Back to the future

Early in 2012, HSMC launched its 40th anniversary celebrations with our annual health policy lecture (given, this year, by Sir David Nicholson). This was accompanied by the first of our two annual newsletters, in which each of the previous HSMC Directors summarised the key issues facing the health service in their day and the way in which HSMC responded. This included founding Director, Derek Williams, reflecting on the 1974 changes, HSMC as a ‘reorganisation child’ and the growing importance of health service ‘management’ in the 1970s and early 1980s; John Yates (from the Inter-Authority Comparisons and Consultancy unit hosted at HSMC) summarising their work on trends from routine data; Mike Drummond and Peter Spurgeon on the nature and limitations of markets in health care (and in higher education); Chris Ham on GP fundholding and on tackling long waiting times; John Clark on medical leadership; Edward Peck on integrated care; and Helen Parker on shifting care from hospitals to community settings and the development of the primary care market. Although each of these contributions reflected on the main issues facing HSMC and the health service at a particular point in time, it was intriguing to see how similar many of these themes were to current debates taking place around the Health and Social Care Act.

On a bad day, it might seem more than a little dispiriting that the same underlying problems and tensions still exist. On a good day, perhaps there is some reassurance that there seem to be few easy answers and that others have also struggled with the same issues that confront us. Ultimately, perhaps the things we find hard to resolve are just genuinely difficult - if not, then we might have solved them some time ago!

Following on from the themes in our first newsletter, this edition invites current staff to reflect on some of the issues identified by our predecessors and/or to explore how HSMC is responding to such themes today. Alongside the usual updates on research, teaching and consultancy, the newsletter contains short pieces by Martin Powell (on market-based reform), Russell Mannion (on changing culture), Helen Dickinson and Iain Snelling (on medical leadership), Yvonne Sawbridge (on quality) and Robin Miller and Hilary Brown (on inter-professional working). There is also a fascinating piece by Shirley McIver on the history of nursing – linking the experiences of nurses who used to live at Park House with research conducted by HSMC’s founding Director (Derek Williams) and recent HSMC research into older people’s experiences of service transitions.

Alongside the health policy lecture and our two newsletters, there are various other ways to find out about and take part in our 40th anniversary celebrations – including contributing memories of HSMC via our ‘40 faces’ website (www.birmingham.ac.uk/hsmc-faces-memories). To find out more about our work generally, please contact Sue Alleyne (s.e.alleyne@bham.ac.uk).

In this issue:

- Market-based reform 2
- Cultural continuity through structural change 3
- Medical leadership 5
- Inter-professional learning - only good for the frontline? 6
- Making the shift 2 8
- The changing face of nursing 10
- Postgraduate programmes 12
- Projects update 14
- Forthcoming events 18
- Selected recent publications 19
- People at HSMC 20

Read Sir David Nicholson’s Birmingham Perspective “40 years of change in the NHS” and watch a clip of Sir David being interviewed ahead of the Health Policy Lecture by Professor Jon Glasby at the following link:

www.birmingham.ac.uk/research/impact/perspective/change-NHS-nicholson.aspx
Market-based reform

Market-based reform, involving choice for consumers and competition between providers, forms the basis of contributions from three former Directors of HSMC (Mike Drummond, Peter Spurgeon and Chris Ham).

It has long been a controversial topic in health policy, and has seen extensive discussion in the UK since the introduction of the ‘purchaser/provider split’ in 1991 (e.g. Mays et al., 2011; http://hrep.lshtm.ac.uk/ including the study led at HSMC: http://hrep.lshtm.ac.uk/publications/Comparative_powell.pdf).

Peter Spurgeon notes the close parallels between the early 1990s and the current period. However, while there are clear similarities, there are also some key differences. First, the Conservative reforms of the 1990s were ‘internal/wholesale’, while the New Labour and Coalition reforms are ‘external/retail’ (Powell, 2003). The Conservative period saw a largely internal market with competition between different NHS providers and limited choice for individual patients. Most contracts were ‘block’ resulting in patients following the contracts rather than contracts following the patients. New Labour stressed more provider plurality with NHS providers competing with external providers (e.g. private hospitals, ISTC, social enterprises), and individual patients making choices.

Moreover, it has been argued that the Conservative reforms had limited impact. According to Julian Le Grand, the incentives were too weak, and the constraints too strong (in Mays et al., 2011). As Alain Enthoven memorably put it, if the Soviet command economy is ‘0’ while the ‘free market’ of economics textbooks is a ‘10’, the NHS reached perhaps a 2-3 (in Powell, 2003). Le Grand, advising Tony Blair, attempted to ensure that incentives were stronger and constraints were weaker under New Labour. A wider range of competitors and greater individual choice provided the potential for more far-reaching changes. The precise details of how the Coalition reforms will play out in practice still remain uncertain, although the direction of travel is clear. Despite recent Labour protestations of too much competition and too much market in the NHS, it seems to me that Le Grand is correct in his view that current reforms are largely consistent with Labour’s reforms, and that the differences between them are not substantial (see also Millar et al., 2011).

The pros and cons of market-based reform are argued in academic articles, newspapers and blogs (see also Mays et al., 2011; http://hrep.lshtm.ac.uk/), but the problems of markets in health care were clearly spelled out by George Bernard Shaw early in the twentieth century in his ‘The Doctor’s Dilemma’:

‘that any sane nation, having observed that you could provide for the supply of bread by giving bakers a pecuniary interest in baking for you, should go on to give a surgeon a pecuniary interest in cutting off your leg, is enough to make one despair of political humanity’.

However, a number of points tend to be neglected in these debates. First, there is a danger of ‘four legs, good; two legs, bad’. The NHS has long contained a (changing) mix of market, hierarchy and network (Exworthy et al., 1999). There are examples of ‘state failure’ in the scandals in long-term NHS hospitals in the 1960s and 1970s. The favourite and lazy example of the USA disguises the fact of the long history of greater provider pluralism in European health care systems. Second, there is a danger of current evaluations failing to disentangle the effects of ‘markets’ from ‘Nicholson challenge’ and from broader organisational upheaval. Third, many commentators tend to focus on ‘paper policies’ rather than policies in action. I would echo Chris Ham’s views of being wary of easy slogans of vested interests (such as ‘defend the NHS’: if we had listened to the BMA in the 1940s, we would not have had a NHS!). I also share his optimistic view that ‘the experience of the last 20 years underpins my scepticism that the current NHS reforms will undermine the principles on which the NHS is based and lead to widespread privatisation’ [cf Powell, 1996]… reports of the impending death of the NHS should be regarded as premature’.

Over the years a number of governments have produced ‘the biggest change in the history of the NHS’, and many commentators have confidently predicted that particular policies would signal the ‘end of the NHS’. The first example I can find of this is Aneurin
“The past is a foreign country” - wrote LP Hartley in his novel *The Go Between* – “they do things differently there.” Would this sentiment apply to the NHS of 40 years ago? To be sure, the NHS has changed in many ways over the intervening period. It has been subject to radical structural reform, new organisational and job titles have been created and new lines of accountability and control have emerged. Yet, service realities have often remained stubbornly resistant to change. One of the ways of unravelling this apparent paradox is to understand the role of informal social structures in health care delivery. These informal structures, which underpin and support formal structures in the NHS, can be thought of as its organisational ‘culture’.

Bevan’s ‘In Place of Fear’ written in the early 1950s. My ‘iron law of NHS reforms’ states that the impact of reform is rarely as positive as predicted by proponents or as negative as feared by opponents. Health policy confirms the problematic nature of the ‘Webbsonian’ approach to social policy (the Webbs lost interest in policy once it had arrived on the statute book). As we teach on our courses, implementation problems suggest that policy should be judged more on subsequent events and actions rather than by the words on the policy document. Policy in the NHS is re-made every day, sometimes for better and sometimes for worse, ‘from board to ward’ by ‘street level bureaucrats’, and it is their actions, rather than the writing on ‘academic scribblers’ to use Keynes’ term, that directly touch the lives of millions of citizens.

m.powell@bham.ac.uk

References

Russell Mannion

To speak of an organisation’s culture is to assess that which is shared between individuals within an organisation – their beliefs, values, attitudes, norms of behaviour and the established organisational routines, traditions, ceremonies and reward systems. These shared ways of thinking encompass the meanings that people place on their working lives and the narratives they use in making sense of their organisational contexts. They are the social and normative ‘glue’ that bind people into collective enterprise; or ‘the way things are done around here.’ Much of culture emerges from largely hidden and taken for granted assumptions, making it difficult to recognise and harder to understand and change: as the old Chinese Proverb has it, ‘the fish is always last to discover the sea.’

