (April 2013)

Aspiring Directors Leadership Development Programme

The eighth cohort of this successful programme designed and delivered by HSMC and Manchester Business School, led by Joan Durose, is about to end in May. The programme has evaluated extremely well over the past three years, such that the SHA have commissioned a further cohort to commence in October 2011. This will include some redesign to take account of the needs of new GP leaders and the new healthcare context. Joan is also working with the Institute for Leadership and Management (ILM) to accredit the programme.

Care home closures

In response to a number of high profile care home closures, HSMC were asked by the Association of Directors of Adult Social Services and the Social Care Institute for Excellence to produce good practice guidance on assessing and resettling older people. This builds on work HSMC has been doing to evaluate the home closures process in Birmingham – believed to be the largest programme of its kind in Europe.

Talent Management

In 2004 the NHS introduced ‘Talent Management’ (TM). A working definition of TM involves “the systematic attraction, identification, development, engagement/retention and deployment of those individuals with high potential who are of particular value to an organisation.” It is clear that the NHS had carried out much of this activity before 2004, in an approach that we term ‘mf’ (managing talent).

The research design is a mixed method quantitative (questionnaire) and qualitative (interview, focus group) examination of how four different cohorts of managers navigate the multiple routes through their careers. It consists of a quasi-probability element that focuses on a maximum variety sample and a purposive element that seeks policy views at central and SHA level, and examines TM in high performing NHS organisations.

There was no clear agreement on the appropriate system architecture, whether the NHS is a collection of competing organisations or a collaborative system. Most respondents considered that the NHS should adopt a more “inclusive” approach to talent rather than the “exclusive” where TM is restricted to “high
fliers. There was little discussion of barriers in the qualitative interviews, but over a third reported barriers in the quantitative survey. The links between TM and organisational performance are rather tentative, but possible factors include development being seen as important in the organisation, with clinical leadership and Personal Development Plans arising from the appraisal process being taken seriously, and a more inclusive approach to TM.

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Review of the evidence on board performance

Russell Mannion with colleagues at the University of Manchester has won funding from the National Institute for Health Research SDO programme to undertake a synthesis of the evidence on Board governance, board effectiveness and board development. The aims of the literature synthesis are to provide intelligence for enhanced NHS board effectiveness, to understand the strengths, weaknesses and gaps in existing theories about boards and to offer a practical guide for NHS boards for their development. The project is being led by professor Naomi Chambers at Manchester Business School.

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Joint commissioning project

HSMC are carrying out a research project with Helen Sullivan and Stephen Jeffares from the School of Government and Society into joint commissioning between health and social care organisations. This project is funded by the NHS SDO and seeks to explore the practices, processes and outcomes of joint commissioning. This two stage research project is now into its second phase which involves conducting five in-depth case studies into joint commissioning arrangements in different parts of England. The first phase consisted of the use of the POETQ tool which was devised by members of the research team.

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Leicestershire County and Rutland Community Health Services

In 2009, HSMC and Leicestershire County and Rutland Community Health Services came together to create a research and development partnership programme, to build the infrastructure, skills and capacity to become a research and development based organisation. The programme comprised:

- An annual programme of seven days to develop primary research skills;
- The establishment of four multi-disciplinary research and development groups;
- Four research seminars, focusing on the application of research into practice (RIP) for front-line staff;
- The establishment of an OD Task Force to support the embedding of a research and development culture in LCRCHS;
- The development of an on-line R&D resource for front line staff;
- A multi-level evaluation looking at impact of the overall programme, and the outcomes of the five multi-disciplinary research and development groups.

The programme has been completed, with only the delivery of the portal and evaluation report outstanding (end of May).

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Leadership programme for Specialist trainees for NW Deanery

HSMC is working with Manchester Business School on a programme for 150 Medical Specialist Trainees – hospital doctors who are completing their training and will shortly be eligible to apply for Consultant posts - in the North West Deanery. The programme will start in September, for one year initially. The programme is different to more traditional ‘management courses’ in that it is accredited through a work-based project, and will also include supporting trainees through e-learning resources. Iain Snelling and Deborah Davidson are leading from HSMC.

