Focus on making a difference

As the NHS reforms go live, the health and social care system faces a series of key challenges. Amongst others, these include:

- The need to respond to a series of scandals around care quality, finding new ways in which we can support front-line staff to deliver high quality, person-centred care.
- The negative perceptions that this has created in the media, making some patients worried about the care they might receive and some staff ashamed rather than proud of what they do.
- Significant financial pressures (which seem set to last for many years to come).
- A loss of organisational memory and personal relationships as major organisational changes take place.

Any of these by themselves would be difficult – but all of these (and more) at once feels extremely challenging (to say the least).

Against this background, HSMC’s commitment to ‘rigour and relevance in health and social care’ has never been more important. In difficult financial circumstances, knowledge of what works and of how to implement major change will be crucial. If widespread cultural change is needed, we need to understand what culture is, how it operates, whether/how you can try to influence it and what success might look like. If services have too often failed to deliver dignified care, we need to find new ways of supporting staff to deliver compassionate care. If some staff are feeling challenged by the media and change weary, we need to enable them to be resilient and passionate about their work, to overcome the inevitable upheaval and to seek every opportunity for improving services for patients and their families. All this will involve, knowledge of what works and the ability to translate this into practice – all underpinned by a clear and transparent value base.

In this edition of the newsletter, we showcase some of the ways in which HSMC tries to make a difference in policy and practice. First of all, Russell Mannion, Tim Freeman and Ross Millar describe national research into the role of Boards in promoting safe care – a crucial topic at the best of times, but even more important following the conclusions of the Francis Inquiry. Next, INLOGOV’s Catherine Mangan and HSMC’s Robin Miller explore the role of Health and Well-being Boards as the potential leaders of the new system and key questions for such Boards to ask as they take up their new role. Yvonne Sawbridge then summarises HSMC’s work around compassionate care, describing work undertaken with the Samaritans to find new ways of supporting front-line staff and reconceptualising health care as a form of ‘emotional labour’. While the formal work of HSMC’s staff is important, they also have a broader civic role in a range of settings – as Non-Executive Directors, Governors, Trustees and so on. In our fourth article, Hilary Brown describes lessons learned as an FT Governor and a Director of the FT Governors’ Association, exploring key challenges and ways forward following the Francis Inquiry. At the same time, HSMC also works with a large number of middle level and senior leaders (both managerial and clinical) via our many MSc and leadership development programmes. Later in the newsletter, two of our students describe service improvement projects they undertook as part of their time at HSMC and some of the impacts this had on their organisation and on the whole system. Given that HSMC celebrated its 40th anniversary last year, the number of such students who have taken their learning and used it to make a practical difference is innumerable and reflects our commitment to evidence based change.

As this newsletter went to press, HSMC was also working hard with the NHS Leadership Academy and with its partners (KPMG, the University of Manchester and National Voices) to design and begin delivering what is believed to be the largest and most ambitious suite of leadership development programmes in the history of the NHS (see p. 9 for further details). Given all the challenges we face (but also the major opportunities which large-scale changes also bring), the time has never felt more appropriate for such programmes. As 2013 unfolds and HSMC enters its second 40 years, everyone involved in health and social care will need to reflect upon and be clear about how they make a positive difference in difficult circumstances.
Effective hospital board governance of safe care

Despite a plethora of guidance available to NHS Boards on effective governance, both in general terms and with specific reference to safe care, we still have a weak evidence base on which to offer guidance around effective Board practice with regards to patient safety. In particular we lack a full understanding of what Boards actually do in relation to promoting patient safety. So, for example, how do Boards attempt to embed and sustain a culture of safety throughout the organisation? What information (hard and soft) do Boards review on a regular basis to determine whether they are providing safe care? What is the impact of external commissioning arrangements and incentives on Board oversight of patient safety? How are Board agendas constructed? What is the relative role of Boards versus Councils of Governors in Foundation Trusts with regards to patient safety? And how do Boards respond to adverse events, seek to learn from them and put systems in place and engage with operational practices to prevent them recurring?

Above all we have little robust evidence on how different Board practices actually impact on patient safety processes and outcomes. Moreover, it is clear that Hospital Boards do not act in a vacuum, but operate in a complex and at times (especially now) rapidly changing environment. Commissioners and strategic oversight agencies such as the Care Quality Commission also have a role in shaping the debates and practices of Hospital Boards, and it is important to understand these contingencies if we are to better design not just safe organisations but safer systems.

Against this background we are undertaking a three year NIHR-funded research project which addresses these and related questions and is generating empirical evidence on the associations between Board practice and patient safety processes and outcomes with the aim of improving Boards’ understanding and accountability for patient safety. The specific aims of the project are to:

- Identify the types of governance activities undertaken by Hospital Trust Boards with regard to ensuring safe care in their organisation.
- Explore the role of Boards versus Councils of Governors in Foundation Trusts with regards to the oversight of patient safety in their organisation.
- Assess the association between particular Hospital Trust Board oversight activities and patient safety processes and clinical outcomes.
- Identify the facilitators and barriers to developing effective Hospital Trust Board governance of safe care.
- Assess the impact of external commissioning arrangements and incentives on Hospital Trust Board oversight of patient safety.

Given the diversity of views and approaches to understanding Board governance of patient safety, and the intrinsic complexity of any relationships between Board governance and patient safety processes and outcomes, we have adopted a multi-method approach, integrating qualitative and quantitative elements in order to examine these relationships in both **breadth** and **depth**. In order to capture the breadth of any associations, we are undertaking (in collaboration with Dr Foster) national surveys of Hospital Board activity, which are linked to national quantitative data on patient safety processes and clinical outcomes. In order to explore these associations in depth we are undertaking longitudinal case studies in a number of Hospital Trusts which involve the observation of Hospital Boards in action and the analysis of the way in which patient safety incidents are handled from ‘Board to ward’. Our goal is to make evidence-informed recommendations for effective Hospital Trust Board oversight and accountability, and Board member recruitment, induction, training and support - both in the NHS and other health systems.