Many commentators agree on the layered nature of culture with Schein’s identification of three levels of ascending importance being one of the most useful and widely used frameworks for cultural analysis (Box 1 overleaf). Despite espousing the need for cultural transformation and renewal, many reforms in the NHS have impacted merely on changing the most visible and surface manifestations of culture (Level 1) and have largely failed to change the deep-rooted cultural values and beliefs that shape and guide professional and managerial behaviour (Levels 2 and 3). This is particularly true of reforms related to improving service quality and patient safety.

Over a decade ago, the Kennedy report identified the cultural characteristics at Bristol Royal Infirmary that had colluded in
fostering a climate where dysfunctional behaviour and malpractice were not effectively challenged. Kennedy recognised that while some problems were specific to Bristol, in many ways the Bristol experience exemplified national issues in the NHS. In making recommendations, the report highlighted a number of cultural shifts seen as necessary to transform the NHS into a high quality, safety-focused institution - one that was sensitive and responsive to the needs of patients. The key cultural prescriptions included shifting established working practices towards:

- **A culture of openness**: a greater openness and transparency with and between staff where staff feel free to discuss openly matters of concern relating to the care of patients and the conduct of fellow workers.
- **A culture of accountability**: the need for a clear articulation as to who has a responsibility for quality of care in and between organisations and thus is accountable for it.
- **A culture of quality and safety**: a concern that quality and patient safety must be a priority at all levels of the service and this must be reflected in the systems and policies of the NHS and individual trusts.
- **A culture of public service**: a shift from allegiance of clinicians from professions and Royal Colleges towards more of a corporate perspective with more of a loyalty to the particular organisation in which they work.

**Box 1: Levels of organisational culture**

**Level 1**: artifacts – the most visible manifestations of culture including dress codes, rituals, reward structures and ceremonies; especially concerned with the observable patterns of behaviour within organisations.

**Level 2**: beliefs and values – espoused beliefs and values may be used to justify particular behaviour and for choosing between alternative courses of action and distinguishing ‘right’ from ‘wrong’ behaviour (e.g. whether to ‘whistle blow’ on apparent malpractice).

**Level 3**: assumptions – the unspoken, largely unconscious beliefs, values and expectations that underpin day to day work (e.g. assumptions about the nature and source of ill health; and the relative role and power of doctors and nurses in clinical settings).

(Adapted and expanded from Schein, 1995)

- **A culture of teamwork**: a recognition that teamwork is the collective collaborative effort of all those concerned with the care of the patient and that patients do not belong to any one professional; they are the responsibility of all who take care of them.

No doubt there has been some progress in nurturing and embedding these cultural attributes across the service. Recent high profile hospital scandals and failings in professional practice, however, would suggest that in many NHS organisations, such changes have been at only a superficial level. If culture change efforts are to bear fruit then they must go beyond merely tinkering with the surface manifestations of culture and address the deep-seated assumptions that have been affirmed over decades and woven in to the fabric of service delivery. While there are no quick fixes or easy solutions, future reforms are likely to be more effective and ownership of change is likely to be stronger, if the managers and professionals involved have some basic understanding of the culture they are working in and if policy makers pay more attention to linking the structural and cultural dimensions of change.


r.mannion@bham.ac.uk

**References**


---

HSMC’s 40th Anniversary Event – 12 October 2012

HSMC’s 40th Anniversary Celebrations continue with a half-day workshop followed by an early evening social event on Friday 12 October. All HSMC friends, colleagues and supporters are invited to attend.

The workshop will run from 2 to 5pm on Friday 12 October and will include:

- A short lecture by HSMC Director Jon Glasby entitled ‘Equity and excellence: do you feel liberated yet?’
- A ‘Question Time’ style panel with participants including amongst others: Prof Viv Bennett, Director of Nursing, Dept of Health
  - John Wilderspin, National Director, Health and Wellbeing Board Implementation, Department of Health
  - Dr Judith Smith, Head of Policy, Nuffield Trust
  - Dr Nick Harding, Interim Chair, Sandwell and West Birmingham Clinical Commissioning Group

From 5pm, there will be a BBQ and drinks on the terrace, a chance to enjoy the HSMC gardens (weather permitting!) and scope to catch up informally with former colleagues.

In order to book your place at this free event please contact Sue Alleyne (email: s.e.alleyne@bham.ac.uk) if you are able to come and also let her know whether you will be able to join us for the BBQ at 5pm so that we can make appropriate catering arrangements.
Medical leadership

In the last Newsletter, John Clark, our former colleague at HSMC and now Senior Fellow in Medical Leadership and Engagement at the King’s Fund, wrote of the development of medical leadership since the Griffiths report was published in 1983. He concluded by noting that management and leadership competences are now required by all doctors (and other clinical professionals) as part of their registration process, and that HSMC might in the future offer more joint programmes with doctors, and other clinical professions working with non-clinical managers and leaders.

In this article we consider these issues from our research experience, and our work with a number of ‘mixed’ groups involving clinicians, as well as General Managers. We are particularly concerned here with medical leadership within provider organisations, and particularly hospitals. Clinical commissioning provides a particular arena for medical leadership, and how clinical commissioners relate to medical leaders in Trusts is likely to become more important in the future as Clinical Commissioning Groups develop (see p.12 of the newsletter for details of HSMC’s new PG Cert for clinical commissioning).

Medical leadership is increasingly being seen in the context of dispersed or shared leadership. While this model is relatively new to the NHS (King’s Fund, 2011), it has a longer theoretical association with professional bureaucracies (Ham and Dickinson, 2008). The development of the Medical Leadership Competency Framework by the NHS Institute (NHSI) and the Academy of Medical Royal Colleges, is based explicitly on a model of shared leadership, and is part of their ‘Enhancing Engagement in Medical Leadership’ project. John Clark had a central role in the project, as did Peter Spurgeon, a former HSMC Director who also contributed to the last newsletter. HSMC contributed literature reviews (Ham and Dickinson, 2008; Dickinson and Ham, 2008) and a study of Medical Chief Executives (Ham et al., 2010).

Our thinking about medical leadership within provider organisations, and particularly hospitals, is influenced by two key distinctions:

- First, between medical and clinical. ‘Medical leadership’ clearly refers to management relating to doctors – sometimes by doctors, and sometimes of doctors. Clinical leadership tends to relate to all clinicians, although sometimes in using the term there seems to be an emphasis on doctors. So, we need to be clear what we are talking about when considering programmes of research and development.

- Second, between the management and leadership skills required by doctors as clinical professionals and those that are required for those in a ‘leadership’ position. The Medical Leadership Competency Framework was designed for the former — for all doctors as part of their role as a doctor. Is there a difference between leadership competences needed to be a doctor and those needed in leadership positions? In distributed leadership, roles may be many and varied, formal and informal. Leadership can come from anyone. But doctors require leadership skills and are required to exercise them in the carrying out of their clinical role.

It seems important to be clear about these distinctions when considering development programmes and future research.

HSMC newsletters regularly include updates of our work with the NHS Management Training Scheme and the NHS Leadership Academy’s Clinical Leadership Fellows. Medical Leaders from the North West Deanery join the MTS programme and so learn with Management Trainees. The Clinical Leadership Fellows programme is open to all clinical professions, and approximately a third of the group of 60 in 2011/12 were doctors – so here is learning by clinicians together, but without general managers. And in our work with the North West Deanery on a leadership programme for hospital based specialty trainees – 160 graduated through the programme this year – participants learn uni-professionally. So HSMC works with 3 models of learning for doctors: on their own, with other clinicians and with general managers. All of these three programmes are run jointly with...
Manchester Business School. Our own open programmes are of course open to all.