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Events

A co-operative approach to social care

Thursday 30 June 2011

This event will increase people’s awareness and understanding of co-operative models in social care and will provide an opportunity to reflect and discuss these with presenters and other attendees. The event will cover both the ‘principles’ of co-operative organisational models and how these have been ‘practically’ applied in social care settings. Presenters include leading representatives from the co-operative movement, the Cabinet Office and the Department of Health and also people who have developed successful co-operatives delivering a range of social care services, including foster care, home care and advocacy.

A once in a lifetime chance or nobody’s priority? Mental health in an era of GP-led commissioning

Friday 23 September 2011

This one day seminar, chaired by Professor Jon Glasby, is aimed at GPs and primary care colleagues, PCT/local authority commissioners and mental health providers with an interest in developing new approaches to mental health. With a series of inputs from leading national figures, as well as from local case studies, the workshop also contains plenty of opportunity for questions, discussion and networking.

Setting priorities and rationing in health and social care: using evidence to inform practice

Friday 30 September 2011

With input from leading researchers and practitioners, this one day seminar draws on recent work by HSMC and colleagues at the Nuffield Trust which has explored the types of priority setting currently undertaken across England and how commissioners are responding to resource scarcity. Chaired by Dr Suzanne Robinson, the aim is to highlight the key skills and capacity needed for effective future practice.

For more information on all events, please contact Ann Thomas T: 0121 414 7058 or E: a.d.thomas@bham.ac.uk
HSMC welcomes Yvonne Sawbridge who joined HSMC at the beginning of May as a Senior Fellow. Yvonne has over 30 years’ experience in a variety of roles and settings in the NHS and has been a Director in a number of PCTs over the last 10 years.

At HSMC Yvonne will take the Course Tutor role for the Aspiring Director programme, teach on commissioning and quality modules and look to develop opportunities to support GP Consortia. She has an interest in a number of areas including supporting nurses in commissioning, and capturing the patient experience as an improvement tool.

HSMC also welcomes Jennifer Lynch who was awarded an ESRC PhD studentship 2011-2013. Jennifer’s PhD research aims to evaluate telecare services and explore different assessment and referral methods currently in use internationally.

HSMC has also recently welcomed Sharon Casey and Christopher Thomson-Drew who have joined the HSMC administrative team.

HSMC at the Madrid International Congress for Long-Term Care and Quality of Life

HSMC academic Kerry Allen was invited to address the Third International Congress for Long-term Care and Quality of life, which took place in Madrid at the end of March. Kerry gave a presentation on high impact areas for integrating prevention into older people’s services and was part of a panel discussion around scientific, healthcare and social advances in prevention. This contribution drew on a recent HSMC policy paper written by Jon Glasby and Kerry Allen and their European collaborative research into the modelling of long-term care systems, Interlinks.

Links down under

Russell Mannion visited the Centre for Clinical Governance Research at the University of New South Wales, Sydney during April and presented a series of seminars on his research into hospital quality and performance. Russell is a Visiting Professor at UNSW and he is developing a joint portfolio of research between HSMC and UNSW around patient safety and health care quality.

JHOM

A cohort of HSMC academics have recently been appointed to the editorial team of the multi-disciplinary Journal of Health Organisation and Management. Helen Dickinson and Suzanne Robinson have been appointed as editors with Russell Mannion and Iestyn Williams as associates.

The journal actively encourages research based on empirical and theoretical perspectives drawing upon a wide range of disciplines and perspectives. Its coverage includes organisational behaviour, governance, management and leadership, management education and training, and industrial relations and human resource theory and management. In addition, the journal welcomes contributions which question the established paradigms whether through debates within gender studies, critical management studies, ethics, post-modernism or critical realism.

The editorial board seeks both contributions from academics, students and practitioners that are complete in their conception, analysis and delivery, but also those in development.

For further information on the Journal of Health Organisation and Management visit www.emeraldinsight.com/products/journals/journals.htm?id=jhom

Selected recent publications


Congratulations

Congratulations to Denise Thomson (Postgraduate Office) and Ann Evans (Library) who were presented with their Level 3 Award in First Line Management certificates. The ILM Level 3 Award in First Line Management is administered by the People and Organizational Development (POD) department at the University and has been specially designed by the Institute of Leadership and Management to give practising or aspiring first line managers a solid foundation in their formal development as a manager. The ceremony was held in the Business School on Thursday 9 June.