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Reference
Health and Well-being Boards: supporting the development of system leadership

Last year the King’s Fund published a paper called *Health and Well-Being Boards – system leaders or talking shops?* (Humphries et al., 2012). This reflected on the opportunity there was for Boards (HWBs) to make a real difference but sounded a note of caution about whether HWBs would be able to rise to the challenge. HSMC and INLOGOV, through the delivery of 10 ‘challenge’ events for over 70 Boards, have been directly supporting HWBs to rise to this challenge and fulfil the potential of this new way of working.

The regional challenge events were funded by the Local Government Association (LGA) and provided HWBs with a safe developmental space in which they could consider how to respond to the real issues they will face, observe the way in which they worked together on these challenges and identify their developmental needs. The events had a strong focus on identifying Board development needs and translating these into firm actions.

There were two key elements to the events which participants said they found particularly helpful. Firstly the use of scenarios to provoke challenge and debate. The scenarios focused on real world challenges and ranged from the re-configuration of accident and emergency provision in an area, to challenges from providers about cuts in services, to concerns about the quality of dementia care and social housing. These proved to be an excellent mechanism to engage Boards fully in identifying their strengths and identifying developmental actions. They also provided a useful opportunity to observe how Board members were thinking about and working on issues together, and the dynamics that were thrown up.

Secondly, participants welcomed the use of observers, who observed the Board during their deliberations, and provided feedback and challenge on language, behaviour and member interactions. This external perspective was valued by Boards, some of which requested a follow up session with the same observer.

Across all events, there was a great deal of energy and engagement throughout and a high level of motivation to seize the opportunity to make a difference. Observers reported many ‘light bulb’ moments where Board members realised they had not yet considered fundamental issues, ranging from not having a deputy chair, to how to deal with a highly political situation. The events helped HWBs identify and tackle some key issues.

Working with the scenarios and the feedback from the observers helped Boards to think about who they need round the table to help them work on issues. This was particularly valued by Boards where there was a dominance of either health or council members. The observers reflected the lack of other voices and viewpoints and helped Boards to think how the discussions might be different with others in the room. Boards recognized they need to demonstrate shared leadership and not, for example, leave council officers to deal with social care issues and GPs to deal with health issues. Boards also gained clarity about who else should be a member (whether this be representatives of NHS England or key providers - including acute providers and/or the third sector).

“*The event provoked a level of understanding that was not there before.*”

Observers also helped Boards reflect on how the meetings were run. For example, one Board had 30 members as it covered a large county with many district councils that needed to be engaged. During the event they discussed whether membership could be reduced without disengaging the district councils through a number of sub-structures. Observers also reflected the impact of particular styles of chairing and challenged Boards to consider whether this was promoting full engagement of all Board members.

The scenarios provoked a great deal of discussion about governance arrangements, which were then debated and worked through. Key issues included, the relationship of the Board to the Health Overview and Scrutiny committee, communication protocols (i.e. who was empowered to speak on behalf of the Board) and how best to manage Board agendas.

A longer term impact was the recognition that Healthwatch had yet to be fully engaged. On average, Healthwatch representatives accounted for only 8 per cent of event participants. Despite some HWB chairs being LINks chairs, a specific scenario on Healthwatch and a compulsory item on user representation, there was very little commentary about Healthwatch in Board reflections, action plans and observer notes. Many Boards highlighted this as an area for development.

It is obvious from analyzing the evaluation forms and action plans that Boards were enthusiastic about the experience and insights gained from the day; they wanted to share this with other members of their Board, and find a way for them to have a similar experience. They therefore:

- Agreed to take back the learning and feed back their experiences at the next board meeting.
- Took away the materials to facilitate a similar day for other Board members.¹
- Discussed how to design regular spaces for development and more in-depth discussions into local processes.
- Discussed ways of engaging other Board members to look at the form and frequency of meetings.

For further details, see: [http://www.local.gov.uk/health-wellbeing-and-adult-social-care](http://www.local.gov.uk/health-wellbeing-and-adult-social-care)

**References**


¹ Scenarios are available on the LGA website via: [https://knowledgehub.local.gov.uk/home](https://knowledgehub.local.gov.uk/home)
Time to care? - finding ways to help nurses deliver compassionate care

In the wake of the Francis report (2013), a prevailing theme is the need to change culture: to move from a culture which does not always place patient interests at its heart, despite the rhetoric, to one in which compassionate care is considered the norm, and valued and supported as highly as new medical technologies and clinical competencies. Academics and practitioners alike will recognise this as no mean feat.

HSMC has been examining the rich stream of evidence which concludes that supporting staff is an equally important part of the patient experience equation and an important aspect of the requisite cultural change (Sawbridge and Hewison, 2011). Our research takes these ideas into three hospitals in the West Midlands, to work with ward staff to co-design a support system which is both practical (in terms of busy ward environments) and effective.

Our partners in this action research are the Samaritans, chosen because they consistently support their volunteers in a purposeful manner, believing that their service can only operate effectively if they truly care for their volunteers. They also have a strong value set, described at a recent project meeting as “people supporting people - helping others to grow”. This sense of collective responsibility chimes greatly with current failings in the NHS, where systems and individuals often struggle to create an environment in which this shared responsibility is enacted - for either patients or staff. This action research aims to apply this principle and use it as a tool to shift cultures and mindsets - an ambitious endeavour!