Helen Dickinson, Chris Ham, Iain Snelling and Peter Spurgeon have recently submitted a research report to SDO on Models of Medical Leadership and their Effectiveness, based in acute Trusts, which includes case studies of medical leadership, and an exploration of how medical leadership works within the different structures that have emerged across the country. We offer the following observations and questions from our work with doctors and other clinicians, and our research into medical leadership:

- A key area for further research concerns doctors who are not in formal leadership roles, and what leadership, as part of their role as a doctor, means to them and others they work with.
- The leadership development needs of doctors will change over the course of their careers. Specialist Trainees for example may be more comfortable learning with close peers, as their training environment may still be quite medically dominated and hierarchical.
- Not all doctors are the same – in our research on Models of Medical Leadership, we found that some specialties with a more explicitly multi-disciplinary service model were more comfortable with a shared leadership approach.
- Clinical leaders of all sorts may feel challenged by the widespread view that clinical leadership can do what ‘management’ can’t. Cost reductions in management may leave clinical leaders isolated, and short of management support.
- Since the medical workforce is becoming more managed, through the Consultant Contract and Revalidation for example – medical managers will need to develop skills to undertake these tasks. Using the distinction between management and leadership may help to develop greater clarity about what is expected of medical leaders.
- With clinical governance and the clearer focus on quality and safety, is the traditional divide between management and medical views being eroded? Medical management in organisations with a clear ‘culture of engagement’ between these perspectives, especially where they are clearly acknowledged and discussed, may be different than in organisations where the ‘divide’ is still alive and well.
- The ‘triumvirate’ model in Directorates, of doctor, manager, and nurse, that was reported in early research, seems to have given way to a ‘duality’ of doctors and managers. This too seems an important development worthy of research to understand in more detail why this shift has come about and what the implications are for wider clinical leadership.

The single clear message to come from this is that we need to develop clear evidence about medical and clinical leadership development. Evaluations of our existing programmes, as well as our research in these areas, will contribute to that.

i.n.snelling@bham.ac.uk
h.e.dickinson@bham.ac.uk

References
King’s Fund (2011) The future of management and leadership in the NHS: no more heroes. London, King’s Fund

Inter-professional learning - only good for the frontline?

An issue that is as pressing now as it was 40 years ago is the challenge of how to successfully bring together different professional disciplines to work in an integrated and effective manner. Indeed, one of the first programmes that HSMC ran when it opened in 1972 was around the ‘Management of Integrated Health Care’ (to help support the 1974 NHS reorganisation). Of course, integration is often talked about in simple terms, highlighting the perceived clash between the ‘medical’ model of doctors and the ‘social model’ embraced by social workers, and also in the different styles and priorities of managers and clinicians. The reality, however, is much more complex, with subtle but significant professional differences between the considerable range of health and indeed management disciplines that are contained within the NHS. In social care, one of the
contributing factors to the great divide between children and adult services are the alternative models of practice followed by adult and children social care practitioners. Part of these tensions are factors relating to the different perspectives, bodies of knowledge and working cultures that these professions embrace and which - if we can successfully bring them together - can lead to more holistic responses to patients and service users. However, there are also more negative undercurrents connected with professional rivalry, role protectionism and concerns that disciplines may become diluted or lost altogether through loss of professional distinctiveness and/or other professions taking on key parts of their roles. Within our current system, we have arguably added a further layer of complexity through the introduction of ‘commissioners’ – whilst there is not a professional body or standardised qualification for commissioning (as yet), there is increasing recognition of the particular skills, knowledge and values that people undertaking such roles should exhibit, and over time people may have to choose between ‘provider’ and ‘commissioner’ career routes.

One intervention that has been promoted to address such difficulties is that of Inter-Professional Education (IPE), in which different disciplines participate in shared learning opportunities. This is based on the assumption that learning together will enable professions to understand more about each other’s roles and contributions, discover how they can better communicate and co-ordinate their work, and overcome the common stereotypes that often act as barriers. This logic led to IPE opportunities being adopted in a number of undergraduate health and social care programmes in the UK and further afield, and there have also been examples of the approach being applied in post-qualifying programmes. As is often the case with integrated working, delivering the hoped for improvements has proved hard to achieve, sustain and evaluate in practice, but there is evidence that, with the correct design and context, IPE can have significant impact in relation to different professions’ perceptions of their colleagues.

Less common is the use of IPE as an intervention to enable people in senior management and commissioning roles to better work together. This is despite recognition that issues such as different terminology, expectations and agency priorities that prevent joint working at the frontline can also be present at a strategic level. Furthermore, working at a strategic level brings in additional dynamics through the involvement of elected members, who whilst not a profession as such do have a common set of responsibilities and accountabilities that sets them aside from other managers and senior clinicians. To explore the potential of IPE in this more senior context, HSMC recently ran a programme bringing together teams of commissioners and senior provider managers from across local health and social care economies. Focussed around an actual priority for local integrated working and with a strong emphasis on individual and team reflection, the Integrated Care Development Programme included input from Finnimore Consulting on business case development and was funded by the West Midlands Strategic Health Authority and Joint Improvement Partnership.

The programme will be evaluated in the Autumn, but the evidence gathered to date provides initial insights regarding inter-professional working at a senior level and the use of IPE as an intervention for strategic integration:

1) Professional identity – many of the participants had begun as clinicians or social workers, but had worked for many years as managers and/or commissioners. They therefore had multiple professional groups that they could affiliate with, but a number reported their identity as being most closely tied to their initial practice discipline, showing how strong this construct remained for them.

2) Boundary spanning – the potential role of key people who can work across agencies and act as a facilitators between different languages and cultures is well established, and there were participants who saw boundary spanning as one of their key roles. This included those who were employed by an agency dominated by different professional groups and this could lead to them feeling isolated.

3) Understanding different professions – despite all the participants working with other disciplines within the course of their often considerable careers, it was clear that for many their knowledge of the work and pressures of professions in other agencies and the performance and legal framework of these agencies was limited.

4) Benefits of learning together - at least half had not previously been involved in IPE to any significant extent, but the benefits of undertaking a programme with colleagues from different health and social care disciplines was fed back by all.

As we go forward into a new set of arrangements for the co-ordination of strategic commissioning and delivery through health and well-being boards, the ability of health and social care leaders to understand and respect their professional differences and to be able to use these as a source of creativity will be key to us achieving the integrated system that we aspire to. IPE provides a means to facilitate these relationships and build a solid platform on which the many challenging and complex decisions we face can be made.

r.s.miller@bham.ac.uk
h.i.brown@bham.ac.uk

For further information on HSMC’s new Integrated Care Development Programme, see: www.birmingham.ac.uk/schools/social-policy/departments/health-services-management-centre/courses/integrated-care-development-programme.aspx

For information on HSMC’s MSc in Managing Integration for Health and Well-being, see: www.birmingham.ac.uk/students/courses/postgraduate/taught/social-policy/manage-integration-health-wellbeing.aspx
Making the shift 2

In our last newsletter, Helen Parker described three key policy issues which continue to resonate as much today as they did during her time at HSMC. However, these three themes (shifting care from secondary to primary services; choice and competition; and integration) aren’t an end in themselves – but can all be seen as components of a quality improvement agenda (with their purpose being to drive up quality in order to benefit patients, users and the public). It is the shift in the quality agenda which this article now explores.

The duty of quality
As far back as the 1980s, the health service began adopt quality improvement processes to respond to the requirement to provide both effectiveness and value for money for tax-payers. Clinical audit, guidelines and evidence-based practice were widely adopted tools, together with the “plan-do-study-act” developed by Deming in 1986 (Boaden et al., 2008).

High profile cases of poor care (for example, Bristol, Shipman and Alder Hay) coupled with a New Labour government, resulted in a new term of “Clinical Governance” cited in The New NHS: Modern, Dependable (Department of Health, 1997) and further developed in A First Class Service (Department of Health, 1998). For the first time, Boards of NHS organisations had a statutory duty of quality alongside their statutory duty to achieve financial balance. This heralded a new dawn. Clinical governance leads were routinely appointed in organisations, the seven pillars of clinical governance were common parlance, and this approach was reinforced by the development of new national assessments devised and administered by the Commission for Health Improvement (CHI). Later this organisation became the Health Care Commission (HCC), and latterly, the Care Quality Commission (CQC).