Engaging staff in this research has been complex and time-consuming. Gaining understanding for a project which aims to identify the means by which to systemise caring for each other as a tool for improving patient care, was difficult and almost counter-intuitive to many. We are indebted to all those who took the time to help us with this and have volunteered to be part of the learning. A training session has been developed by the Samaritans, building on the training they currently provide to volunteers - but adapted significantly to meet the constraints of releasing staff time and recognising the difference in environments, roles and responsibilities. The first session is about to be delivered to a group of ward staff. This feels a significant turning point from which the project can gain momentum and hopefully demonstrate an impact upon the aggregate staff well-being levels on the wards (measured by the Asset Survey designed by Robertson-Cooper), which in turn will lead to an improved ability to consistently deliver compassionate care.

It has also expanded our thinking and identified a number of areas ripe for exploration. For example, what is the “science of compassion” (Cole-King and Gilbert, 2011) and can we recruit and train staff to be compassionate? Can we view ‘emotional labour’ as a core competency – “a skill that can be learned and refined” (Mastracci, et al., 2012, p.28) and what implications does this have for our understanding of the development needs of ‘emotional labourers’, wherever they work? HSMC are also keen to share the learning from this - both pit-falls and pleasures - so that others can begin to experiment with implementing models of support systems for staff. We are exploring the development of a national action learning set, and will be happy to receive expressions of interest from anyone interested in this.

The best hope of achieving the impact required post-Francis (2013) is to find new methods of applying such evidence in the workplace. At HSMC we will continue to look at ways to do this, with research that is both rigorous but also highly relevant. y.sawbridge@bham.ac.uk

References


Patient and public involvement - the role of the FT governor

Hilary Brown

The Francis inquiry seminar on patient experience, held in November 2011, emphasised that patient needs must be put systematically at the centre of the way Trusts are organised. Recommendations included: the need for Trusts to continue to seek regular measurement and reporting of feedback to wards and departments and at Board level, and developing initiatives that allow staff, including Trust leaders, to see the delivery of care from the patient’s viewpoint.

The Francis inquiry has focused on proposals to strengthen the voice of patients and the public more systematically. These include the involvement of service user representatives on Care Quality Commission (CQC) inspection teams and the establishment of a patients’ consultative council within the CQC infrastructure. Similarly, Francis suggests that Monitor should also incorporate greater patient and public involvement into its structures.

Francis notes that the form and functions of Health Overview and Scrutiny Committees and Local Healthwatch organisations could also be beneficially strengthened to make them effective mechanisms for amplifying the public and patient voice, while new commissioning organisations (CCGs) should introduce membership systems and consider other proposals for greater involvement such as having lay members on the Board. The role of FT governors is also highlighted and a number of suggestions are made to enhance the role significantly, giving it potentially more weight within the system, including an obligation to account to the public in general and to be informed of the public’s views about services offered.

My research and teaching interests at HSMC mean that I have a professional interest in the patient experience and patient and public involvement in health services in general. This includes teaching sessions specifically on the effective use of feedback and patient and public involvement as a quality improvement tool, so I would strongly agree with the proposals that came out of the Francis inquiry seminars. However, it is in my role as an FT governor and a Director on the Board of the Foundation Trust Governors’ Association, that I have felt a strong personal interest too and have considered the final report’s recommendations for governors in this light.

Being a governor is not something to be entered into lightly – I expect like most voluntary roles of a similar nature, there is a level of basic commitment required such as attending meetings and reading Board papers – the volume and complexity of which may be daunting enough. However, to truly get under the skin of an organisation, to really know whether the organisation is performing well, whether patients are receiving a good service and whether staff are happy and motivated, requires a level of commitment which goes beyond the basics. For systems and processes may become the end in themselves, rather than the means; committees and panels get bogged down in procedural issues; reports will only tell you what the author wants you to know; statistics will focus on the positive – ‘85% of patients would rate their experience as good or better’ – that still means that on any given day, 100 people attending A&E say, 15 are not having a good experience. You have to therefore see and listen to the organisation’s beating heart.

As a governor I have taken part in quality walkabouts – speaking to patients and staff, listening, watching and observing. Governors might have read a report about staffing levels and skill mix in a Council meeting but unless you see what this looks like on a shift, you can’t have an informed opinion. Unless you’ve tasted the food, you don’t know whether it’s any good, and unless you’ve tried to find your way from one end of the building to another with the directions given to patients, you don’t know whether the instructions are right.

As a governor I’ve also been privileged enough to attend many wonderful events – carol concerts, where patients, carers and staff talk about their experiences at the Trust – often emotional and always humbling; a staff awards ceremony where the dedication staff have to their patients is plain to see and is frankly awe inspiring; the launch of a patient-made DVD to show clinicians how to communicate with young people in a room full of staff enthusiastic to know more. Each time I do something like this, I feel I am getting to know the organisation better, that I am understanding its ethos and its culture and that I am getting to know its patients and its staff better – what they need and what they value - and I think this makes me a better governor.

So, for me, it’s not about sitting in committees or on panels, it’s about getting out there and speaking and listening to people – both patients and staff. If you are not prepared to do this as a governor, then I don’t see how you can be effective. I worry that we may lose sight of these human aspects a little, as governors are expected to play a more significant role in transactional issues such as approving mergers and acquisitions, which will inevitably mean acquiring a higher degree of commercial and financial acumen. That will increase our skill set which is to be applauded but not, I hope, at the expense of diluting our ability to see and hear.

A spreadsheet doesn’t tell you it’s had to wait ten hours on a trolley and hasn’t been offered a drink of water for the last four. A patient will.