Initially, the assessment and reviews were intended to be developmental. Reviewers were recruited from the NHS and trained to assess other organisations’ clinical governance systems and processes to help them identify areas for improvement. This quickly moved from developmental to regulatory, with the introduction of the Annual Health Check (Department of Health, 2004), and whilst the tools and techniques as well as measurement processes have changed over the years, the prime purpose of assessing and improving quality services remains. Lord Darzi introduced a definition of quality in his report, High Quality Care for All (2008), to include three components: safety, effectiveness and patient experience. This definition has now been enshrined in the Health and Social Care Act 2012, which puts the UK in a unique position.
The impact on services
Considering that the developments outlined above were, at least partly, in response to poor care, it is difficult to describe this agenda as a resounding success – especially given that Maidstone, Mid-Staffordshire and Winterbourne scandals have all emerged post the Clinical Governance age. Indeed Walshe and Higgins (2002) highlight scandals from the 1960s which all seem to have similar themes relating to leadership, culture and communication. Most commentators would predict similar findings in the Francis report, due in October 2012. The formulaic response to these major scandals is to develop a number of key actions and performance measures and hold organisations to account against these using a combination of incentives (financial support) and sanctions (personal (i.e. dismissal), contractual and reputational). However there is little evidence that this approach has been successful previously and our work at HSMC has led us to argue that we need to look at this issue again, through a different prism.

Compassion and kindness
In her work entitled “Why reforming the NHS won’t work” (2011), Illes describes how society has developed a managerial and economic approach which renders the human factors invisible. This is summed up in a quote from the CQC chairman (2011) who stated that “kindness and compassion cost nothing” (Ballatt, 2012, p.1) feels almost impossible, and we are likely therefore to retreat to the comfort of action plans and blaming groups, processes or individuals. The uncomfortable truth is that this is unlikely to work.

Through our research (Sawbridge and Hewinson 2011), we have identified a number of factors which may help us to identify new solutions, and we are undertaking an action research project, working with the Samaritans, to assess the feasibility of implementing the model they use to support their volunteers to equip them for their emotional labour, in a ward setting. We look forward to reporting our findings in Autumn 2013.

y.sawbridge@bham.ac.uk

References
The changing face of nursing

HSMC, and Park House in particular, has a long association with the nursing profession. Occasionally nurses who were trained at Park House return to re-live their memories. On a recent visit last year a small group of nurses agreed to complete a short emailed questionnaire about their training, life as a nurse, and views on nursing practice today. Their views are summarised here and set within the context of current work at HSMC.

The nurses who visited were among 84 who arrived in January 1961. Their training routine involved being woken at 6.30am with the first tasks being room tidying followed by an inspection, then cleaning toilets and bathrooms – all before breakfast. Classes started at 9am in Park House Annex with lectures in the morning and practical sessions in the afternoon. The nurses wrote:

“We remember the skeleton hanging from a drip stand in the corner of the room, and a couple of hospital beds where we took turns to be the patient while others made the bed.”

When their preliminary training was completed they received further training on the wards at the Queen Elizabeth Hospital or Birmingham General Hospital. They recalled:

“We were the junior nurses and all our work was with a staff nurse or ward sister. We usually had the basic duties – fluid intake, bedpans, care of the sluice and keeping records of all that we did… bed bathing, care of pressure areas, turning patients, taking temperatures and blood pressure. We cleaned equipment, trolleys and cupboards, bottles and bedpans – things we would never forget for the rest of our working lives.

“We were kept well away from the consultants on their ward rounds. That was when we cleaned the sluice – silently. It was almost instant dismissal if we dropped a bedpan! When matron did the ward round the place had to be spotless, including the patient in his bed. All bed wheels had to face in the same direction, all linen pristine!”

Nursing practice

In the opinion of these older nurses, nursing practice has changed “totally”. They perceived this to be for two main interlinked reasons. The first is that nurses today spend less time on the wards learning as they work in a ‘hands on’ way from sisters and matrons. The second is the fact that ward sisters no longer have total control of their wards and departments as they used to.

These perceptions seem to be shared by some older people. During a recent HSMC research project examining the views of older people on transitions in care, several interviewees who had experienced a recent stay in hospital commented on how different life on the wards was now compared with their memories of past times as an inpatient (Ellins et al., 2012). For example:

“…it was all so clinical and I think because I’m old, I remember the days when I was younger in hospital, they seem to lose that one to one with the patient. You didn’t have the understanding that you did from the nurses that were in the old days…. I said to my son, I’ve had three lots of hospitals now and I don’t want to die in hospital because the experience I had is cold, it’s not as it used to be.”

One popular solution to perceived inadequacies in nursing care which is shared by policy makers, the public and the older nurses who recently visited Park House is to ‘bring back matron’. But is this...
focus on the pivotal role of the ‘nurse in charge’ justified? Research as long ago as the 1960s drew attention to the complexity of the ward environment and a lack of clarity in the role of the ward sister. Indeed, former HSMC director Derek Williams pointed this out in his study of the management training needs of sisters (Williams, 1969). He reported on the apparent tension between what managers expected of ward and departmental sisters and their own perceptions of the job. For example, one administrator he interviewed said (p.314):

“I’ve been here seven years, and I’ve yet to see a sister treating a patient. The pillow patting days of the sister are over.”

Ward sisters on the other hand repeatedly emphasised the importance of the sister-patient relationship, which they saw as being at the heart of their profession rather than their managerial activities. Clearly the role of ‘ward sister’ or ‘matron’ can mean different things to different people.

One of the most telling findings of the research was that the working environment was changing and this was having an impact on the nursing role. As Williams explained:

“The situation is complicated by the fact that the ward sister’s job is changing, and that some sisters’ jobs are changing more quickly than others under the pressure of particular technical and clinical innovations” (p.315).

Solutions
A more recent investigation by HSMC into solutions to address reports of poor standards in nursing care in acute hospitals echoed some of Williams’ insights. One of the findings from Sawbridge and Hewison’s (2011) work was that ward sisters experienced conflict between the professional and organisational/managerial aspects of their job, leading the researchers to recommend that ward sisters/charge nurses should have a more clearly defined role as clinical leader of their ward. Their research also identified the impact of changes in the design of ward layouts which had implications for nursing practice.

One of the most significant messages from Sawbridge and Hewison’s report, however, was the importance of hospital Trust Boards recognising the emotional labour of nursing and establishing a systematic approach to supporting nurses so, along with innovation and improvement, they can continue to carry out the basic compassionate care that patients value so highly.

s.a.mciver@bham.ac.uk

References


New Postgraduate Certificate for CCG leads – launching early 2013
Following the passage of the Health and Social Care Act, this new Postgraduate Certificate in Healthcare Commissioning is designed specifically for clinical commissioners, all those involved in new CCGs and emerging commissioning support organisations. Although fully tailored to the current policy context, the PG Cert builds on previous successful programmes such as the MSc in Healthcare Commissioning delivered for NHS London and NHS West Midlands, the UK’s first MSc in Public Service Commissioning (delivered jointly with the Institute of Local Government Studies) and a series of local and regional commissioning development programmes delivered throughout the country. Aimed at both clinicians and managers, these previous programmes have been consistently positively evaluated, and feedback suggests they help those in commissioning roles to understand what commissioning is, where it has come from, where it might be taking us and how to do it differently and better.

As shadow CCGs are set up and authorised, there will be an urgent need for training and development for clinical commissioners and those who support them. Although policy emphasises the importance of ‘commissioning’, it has not always enjoyed the infrastructure necessary to equip healthcare commissioners with the right skills and knowledge – and formal, well established development opportunities can be rare. In accessing such support, clinical commissioners will need to balance existing workloads and commitments with the training they need to adapt to new roles – and a PG Cert offers scope to get the best of both worlds (sufficiently in-depth whilst also not taking the time of a full MSc).

The programme consists of three modules:
- Strategic commissioning
- Decision-making and priority-setting
- Procurement and market management.

To receive further details and a full application pack, please contact Kate Vos

HSMC will welcome a new intake of students on 17 September 2012. 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 Studies)
4. MSc in Managing Integration for Health and Well-Being (with the Institute of Local Government Studies)

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.

The next student intake to HSMC MSc programmes will commence on 30 September 2013.

For further information contact Kate Vos email: c.j.vos@bham.ac.uk
Where are they now?

I was at HSMC from 2006-2008 and at the time I was a practising children’s speech and language therapist on the Managing Partnerships in Health and Social Care programme.

I am still a children’s speech and language therapist for 3 days of the week, a student coordinator for speech and language therapy (adults and children ) for 1 day a week and visiting lecturer for 1 day a week at BCU.

During the time I studied at HSMC I particularly remember the support given by the teaching staff; their positive attitude and their commitment to putting service users at the centre of their teaching and ethos of policy development.

Raman Kaur

I studied at HSMC part-time from September 2002 to July 2005 on the MSc programme on Quality Management in Healthcare. When I started I worked for NHS Education for Scotland, and every single element of the course was of practical use in my training role with healthcare professionals. During my studies I moved to the Law Society of Scotland, where I am now Director of Representation and Professional Support, and I found many lessons transferred well from healthcare to law and gave me a cutting edge in a profession that spends less on research, audit, education and quality assurance, and so has less experience in those fields. I love my current role, but still have a passion for healthcare, and was delighted to be appointed as the Privy Council as a member of the General Dental Council, an appointment I’m sure in which my HSMC qualification played a key part. The qualification was well organised and structured, but the stand out memories are of the calibre of staff and speakers who delivered it (with Penny Mullen and Shirley McIver regular stars who led us through topics on which I still refer back to my notes from time to time!). There are too many people I should be thanking from my days there to name everyone personally, but in many ways it was the whole team that made HSMC so welcoming, from Janet in the canteen, through the support staff to those who presented. Learning from international students was also a key element, challenging perceptions and assumptions. I would thoroughly recommend HSMC to anyone.

Neil Alan Stevenson

NHS Leadership Academy Graduate Management Training Scheme

The 2012 cohort of the NHS Graduate Management Training Scheme commences in September 2012. The cohort is made up of approximately 170 trainees from different specialisms (General, HR, Informatics and Finance) as well as Medical Leaders, Northern Ireland and Welsh trainees.

HSMC and Manchester Business School provide a bespoke Postgraduate Certificate in Leadership for Service Improvement for all trainees; and a MSc in Leadership for Service Improvement for general managers. HSMC has been involved with the training scheme for 13 years and is pleased to continue to support the learning and development of our future NHS leaders.

The first event will be held in September in Staffordshire and will include speakers such as Anthony Sumara, Nigel Edwards, Dr Win Tad and Helen Bevan.

t.gray@bham.ac.uk

NHS Leadership Academy Clinical Leadership Fellows Programme.

HSMC, together with Manchester Business School and the King’s Fund, provide the NHS Leadership Academy Clinical Leadership Fellows Programme to develop the thinking required for sustainable improvements in leadership capability. This is the only scheme designed for clinicians in all areas of the NHS across England. The programme supports the transformation of leadership capacity and capability across the NHS, and it offers a unique opportunity to develop leadership skills.

The programme runs on a part-time basis over nine months in the Fellows’ own organisation and in conjunction with their existing clinical role. Fellows are expected to commit to approximately 48 days, 18 of which will be dedicated to in-service project time to work on designing and implementing a service transformation project in their work place. This project will be built on the principles of the Quality, Innovation, Productivity and Prevention (QIPP) programme and alongside this Fellows work towards a Postgraduate Certificate in Leadership and Service Improvement as part of the programme. A new cohort of 80 fellows have been recruited to start in September 2012.

“The Clinical Leadership Fellowship has been a great experience so far. The course has involved learning practical and theoretical aspects of leadership through work with Manchester and Birmingham Universities. Experiential work with the King’s Fund has helped develop our own leadership styles and given us deeper insight into many of the very human aspects of leadership. The training has been excellent and the opportunity to work with so many other caring and committed clinicians has been fantastic.”

Dr Abigail Hine, South West

“The National Clinical Leadership Fellowship has been a fantastic opportunity to network with a diverse group of like minded clinicians, academics and public speakers. It has extended my knowledge, experience and self awareness and has given me confidence to approach my work in a more strategic and open minded manner. It has also highlighted the difference and difficulties between theory and practicalities of implementing change. Although the work schedule is demanding the in-service project and the residential modules allow time out of the day job to focus and consolidate the course work. The King’s Fund and Manchester / Birmingham modules have a very different style but complement each other well. I consider myself very fortunate in having experienced the first Clinical Leadership Fellowship and would encourage anyone to put themselves forward for a similar opportunity.”

Julie Burden, AHP, West Midlands

For further information please contact Tracey Gray (t.gray@bham.ac.uk)
Projects update

SDO Care Transitions project
The final report from the SDO-funded Care Transitions project has been published, and is available from the HS&DR Programme website (www.netscc.ac.uk/hsdr/) and the HSMC website. The study explored older people’s experiences of transitions in their care, and was carried out in partnership with 22 older co-researchers. In-depth interviews with older service users and carers in four areas of England showed that experiences of transition were frequently accompanied by a sense of disorientation and feelings of uncertainty. While positive relationships with care providers, good communication and a pro-active approach to service planning could help to ease disorientation, care was not always provided in this way – which left older people anxious about what was happening to them and what the future held. The study team and co-researchers fed back the findings of the in-depth interviews to service providers and commissioners in the case study areas, and worked with them to make changes to local policy and practice in older people’s services. The outcomes of this implementation phase and the findings from the evaluation of the co-research model – which explored its impact on the study process and outcomes – are included in the final report.

Leicestershire Partnerships Trust: Families, Young People and Children’s Division
HSMC is supporting the Senior Management Team (merged from four organisations) to build an effective culture in the SMT and in the Division as a whole. In addition, support is being provided to develop the Division’s plans for a Service Development Initiative (as part of their Foundation Trust application) which looks to radically change the way in which community health and mental health care is provided, while also reducing costs significantly over a five year period.

d.c.davidson@bham.ac.uk

Public Service Academy
The Public Service Academy (PSA) led by Helen Dickinson has now been established and Helen has been working with colleagues from UoB and Birmingham City Council (BCC) to set priorities and plans for this. The PSA held an event with academics across the College on the 24th May to discuss research priorities and a series of events have been organised for the remainder of the year. The first major package of work for the PSA concerns the notion of a twenty-first century public servant and a series of activities ranging from roundtables, research with undergraduates regarding their perceptions of public service, streamlining student placements, setting up new internship opportunities and working with alumni have been planned for the rest of 2012. In early 2013 a further work package will then be established focusing on digital and social media and particularly the way this alters young people’s interactions with public services. For further information on the PSA see www.birmingham.ac.uk/schools/public-service-academy/index.aspx.

h.e.dickinson@bham.ac.uk

Health and Wellbeing Boards simulation events
Autumn 2012
Health and Wellbeing Boards (HWB) are vital to the better integration of public health, social care and the wider NHS. However, they face the challenge of complex change in a time of severe austerity and rising demand for services against a background of increased health inequalities in local communities.

The LGA have commissioned the Institute of Local Government Studies and the Health Service Management Centre, at the University of Birmingham, to design and deliver a series of ‘simulation events’. These provide an opportunity for HWB members to explore these challenges, and understand the inherent complexities and conflicts of interest within their roles, within a safe and developmental space. In doing so, they encourage accelerated learning and strengthen the shared leadership capacity of Health and Wellbeing Boards.

The events are fully funded by the LGA and FREE to Health and Wellbeing Board members. Early booking is advised as places are limited.