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As well as the work of its own staff, HSMC makes a difference through the support, ideas and concepts it provides to students on our MSc programmes – who then use this to make a practical difference back at work. The following two articles describe service improvement projects undertaken as part of HSMC’s MSc in Leadership for Health Services Improvement

Caring for dying patients and their families in an acute setting

In June 2010 during the first phase of the move into the new Queen Elizabeth Hospital Birmingham (QEHB), over 500 patients were transferred in three days. This included all of the inpatients from Selly Oak Hospital and a proportion of patients from the old Queen Elizabeth Hospital.

One of our most significant challenges was to move the dying patients and their families, not knowing whether the patients would survive the journey, or die during transfer in the ambulance.

The dying patients were made a priority and moved first on each of the days and were reunited with their families as soon as they arrived at the new hospital. Thankfully, all the patients were able to spend their last hours with their families, each in a single room with en-suite facilities and privacy to be together as a family.

Assumptions were made that having 40 per cent single rooms in QEHB would provide many benefits, particularly for the dying and their families. However, since the move, evidence from our local Bereavement Service surveys, and PALS contacts has highlighted that at times patients and families have felt isolated and that staff may sometimes avoid the single rooms. This theme was explored in focus groups with staff caring for dying patients and their families. The staff expressed feelings of awkwardness and that they felt that were intruding on precious family time.

In order to try and address these issues a pilot project called ‘Comfort Care Packs’ (CPP) was instigated utilising charity funding in the 10 clinical areas staffed by members of the focus groups. The packs were given by the ward staff to patients in the last few days of life and their relatives. The packs contained a selection of items to provide comfort and relief for patients such as pre-moistened lemon and glycerine mouth care swabs and lip balm. Snacks were also included for relatives reluctant to leave the patient’s bedside as well as a small pack of toiletries to refresh themselves. There were also tokens which allowed relatives to leave the hospital, following a death, without having to pay for car parking. The packs also included a tick box rating scale for users to rate the content of the pack with a free text option.

**Comfort Care Pack**

So far feedback from bereaved relatives has been positive with comments such as ‘...a pleasant comfort at such a sad time. It demonstrated compassion and sensitivity from the hospital’ and ‘It was a wonderful gesture’ as well as ‘...the only thing missing from the pack was a big hug ...and I got that from the staff.”

Evidence from staff comments has also demonstrated that the CCP have enabled them to initiate conversations with grieving relatives, which they would have previously struggled to start and that they are a point of connection in the relationship that subsequently forms. Staff have also reported that they feel the packs help to reinforce the invitation for relatives to stay and assist with care, making them feel more welcome at the bedside.

The pilot was so successful that it was difficult to limit to the 10 areas identified, as staff were demanding that they could use the packs in other clinical areas for their patients and families. The decision was quickly made to roll out the packs to all areas, even though future funding had not been secured, and if necessary to reduce costs by limiting the packs to the top six items identified by the rating scale (these included the car park token, the snacks, lemon mouth care swabs and the tooth brush with tooth paste). However, this was not necessary as the funding was promptly agreed.

Other key themes which threaded through the data from the surveys, and focus groups related to communication, particularly was difficult end of life conversations and the avoidance of using the words ‘death and dying’. Training and development needs were also identified and in order to address these issues a number of training initiatives are being instigated. There has been a particular focus on communication skills training, recognising not only the needs of those breaking bad news, but also acknowledging staff such as healthcare assistants, housekeepers, domestics and porters who are often used as confidants by patients and relatives.

In April we will be launching the “Priorities of Care - for the dying patient and their families” campaign with clinical champions in each area who will have received accredited communication skills training, as well as end of life and bereavement care briefings. An information leaflet for relatives of dying patients and a resource pack for the clinical areas will also be launched.

Currently under development are electronic resources to support medical staff caring for patients at the end of life and their relatives. The electronic format will assist with areas such as anticipatory prescribing and ‘do not attempt CPR’, as well as providing easily accessible treatment plans and communication records.

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Large scale complex system change

Prompted by the National Audit Office report (2007, p.26) in which the South West region was cited as having the greatest dementia “diagnosis gap” in England, the South West Strategic Health Authority set for the region the ambition to improve the mean rate of diagnosis of dementia for its 13 Primary Care Trusts from 33.8% in April 2010 to 60% of estimated local prevalence for dementia, by 31 March 2012.

The complexity of the system within which we were working, and the scale of the change required in terms of size, pervasiveness and depth led to this project being designed iteratively, as a mixed-methods, sequential, two-phase design over two years. Working with PCT commissioners, Phase 1 largely focused on activity rather than systems. As diagnosis rates were incentivised by the general practice Quality Outcomes Framework (QOF) scheme, we assumed that audit, benchmarking, and feedback on performance would drive improvement; that engagement with service commissioners as a group, and transparency about structure, processes and outcomes would generate and drive change and improvement. We found that improvement was limited to isolated pockets of activity, and concluded that there was a need for change at multiple points both across and within systems in order to drive both the pace and degree of improvement.

In order to test this, in Phase 2 of the project we focused on systems and factors affecting change therein. With commissioners, we reviewed local improvement plans and the mechanisms for change they identified. We mapped these within a driver diagram in order to identify causal and contributory factors in the diagnosis process. To inform a deeper level of analysis, we designed a matrix to provide a framework for understanding key contextual factors and interdependencies between different parts of the systems with which, and within which, we were working. This became our organising framework for the design of a multi-level, multi-method approach, enabling us to consider those components of the systems which might present opportunities for change and to identify associated levers and methods for change at micro (local), meso (PCT), and macro (regional) level (Ferlie and Shortell, 2001).

Drawing from Plsek’s (2008) emerging model of Large Scale Change, our hypothesis was that by employing a large scale change approach and methodology within and across complex systems, a number of changes at different points and levels were required in order to improve the diagnostic process. It was similarly recognised that greater engagement with, and leadership from stakeholders would be required; and that system change would be incremental, interdependent and protracted. We therefore designed and introduced a model.
for large scale complex system change, predicated on the assumption that change would need to be both generated and directed through a process of multiple cycles which would connect, reframe and initiate interventions at multiple points and levels (Diagram 2). Whereas Plsek’s model suggests that the momentum behind change is neither managed nor directed, our hypothesis is that deliberate, targeted interventions directed at strategic points within systems will deliver change.

Working with key stakeholder groups including commissioners, service providers, GP regional leads for dementia, people with lived experience and mixed ‘Expert Reference Groups’, we designed a programme of interventions predicated on the principle of distributed leadership. We facilitated a programme of ‘task and finish’ improvement interventions, actively developing and disseminating tools, resources and learning across the system designed to ‘catalyse’, ‘accelerate’ and ‘enable’ change and improvement.

This approach has achieved considerable focus, and has driven activity in different parts of the systems. Whereas evaluation of the impact of specific interventions was not within the scope of the project, the South West has delivered the greatest improvement in diagnosis rates in England in 2011-12 (12.7%). The approach has been framed as the ‘Ten Key Steps’ (Schneider, 2013) to improving dementia diagnosis and diagnosis pathways, and published by the NHS Commissioning Board. Most importantly, we have found that the enquiry process, working with and through stakeholder groups, has prompted greater insight and understanding and reflects a shift from the drive to improve rates of diagnosis as a target-driven activity, to a focus on the quality of services provided for people with memory problems and improving their experience of the diagnosis pathway. The challenge to the new system will be to sustain this.

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References


STOP PRESS: Transformational healthcare leadership for the NHS

The Health Services Management Centre and Birmingham Business School - as part of a consortium of internationally-renowned institutions - have been selected to support the NHS to deliver the largest and most comprehensive programme of leadership development ever undertaken in the NHS. Around 25,000 NHS staff including doctors, nurses, allied health professionals, healthcare scientists, and HR and finance staff will have access to foundation, mid and senior level leadership programmes from September.

The Health Services Management Centre is central to the design and delivery of the mid and senior level leadership programmes, and draws on a long history of providing exceptional management and leadership development programmes in health and social care, including the multi-award winning educational component of the NHS Management Training Scheme - the fast-track route to becoming a future NHS leader - in partnership with the Manchester Business School.

The consortium for the mid and senior level programmes was led by KPMG and includes the Health Services Management Centre and Birmingham Business School at the University of Birmingham, National Voices, Manchester Business School, Line Communications Limited, Unspun Limited, Harvard University, Rotterdam School of Management, Erasmus University and the University of Pretoria. Together they will work in conjunction with the NHS Leadership Academy, local delivery partners, charities and Education Boards to co-design and deliver a programme that will support the transformation of healthcare for the 21st Century - putting patients at the centre with compassionate leadership as the norm, rather than the exception.

Professor Jon Glasby, Director of the Health Services Management Centre commented “I am delighted that the Health Services Management Centre will continue to be at the heart of leadership development in the NHS. Centre staff will bring their wide knowledge of the UK and international health systems gained through research and consultancy activities, as well as their own professional experience to help deliver this unique, ground-breaking initiative to the NHS”.

Deborah Davidson, Senior Fellow in Organisational Development and Leadership at the Health Services Management Centre who led the consortium bid on behalf of the University added, “This work builds on our commitment to work alongside patients as partners and builds on the existing strong relationships that we have with many large public service providers. It also further adds to existing organisational development, leadership and management programmes delivered by the Health Services Management Centre including masters level programmes in Healthcare Policy and Management, Leadership for Health Services Improvement and Public Service Commissioning”.

The organisations selected as part of the consortium were chosen through a competitive and rigorous tender process, which saw more than 30 organisations bid to be part of the consortia.

Karen Lynas, Deputy Managing Director of the NHS Leadership Academy, said “Our goal is for NHS patients to be treated in a culture of compassion, dignity and respect, and, as we have seen, this cannot be achieved if we don’t have appropriately skilled leaders at every level of the service.

“We want all NHS staff to work in an environment of excellence in care, where they feel liberated to focus on those things that attracted them to work in the NHS: providing exceptional care to patients. We want to ensure that the pockets of excellence that already exist in the NHS become the norm, become what we expect our NHS to be. This requires support and development for all our leaders.

“The Academy will be working with globally respected academic institutions and high performing organisations with a history of leadership development to design and deliver three exceptional leadership programmes”.

More information about the NHS leadership programmes can be found at http://www.leadershipacademy.nhs.uk/grow/core-programmes/

More information about studying with other part time or full time masters level degree programmes with the Health Services Management Centre can be found here: http://www.birmingham.ac.uk/schools/social-policy/departments/health-services-management-centre/courses/index.aspx
HSMC will welcome a new intake of students on 30 September 2013. The department delivers a number of UK-based Masters programmes as well as contributing to a number of interdepartmental programmes.

HSMC offers an MSc in Healthcare Policy and Management with optional specialisms in Commissioning, Quality and Service Improvement and Integrated Care. The programme consists of:

a) Four core modules:
- Health Service Management
- Health and Healthcare Policy
- An Introduction to Organisational Development in Health and Social Care
- Public and User Involvement in Health Care

b) Two optional modules which are selected according to specialism if a specialist track has been selected (20 credits each)

c) Dissertation/Research Project

The programme is designed for senior managers, clinicians and policy makers working in or with health care organisations, or with an interest in developing their careers in this direction.

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.

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New Postgraduate Certificate for CCG leads - just launched!!