Dates have been set for regional events, and registration for attendance is being handled through local HWB facilitators. The dates and contact details are as follows:

<table>
<thead>
<tr>
<th>Dates</th>
<th>Region HWB</th>
<th>Contact for attending</th>
</tr>
</thead>
<tbody>
<tr>
<td>21/9</td>
<td>South East</td>
<td><a href="mailto:Katie.barnes@hscpartnership.org.uk">Katie.barnes@hscpartnership.org.uk</a></td>
</tr>
<tr>
<td>25/9</td>
<td>East Midlands</td>
<td><a href="mailto:Sarah.Hassell@dh.gsi.gov.uk">Sarah.Hassell@dh.gsi.gov.uk</a></td>
</tr>
<tr>
<td>26/9</td>
<td>North West I</td>
<td><a href="mailto:Bernadette.Hurst@transitionalliancenw.nhs.uk">Bernadette.Hurst@transitionalliancenw.nhs.uk</a></td>
</tr>
<tr>
<td>27/9</td>
<td>North West II</td>
<td></td>
</tr>
<tr>
<td>4/10</td>
<td>South West</td>
<td><a href="mailto:Katie.barnes@hscpartnership.org.uk">Katie.barnes@hscpartnership.org.uk</a></td>
</tr>
<tr>
<td>10/10</td>
<td>West Midlands I</td>
<td><a href="mailto:r.poulter@wmcouncils.gov.uk">r.poulter@wmcouncils.gov.uk</a></td>
</tr>
<tr>
<td>TBA</td>
<td>North East</td>
<td><a href="mailto:andy.robinson@northeastcouncils.gov.uk">andy.robinson@northeastcouncils.gov.uk</a></td>
</tr>
</tbody>
</table>

Currently, there are no plans for the Yorkshire and Humber region.

d.c.davidson@bham.ac.uk
findings will be disseminated widely.

research begins in the Autumn, and the support they use for volunteers, and adapt it to Samaritans to introduce the model of project with 3 hospitals, working with the West Mercia Cluster have commissioned HSMC to undertake an action research which identified that one of many factors which may need addressing is the emotional labour of nursing. In response to this paper, the Mental Health Alliance brings together the skills and expertise of HSMC, Mental Health Strategies, Contact Consulting and the Centre of Mental Health in order to support commissioners on a long-term basis to develop their capacity and skills.

The Mental Health Alliance (HSMC) is one of the founder members of a new partnership that has been created to support local health and social care commissioners of mental health services. The Mental Health Alliance brings together the skills and expertise of HSMC, Mental Health Strategies, Contact Consulting and the Centre of Mental Health in order to support commissioners on a long-term basis to develop their capacity and skills.

Coaching
A number of HSMC staff are experienced executive coaches accredited by the Institute of Leadership and Management, and provide individual support and development coaching. Current work includes support for a Director General, for NHS staff leading an innovative community mental health service to GPs in London and career development coaching to a number of NHS staff who are looking to change their roles, as a result of the structural changes.

d.c.davidson@bham.ac.uk

HSMC academics visit China
Russell Mannion and Iain Snelling visited China during May to discuss possible future research and teaching collaboration with a number of leading universities. Meetings were held with colleagues from Peking University, Shanghai Jiaotong University, Guangzhou Medical University and Sun Yat Sen University. The meetings were very positive and there was a strong willingness to collaborate in all the universities visited. Further discussions are underway and a joint research seminar in Beijing has been organised in October with colleagues from the Department of Health Policy and Management at Peking University.

r.mannion@bham.ac.uk
i.n.snelling@bham.ac.uk

Time to care
Yvonne Sawbridge was invited to attend Jane Cummings’ (the new Chief Nursing Officer) Landmark event on July 9th to develop a new nursing strategy. She was asked to present the findings from the HSMC Policy paper ‘Time to care? Responding to concerns about poor nursing care’ (2012) which identified that one of many factors which may need addressing is the emotional labour of nursing. In response to this paper, the West Mercia Cluster have commissioned HSMC to undertake an action research project with 3 hospitals, working with the Samaritans to introduce the model of support they use for volunteers, and adapt it for nurses working on the wards. This research begins in the Autumn, and the findings will be disseminated widely.

y.sawbridge@bham.ac.uk

Local evidence for social care prevention
HSMC have recently completed a School for Social Care Research study on local authority preventative services. With a particular focus on evidence, the project looked at how services monitor activities and demonstrate impact. HSMC hosted a dissemination event in June to showcase findings, including input from key academics and researchers in the field from the Social Care Institute for Excellence and the Personal Social Services Research Unit.

k.allen@bham.ac.uk

Chronic kidney disease home therapies research
Despite international evidence to suggest that home dialysis can increase life expectancy, improve quality of life and provide cost savings, the uptake of home therapies in the West Midlands remains very low (around 5% of all patients needing dialysis). HSMC continue working in collaboration with the School of Health and Population Sciences to examine approaches to renal home therapies in four West Midlands Acute Health Trusts. This research forms part of the West Midlands Health, Education and Innovation Cluster (WMC HIEC). It seeks a greater understanding of how and why innovations, such as renal home therapies, become embedded in health services and what blocks this process.

k.allen@bham.ac.uk

Mental Health Alliance
HSMC are one of the founder members of a new partnership that has been created to support local health and social care commissioners of mental health services. The Mental Health Alliance brings together the skills and expertise of HSMC, Mental Health Strategies, Contact Consulting and the Centre of Mental Health in order to support commissioners on a long-term basis to develop their capacity and skills.

r.s.miller@bham.ac.uk

NHS reforms and cancer services project
HSMC is currently evaluating the early impact of the NHS reforms and efficiency savings on cancer services in England. The study, funded by Cancer Research UK, is analysing trends since early 2010 in referral and diagnostics waiting times and in expenditure on cancer services. In addition, the team are carrying out in-depth qualitative interviews nationally and in eight selected cancer network areas to explore the perceptions and experiences of key stakeholders in the cancer community. The findings will be published later this year.

j.ellins@bham.ac.uk

Simulation event - how will CCGs utilise CSSs in the new world?
HSMC were commissioned by the NHSCB, SHAs and the Clinical Commissioning coalition to design and deliver a simulation event to test how CCGs would utilise CSSs in the new world. Over 60 participants attended from across England, and were grouped into 4 CSSs and 6 CCGs. An Acute Trust was also represented. They were given a fictitious name and location (Middlechester) and were placed in April 2013. Their tasks included developing their operational plan; redesigning the system to deliver COPD services more efficiently and effectively; and handling a number of media concerns and crises along the way. One participant said “the issues we addressed today matched what is really happening in our locality”, and it therefore appeared to be an effective tool to facilitate their learning. The final report, ‘Steering or Rowing?’, published by the NHSCB, is available at: www.birmingham.ac.uk/nhscb-report. The learning will be used to enable the NHSCB to provide ongoing support to CCGs and CSSs. The HSMC team have also been approached to deliver 2 similar events for a local cluster in London later this year.

y.sawbridge@bham.ac.uk

Social Inclusion Process
Academics from across the College of Social Sciences are currently involved in supporting a Social Inclusion Process across the city. Led by the Bishop of Birmingham, the Right Reverend David Urquhart, and in conjunction with the city’s local strategic partnership, Be Birmingham, this process aims to bring together the combined energy, resources and wisdom of the city’s key organisations and leaders to
Projects update continued

address fundamental social and economic issues in the city. The aspiration is that this process should aim to improve opportunities and aspirations for all and especially those who are most disadvantaged. The process comprises five key lines of enquiry around: diversity of place; diversity of people; inclusive economic growth; young people; and health and well-being. Helen Dickinson is involved in supporting the wider process through her role with the Public Service Academy and individual academics from across the College are also involved in specific aspects of this investigation (for example Jon Glasby is supporting the health and wellbeing key line of enquiry).

h.e.dickinson@bham.ac.uk

Making the case in safeguarding: enhancing safe practice at the interface between hospital services and children’s social care

HSMC join colleagues in IASS for a new project looking at the potential role of hospitals in improving children’s safeguarding practices. Patient safety is the subject of a high profile NHS initiative, Patient Safety First (PSF). The project seeks to develop transferable methods, based on clinician-led innovation in one hospital (Pennine Acute Trust), extending and adapting extant PSF tools. The aim of the tool-kit is to help foster a safeguarding culture within the hospital environment that will detect children at risk of abuse and devise appropriate protective actions before discharge, typically involving other agencies. Through careful inter-agency follow-up, the study will rigorously appraise hit, false positive and miss rates, enabling ‘signal detection’ performance to be robustly appraised. An action research methodology will be followed, with three main phases. Current design work on the tool-kit will be completed in Pennine, using user-centred methods, including interview, observation and design workshops. Evaluation will then be carried out, focused on the quality of decision-making regarding safeguarding. This will involve an analysis of complaints to help to detect any increase in false-positives and follow up with external agencies (e.g. GP and statutory children’s services).