After discussions with local GPs working in CCGs, HSMC has designed a new PG Certificate in Healthcare Commissioning (jointly badged with NHS Clinical Commissioners). It 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, previous participants have given consistently positively evaluations, and state that these programmes 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.

Based on three 5-day modules, the programme consists of:
- Strategic Commissioning
- Decision-making and Priority-setting
- Procurement and Market Management

For further information contact Kate Vos: c.j.vos@bham.ac.uk

New Masters specialism in Integrated Care

In 2013 HSMC is introducing a new MSc specialism in integrated care. Alongside broader inputs around health service management, health care policy, organisational development and patient involvement, the programme will focus in particular on the skills, knowledge and concepts necessary to work successfully with people from different professional backgrounds and with partners from different parts of the health and social care system. Key topics will include current barriers to integrated care, the benefits of working together, the governance of partnerships, the outcomes of integrated care and the importance of organisational culture.

For further details, contact Kate Vos: c.j.vos@bham.ac.uk
The Clinical Leaders Fellowship programme, commissioned by the Leadership Academy, is aimed at clinical professionals who are still engaged in clinical practice but want to develop their capacity to lead clinical teams and improve services. The programme comprises academic and experiential components, delivered by the Universities of Birmingham and Manchester together with The King’s Fund. On the second run of the programme, the Universities and the King’s Fund have combined our residential programmes rather than running them separately. This has focussed our minds, and the Fellows, on their development in terms of skills (which are often addressed in experiential learning - learning through experiences such as visiting a theatre production to consider team working) and the knowledge and critical thinking which is associated with academic programmes. Since assessment requires criticality at masters level, including skills development more explicitly in the combined programme has provided some challenges and opportunities because of the understandable focus on assessment which is orientated towards knowledge rather than skills. The programme and the way it has developed in the partnership between the Universities and the King’s Fund has given us valuable experience of thinking about the relationship between skills and knowledge in development programmes. Each Fellow is working on a project throughout the period of the Fellowship and all the assessments are based on their projects.

The current programme has just completed module 4 out of 6 and the Clinical Fellows will come together as a national cohort in May at Yarnfield Conference Centre for module 5.

For further information about the programme please contact Tracey Gray at t.gray@bham.ac.uk or for details of how to apply to the programme please go to: http://www.leadershipacademy.nhs.uk/grow/clinical-leadership-fellowship-programme/

NHS Graduate Management Training Scheme

The NHS Graduate Management Training Scheme is currently providing education for the 2012 cohort of General, Finance, HR and Informatics trainees. There are also 7 Medical Leaders, 13 trainees from Wales and 3 from Northern Ireland in the cohort. All trainees have just begun their final module of the PG Certificate in Leadership and Service Improvement which takes place in 5 locations across the UK. The programme is delivered by HSMC and MBS, University of Manchester and is commissioned by the Leadership Academy.

In January 2013 the Scheme was presented the ‘best use of social media in the public sector’ award at the national Graduate Recruitment Social Media Conference Awards. This award is voted for by prospective trainees and further details can be found at http://www.leadershipacademy.nhs.uk/about/media/news/management-training-scheme-3/nhs-graduate-scheme-wins-top-social-media-award/

For more general information about the training scheme please go to http://www.nhsgraduates.co.uk/ or contact Tracey Gray at t.gray@bham.ac.uk

Where are they now?

On completing the Management Training Scheme I took a decision to move back to North Wales, where I was originally from, which meant a move into the Welsh NHS. My first role was as a Project Manager for the then Local Health Authority. In 2003 I went to work as a Modernisation Manager for the Wrexham Local Health Board focusing on Primary Care and leading on the implementation of the GP contract, I then later became Assistant Director of Commissioning with the Local Health Board.

In 2007, although I loved my role in the Local Health Board, I decided it was time to take the plunge and go back into an acute trust as Deputy Divisional Manager of Surgery, managing Orthopaedics, Orthodontics, ENT and Pain in one hospital and Maxillofacial Surgery across North Wales. I then moved to my current role in 2009.

I currently work for the Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust, which is a specialist Orthopaedic Trust near Oswestry in the West Midlands. My current role is Business Planning Manager and I am responsible for the delivery of robust business planning and performance systems for the Trust.

In addition to my NHS role I also guest lecture from time to time at De Montfort University on Performance Management in the NHS to 3rd year undergraduates and I am a Mentor to two undergraduates at Birmingham University.

Helen Ashcroft, MSc, Health Service Management (2006)

Read the full interview with Helen at: http://www.birmingham.ac.uk/schools/social-policy/alumni/profiles/hsmc/ashcroft-helen.aspx

Mastersclass – 3 June 2013

Are you considering studying for a Masters in Health Care Management in the next 12 months? Come and meet the experts at our Mastersclass. You will be able to sample some of our teaching, talk to current and former students, and meet the experts who teach on our programmes.

Provisional Agenda

1.00pm - Registration and Lunch - Dining Room
2.00pm - Welcome and Introduction to our Programmes - Southfield Room
Jon Glasby, Director of HSMC lain Snellling, HSMC Director of Learning and Teaching
2.30pm - NHS Reforms: future directions - Southfield Room
Jon Glasby
3.30pm - Coffee/Marketplace - Southfield and Woodland Rooms

HSMC programme/module posters will be displayed in the Southfield Room to help you gain a greater insight into the programmes and modules offered at HSMC, and provides the opportunity to discuss these with our academics.

Alternatively, drop in and meet the HSMC team from 5 - 7pm
Projects update

Danish study tour
A group of senior healthcare managers and communication leads visited HSMC recently to find out more about common health care management issues affecting both countries. A useful exchange of ideas ensued including discussion about identifying and supporting nurses to deal with the emotional labour their role requires; patient and public engagement; and shared decision-making. It is hoped to set up some reciprocal work in the future.

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Improving access to psychological therapies for people with long term conditions
This six month project seeks to embed psychological therapists into a multi-disciplinary enhanced assessment team supporting both the physical and psychological reablement of patients with long term conditions and other physical health problems/disabilities. This is based on the evidence regarding the prevalence of co-morbid mental health problems in cardiovascular disease, diabetes, COPD and chronic musculoskeletal disorders - and the local experience that such patients are not accessing psychological support. HSMC will undertake an evaluation of the impact of the pilot and the processes that have led to these impacts.

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Joint commissioning in health and social care: an exploration of processes, services and outcomes
It has long been suggested that it is important that public sector organisations work together more effectively with one another in order to deliver the best possible services for local populations. In recent years this notion of partnership working has been particularly stressed in terms of the joint commissioning of services.

Despite recent interest in joint commissioning there is very little robust evidence available which describes either the processes (what happens in practice) or provides clear messages about outcomes (the types of impacts) which it produces. This project is the first of its kind to examine the definitions, processes and outcomes of joint commissioning across five ‘best practice’ localities across England. The final report is now available via the HSMC website.

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Commissioning of third sector mental health services
This research is being completed by HSMC in collaboration with the Third Sector Research Centre (TSRC) and will focus on the commissioning of services to support people with mental health difficulties. While the study will focus on mental health, it will also produce helpful learning around joint working across a range of agencies (including health, social care, housing, homelessness, probation, drugs and alcohol, and employment). The research will be based in a sample of four local authorities and involve 3 stages – a survey of third sector organisations (TSOs) who work with people with mental health difficulties; interviews with a sample of TSOs and public sector commissioners; and an event to bring the two sectors together to reflect on the findings and how they can work together to improve outcomes.

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Redesigning public services
Catherine Needham has been funded by the Arts and Humanities Research Council to undertake a policy review on redesigning public services. The review forms part of the AHRC’s Connected Communities research programme. It is a six month project and will work with colleagues from the Institute of Local Government Studies and the College of Arts and Law.

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Joint HSMC and TSRC evaluation of social enterprise published
An evaluation led by the Third Sector Research Centre in collaboration with HSMC has been published into the Social Enterprise Investment Fund (SEIF). The SEIF was launched by the Department of Health in 2007 as a £100 million fund to support and develop social enterprises in responding to unmet needs and gaps within the health and social care system. The final report describes its effects up to March 2011. It suggests that investment in social enterprise by the Department of Health has helped to challenge health inequalities and tackle unmet need. However, the Fund has not met all its aims. A large majority of the fund was used as grants, raising questions over the demand for loan finance amongst social enterprises and charities in the health and social care sector.

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What impact are the health reforms having on cancer services in England?
A new publication for Cancer Research UK, ‘Reverse, Pause or Progress’, reports the findings of research carried out by HSMC to explore the early impact of the health reforms and the NHS efficiency savings programme on cancer services in England. The research team analysed recent trends in cancer waiting times and expenditure, as well as carrying out more than 50 in-depth interviews with key stakeholders in the cancer community including policymakers, surgeons and oncologists, clinical nurse specialists, PCT and CCG commissioners and patient representatives.

The findings present a mixed picture. Despite increases in the number of people being referred for suspected cancer and being treated for cancer overall, the performance of services against national standards has held or even marginally increased. However, policymakers, professionals and patients shared a number of concerns about how the reforms and efficiency savings are affecting cancer services and patient care. Key findings included:

- A widespread view that the current reforms are of a different degree, nature and scale than previous phases of NHS reform.
- Concerns about fragmentation in both the commissioning and provision of cancer services.
- Questions about whether CCGs possess sufficient understanding and expertise in cancer to commission services effectively.
- Evidence that some services – such as clinical nurse specialists and support and rehabilitation services – are soft targets for spending cuts.
- Examples of local planning blight, with views that service development in cancer may have been stalled for anywhere between 18 months to three years.

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Prevention services and the third sector
HSMC recently completed research regarding social care prevention services. This identified that there was a degree of consistency between the participating authorities with reablement, information and advice, and telecare services being commonly represented within the ‘Top 3’
prevention interventions, and decisions to invest in these services being based on a mixture of national guidance, local experience (often through pilots) and the perspectives of senior leaders about what worked. However there was variation in the way in which these services were delivered, other prevention interventions which were seen as promising and the approach to setting and monitoring delivery of outcomes. On the whole, local evidence on effectiveness of these interventions was not gathered in a structured and comprehensive manner and comparison between authorities and with data gathered through previous research was difficult to achieve.

HSMC have since been awarded an extension project to this research which will complement the original findings through:

- Exploring the views of third sector organisations (TSOs) regarding the most effective prevention interventions for older people and the evidence on which this is based
- Identifying what services they provide in relation to prevention, how these are funded and why they have chosen to deliver these services
- Clarifying TSO approaches to setting outcomes and gathering data to evaluate if these outcomes have been achieved
- (Where possible) gathering data regarding the impact of their interventions
- Discussing the predicted and possible role of TSOs in relation to prevention and what support will or prevent them achieving their potential impact.

Work from the initial research study has also been presented as part of the Social Care Evidence in Practice project which aims to explore methods of knowledge exchange between researchers and practitioners in social care to support evidence-informed practice and practice-informed research.

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Evaluation of micro-enterprises in social care
Catherine Needham and Jon Glasby have been funded by the Economic and Social Research Council for a project to evaluate micro-enterprises in social care. The two-year project will be undertaken with partners from the Social Care Institute for Excellence and Shared Lives Plus. It will examine the extent to which micro-enterprises, employing five people or fewer, deliver more innovative and effective support for older people and people with disabilities when compared with larger organisations.