The third phase will comprise an evaluation of the transferability of the tool-kit, by implementation in new sites, namely particular clinical settings within Birmingham Heartlands and Solihull Trust and Birmingham Children’s Hospital.

k.allen@bham.ac.uk

New conversations with new players? The relationship between primary care and social care in an era of clinical commissioning

As debates continue around the impact of the Health and Social Care Act, one thing seems certain. Whatever does or does not happen next, there is going to be a much more significant role for general practice and primary care. As Primary Care Trusts (PCTs) and Strategic Health Authorities form new ‘clusters’, joint working at local level will increasingly take place between social care and the emerging clinical commissioning groups (CCGs). Interestingly, we know relatively little about relationships at this level. While there was significant interest in primary care/social care joint working and in concepts such as GP-attached social work in the late 1990s, the focus since then has often been on local authority/PCT relationships – and GPs have tended not to be seen as key players in these discussions.

Against this background, this study seeks to review the evidence about joint working between primary care and adult social care in an era of clinical commissioning. Specifically, the review will ask:

- What impact can joint work between primary and social care have (at either operational or strategic levels)?
- What helps and hinders such joint working?
- What implications does this have for current and future social care practice?

In order to explore these issues, we will:

1. Review the formal literature on relationships between primary care and adult social care, focusing on services for older people and on material published since 2000.
2. Conduct interviews with key stakeholders about the current and future implications of clinical commissioning for joint working.

This study is funded by the national School for Social Care Research and will be conducted by Jon Glasby, Robin Miller and Rachel Posaner.

j.glasby@bham.ac.uk; r.s.miller@bham.ac.uk; r.d.posener@bham.ac.uk

Black Country Cluster - leadership in the new system of healthcare

HSMC has been commissioned to develop this leadership programme for 30 senior managers working in the Black Country Cluster. It is based on the highly successful Aspiring Directors Programme which delivered its final module in May, ending with a series of creative presentations, outlining the benefits participants gained from the programme.

This new programme commenced in July with the first of four three day modules. It includes the usual mix of experiential and theoretical approaches and audience participation. A group task called “Zin Obelisk” enabled participants to think about teamwork and leadership from a new perspective, and also provided a good deal of fun. As the group were grappling with the task they learned a great deal about skills of communication, listening, perseverance and working together for the greater good. They also managed to get the answer right so lots of personal satisfaction too!

If anyone is interested in finding out more about tailored leadership development programmes for individuals and/or organisations please contact Yvonne Sawbridge.

y.sawbridge@bham.ac.uk

Paying the Third Sector for outcomes

Robin Miller and Ross Miller are part of a TSPRC research project exploring the potential impact of Social Investment Bonds and other outcome based payment initiatives for third sector organisations working with people with mental health difficulties.

r.s.miller@bham.ac.uk
**Culture research used in Mid-Staffs Inquiry**
Professor Russell Mannion’s research with colleagues on organisational culture and health care quality has been called as evidence in the Mid-Staffordshire NHS Foundation Trust Public Inquiry, chaired by Robert Francis QC. The Inquiry is due to report 15 October, 2012.

r.mannion@bham.ac.uk

**SDO Joint Commissioning project**
HSMC’s SDO-funded Joint Commissioning project is now in the reporting stage following 2 years of research aiming to better understand the processes, practices and outcomes of joint commissioning. The research answers longstanding calls to better understand the workings and outcomes of joint commissioning.

The research is particularly concerned with examining whether any distinction might be made between joint commissioning and more general collaborative endeavours. The research has involved over 180 staff and service users/carers across five case study sites that each exemplify a different type of joint commissioning, with the aim of better understanding how joint commissioning is being implemented across the country and the difference these arrangements have made to service user and carer outcomes.

Phase 1 was based on a unique on-line survey known as POETQ, which aimed to surface the range of different meanings associated with joint commissioning. Phase 2 then checked out these meanings with staff and service users from across the five sites and analysed what sorts of impacts joint commissioning has had locally.

The report should be published at the end of 2012.

h.e.dickinson@bham.ac.uk

**Maximising the potential of the NHS workforce**
The NIHR Health Services and Delivery Research (HS&DR) Programme are funding a study – Staff satisfaction and organisational performance: evidence from the NHS Staff Survey - to investigate whether job satisfaction and employee attitudes are associated with improved organisational performance in the NHS.

The researchers, led by Professor Martin Powell, from the University of Birmingham, will be predominantly analysing data from the NHS national staff survey, the largest annual workforce survey in the world. The project will be focusing on four main areas: length of time with the organisation, staff group (clinical/non-clinical), demographic and background factors (age, sex, ethnicity, disability) and finally by trust type and geographical region.

Professor Powell said: ‘This project brings together researchers who have previously examined human resources management and engagement (funded by DH) and Talent Management (funded by NIHR SDO). It focuses on ‘High Performance Work Systems’ (HPWS), and how these impact on the work of NHS trusts. Much of the previous work on HPWS has been on the manufacturing sector in the USA, and we know less about HPWS in the UK in general and the NHS in particular. We aim to discover from the NHS Staff Survey which particular aspects of staff satisfaction and experience are linked to organisational performance, and to suggest policy ‘levers’ that may improve organisational performance’.

The results of this study aim to benefit patients by discovering better ways to maximise the potential of the NHS workforce.

m.powell@bham.ac.uk

**Evaluating NHS South Birmingham’s model of community health service provision**
In 2007, NHS South Birmingham worked to develop a model of community healthcare services across children’s and adult services. Their research showed that high quality, integrated community services were essential to support people with long term conditions to live as independently as possible. As a result, they developed an integrated service model comprising three key functions, underpinned by robust clinical pathways, case management, and seamless working:

- Public health, self care, self management, IT support with assistive technology
- Integrated multidisciplinary teams
- Rapid response team

The intent was to significantly contribute to NHS South Birmingham’s aims of reducing unscheduled admissions into secondary and community beds and reducing average length of stay through early supportive discharge. The development of community health services was iterative over a number of years with the Rapid Response Service (RRS) coming on stream in October 2008 and a series of Integrated Multidisciplinary Teams (IMT) commencing a year later in November 2009. (In October 2012, a further element - a Single Point of Access - was introduced).

In July 2011, when the service model in South Birmingham was proposed as the service model for the whole of Birmingham, NHS South Birmingham commissioned an evaluation of the effectiveness (is the service doing what it should?) and efficiency (value for money) of the community service model. The evaluation we designed comprised a quantitative analysis (unscheduled admissions to secondary and community beds and an analysis of average lengths of stay, productivity analysis), and a qualitative analysis (targeting, assessments, rapid interventions, case management, proactive, integrated, enablement and rehabilitation, specialist nursing and end of life care). The evaluation will be completed mid August 2012.

d.c.davidson@bham.ac.uk
Forthcoming events

HSMC/Nuffield Trust event on commissioning
1 & 2 October 2012
The limits of market-based reforms
1 October 2012
The recent emphasis on commissioning in health and social care has sought to strengthen the market and enable the diversification of provision in a mixed economy of care. Whilst current reforms are not new, and indeed are being echoed in other parts of the globe, they seek to further embed markets in health and social care and as such the time is right to examine the limits of such reforms. The first day is designed to appeal to academics and will focus on the ‘limits of market-based reforms’. We aim to encourage an interdisciplinary exchange and, on day one, we have designed a programme that examines ‘the limits of market-based reforms’ from a variety of disciplinary and methodological perspectives.

The future of commissioning
2 October 2012
The second day is designed to appeal primarily to an NHS and social care audience and will explore the future of health care commissioning, using recent research evidence as the basis for discussion. We will bring together prominent academics and practitioners interested in commissioning to discuss the effectiveness and future prospects of market-based reforms in the NHS in England. The programme will include presentations from academics, managers, policy makers and clinicians, all of whom have researched or worked in health commissioning over many years.

Independence pays? What do personal health budgets mean for the NHS?
11 October 2012
Following longstanding success in social care, both direct payments and personal budgets are being piloted and evaluated in the NHS. These ways of working were reaffirmed in the Equity and Excellence White Paper and promoted as a means of extending public and patient involvement and choice in the NHS.

Described by some as one of the most significant reforms of the welfare state since the Second World War, personal budgets have the potential to revolutionise the way in which services are provided and to transform relationships between patients and clinicians. However, there have also been concerns expressed that this might undermine public sector services, create additional bureaucracy, lead to people using unproven treatments and place patients at greater risk.

With a mix of inputs from research, policy and practice, the seminar is aimed at anyone with an interest in personal health budgets. It is likely to be of particular interest to those seeking to implement this new way of working, clinical commissioners, continuing care leads, strategic commissioners and to service providers from the public, private and voluntary sectors.

For further information on either of the above events please contact Emma Pender, Events and Projects Officer, e.pender@bham.ac.uk

HSMC symposium on telecare and telehealth
Autumn 2013
While telecare and telehealth are not new concepts, these services have seen a global rise in prominence in recent years as health and social care bodies around the world tackle increased demand on services and the challenges presented by ageing populations within the confines of shrinking budgets and uncertain economic futures. In response to these struggles, the technology industry has been eager to demonstrate the seemingly limitless capability of technological innovations to present solutions to the health and social care conundrums forcing commissioners to reconsider traditional service pathways. The UK Government has recently reiterated its continued and unequivocal support for the adoption of telecare and telehealth with the publication of ‘A concordat between the Department of Health and the telehealth and telecare industry’ (2012). This declaration, however, has been accompanied by unclear and minimal results from the Whole Systems Demonstrator programme – the largest randomised control trial of telecare and telehealth in the world, set up to provide a clear evidence base for investment in technology (DH, 2011).

The concordat coincided with the publication of a report identifying that much can be learnt about the roll out of telehealth at scale from the US Veterans Health Administration (VHA), the world’s largest user of telehealth services (Cruckshank, 2012). The Australian Federal Government has similarly declared its support for telehealth by committing $30 million to new trials in the 2012-13 budget.

To date, international research into telecare and telehealth has focused principally on providing proof of concept and evidence of cost effectiveness, but in general has been under-informed by theoretical concepts and the perspectives of patients, service users and carers. Evaluation of services has been further complicated by multifaceted definitions of telecare and telehealth and under-developed approaches to identifying appropriate recipients of the interventions.

HSMC is building on its current research in the areas of telecare and telehealth by developing a cross-disciplinary symposium to appeal to both academics and practitioners who are interested in telecare and telehealth. This 1.5 day event will address questions relating to:

- The alignment of telecare and telehealth practice with policy
- The motivations for supporting and implementing telecare and telehealth
- The role of patients, service users and carers in making decisions about service development and delivery
- The relationship between the telecare and telehealth industry and statutory authorities
- The cost and cost-effectiveness of telecare and telehealth interventions.

A special edition of the Journal of Health Organization and Management will be published in conjunction with this event and a call for abstracts will be made following the symposium.

For more information on this event please contact: Jennifer Lynch (j.lynch.1@bham.ac.uk).

Previous HSMC events

Meeting the “Nicholson Challenge” – how to disinvest in health care services
On 14 May 2012 a seminar, bringing together national and international experts on priority setting, was held at HSMC. The purpose of the seminar was to discuss practical strategies for achieving savings in a context of limited health care budgets. Attendees at the seminar included current NHS commissioners, GPs, academics and managers from acute services amongst others.

The audience was addressed by Dr Craig Mitton and Diane Schmidt from the University of British Columbia, Vancouver, Dr Daphne Austin, Commissioning Advisor at the School of Health and Population Sciences, UoB, and Dr Jonathan Leach, a practicing GP and Medical Director at NHS Worcestershire. Each of the speakers shared their thoughts on the most effective means of disinvestment and used their own experiences to highlight barriers and the ways that these could be overcome.

Following on from the talks and panel discussion the attendees at the seminar were asked to consider responses to the challenges presented and they came up with the following suggestions: creation of ‘collaborative’ structures which link to the National Commissioning Board, creating a unified ‘vision’ for change and a shared understanding of the problems within organisations, employing strong project management functions to drive disinvestment through and increasing collaboration between primary and secondary clinicians.

The presenters and attendees at the seminar left knowing that they faced a tough challenge in finding the savings required but they showed that, with a structured approach and the appropriate responses, the nettle of disinvestment could be grasped.

Tom Daniels - TAD731@bham.ac.uk

Developing a quality improvement culture
Professor Russell Mannion, Deborah Davidson and Yvonne Sawbridge ran a workshop on July 19th with CCGs, providers and a PCT cluster to take steps towards developing a culture across the system which promotes and supports quality improvements. Russell presented the findings from his seminal work on links between culture and performance in healthcare, and Deborah and Yvonne facilitated the afternoon groupwork using the Logic Model to develop a set of actions which can be taken by participants.

y.sawbridge@bham.ac.uk

Selected recent publications


People at HSMC

It is with great sadness that we report Professor Derek Williams passed away peacefully at home at the end of July having lost his long battle with cancer. Derek was the founding Director of HSMC from 1972 to 1986 and in January 2012 Jon Glasby visited Derek at his home in Ludlow to ask him about his memories of setting up HSMC in 1972, the funding and staffing arrangements and the issues in the NHS at the time that influenced the decision to establish the Centre. An extract from this interview can be found on HSMC’s 40th Anniversary celebration webpages at: www.birmingham.ac.uk/derek-williams-interview

Helen Dickinson was shortlisted for a Founder’s Award for Best Early Career Academic.

Iestyn Williams was recruited as a member of the Project Development Group (PDG) for the production of the National Institute for Health and Clinical Excellence Good Practice Guide for Local Formularies. This project is concerned with the systems and processes associated with development and update of local medicines formularies used within the NHS.

Iestyn has also accepted the position of External Examiner for the MSc in Health Management at City University, London.

HSMC teaching award

Many congratulations to Tracey Gray and Iain Snelling who won the Head of School’s prize for the Management Training Scheme (MTS) at the University’s Awards for Excellence in Teaching or Supporting Student Learning 2011-12.

Congratulations also go to Tracey who has just been awarded an MBA with overall merit and a distinction in her dissertation.

Martin Powell presented a paper, ‘Is a high performance work system realistic in the NHS?’ at the Health Services Research Network Annual Conference in Manchester, 19-20 June. This drew on the literature review of his current SDO project on ‘Staff Satisfaction and Organisational Performance’ with Jeremy Dawson and Anna Topokas (University of Sheffield).

Martin was also invited to be a discussant of a paper on social citizenship at the meeting of the Co-operation group on ‘Global Social Citizenship’ at the Centre for Interdisciplinary Research (ZfF), Bielefeld University, Germany, 27-28 June (see www.uni-bielefeld.de/ZfF/).<br/

Birmingham Fellows: health, well-being and value

In 2011, the University of Birmingham launched a global search to recruit over 30 Birmingham Fellows: leading post-doctoral researchers on a trajectory to become the next generation of research and academic leaders. With around 1,400 applications for around 30 roles, the successful candidates came from 6 different continents and are now starting five-year appointments designed to nurture and develop them for future senior roles. In 2012, an additional round of Fellows will be recruited, with HSMC’s Jon Glasby working with colleagues in Philosophy, Law and the Medical School to lead the ‘health, well-being and value’ stream. For further information, see www.birmingham.ac.uk/staff/excellence/fellows/index.aspx

QR codes are similar to barcodes in that they store information which can then be transferred onto your smartphone. Blackberry quickly and accurately. By downloading a free QR scanning App onto your phone you can then read this code and view HSMC’s homepage.