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Evaluation of lay inspections of home care for older people
Catherine Needham has been funded by the Esmee Fairbairn Foundation to work with Age UK Lewisham and Southwark evaluating the use of lay inspections for home care for older people. The three-year project will train local people to undertake lay inspections, building on the successful project that this branch of Age UK runs for lay inspections of residential care homes.

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Review of self-care initiatives in Islington
This evaluation project has been commissioned by Islington Clinical Commissioning Group to help them to understand local progress in introducing self-care initiatives and to identify further areas and opportunities for improvement. The evaluation will bring together different stakeholders who are involved in self-care to discuss their experiences and perspectives and then use these as the basis of a report for the CCG.

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Journal of Integrated Care
Jon Glasby has taken over as Editor-in-Chief of the Journal of Integrated Care, working alongside colleagues Robin Miller and Helen Dickinson as co-editors. This occasion marks the retirement of Peter Thistlethwaite as Editor. Peter was the Journal’s founding Editor in 1992, when it was launched under the title Managing Community Care, and has been a tireless champion for both the Journal and the cause of integrated care more generally.

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Long-term care in Europe: improving policy and practice
Jon Glasby and Kerry Allen were part of an international research team in the 3-year EU study of long-term care, INTERLINKS. The findings of this study have been published as a book challenging the prevailing discourse centred on the problems of demographic change and long-term care provision for older people. The book focuses on emerging solutions building on research in 13 European countries.


Evaluation of person centred change programme
Real Life Options, a leading UK provider of care for people with a learning disability, are undertaking a major change programme in their residential care provision in Birmingham. This will seek to draw upon telecare technology, individual service funds and person centred development and support to achieve a better quality of life for the residents and more efficient use of the resources available. The evaluation will explore the impact of these changes and through taking an action research approach will also help to shape the development and implementation of the programme.

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Decommissioning research grant
HSMC has successfully bid for funding from the National Institute for Health Research (NIHR) to carry out a research project entitled ‘Decommissioning health care: identifying best practice through primary and secondary research’. The project will run from May 2013 to May 2015 with Professor Glenn Robert from King’s College London as the main academic partner. HSMC’s Lestyn Williams will be the Principal Investigator.

Although decommissioning - defined here as the planned process of removing, reducing or replacing health care services – is at the forefront of policy, it remains strikingly under-researched. This project is designed to address this important knowledge-practice gap. The overall aim is to formulate evidence-informed best practice guidance to enable the effective decommissioning of health services. The research will synthesise what is already known about implementing decommissioning in health care and other public sector settings, and will establish the current range and extent of decommissioning in the NHS from the
Projects update continued

perspective of local commissioners. It will then develop understanding of how health care organisations are currently implementing decommissioning policies through a longitudinal investigation of four case studies in the English NHS.

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Towards a framework for enhancing procurement and supply chain management practice in the NHS:
Russell Mannion, with Joe Sanderson and Chris Lonsdale from Birmingham Business School, has been awarded funding from the National Institute for Health Research HS&DR programme to undertake a review of procurement theory, evidence and practice.

The review aims to provide intelligence to enhance procurement and supply chain management (SCM) practice in the NHS and to inform the development of a practical guide for managers and clinicians with responsibility for commissioning and procurement of services. The specific objectives and research questions are to:

- Explore the main strands of the literature about procurement and supply chain management (for example in institutional and production economics, operations management, organisation theory, the resource-based view of strategy, business-to-business marketing, public management etc).
- Understand to what extent existing evidence on the experiences of NHS managers and clinicians involved in procurement and SCM matches these theories and to provide an explanatory framework for understanding the characteristics of effective procurement policy and practice in the NHS.
- Assess the empirical evidence about how different procurement and SCM practices and techniques can contribute to better procurement processes and outcomes.
- Map and evaluate different approaches to improving procurement and SCM practice, including modelling, diagnostic and facilitation tools, and identify how these approaches relate to theories about effective procurement and SCM.

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Nicola North visits HSMC
Nicola is currently Associate Professor in Health Systems, Health Systems Section, School of Population Health, in the University of Auckland’s Faculty of Medical & Health Sciences where she has been based since 2008 – for more information see: http://www.fmhs.auckland.ac.nz/staff/n.north

Nicola hopes that spending about 2 months at HSMC will give her the opportunity to step back from a busy few years, and take stock of how the School of Population Health might develop health management and leadership programmes in the light of what is going on here in the UK. Attending HSMC’s Faculty Day and re-acquainting herself with HSMC’s work through the website, has helped in crystallising ideas. One aim, therefore, is to learn from the current management training scheme and the new Leadership Academy programme with a view to how programmes in Auckland can be refreshed. Nicola’s second aim is to do some work on the changing roles and identities of the main players in the health workforce, both the different health professions and management and unregulated care-givers. Patient-centred services and engagement are clearly of high importance in the UK, but not highly profiled in New Zealand outside of specific populations; even so, Nicola will be interested in familiarising herself with this area too as, sooner or later, New Zealand will have a Francis! Nicola is looking forward to engaging with many HSMC colleagues in conversations in coming weeks, and very much appreciates the welcome she has received.

Nurse Directors Learning Set
This one year action learning set with Nurse Directors from across the West Midlands is drawing to a close, with only two sessions remaining. Participants have valued the time out of their busy lives to think and reflect on their practice and to collectively support each other and solve issues of the day.

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HSMC to host 2014 EHMA Conference in Birmingham
HSMC is pleased to announce that it is to host the 2014 EHMA (European Health Management Association) Conference “Leadership in healthcare: from bedside to board” in June 2014. This prestigious event will be held on University of Birmingham campus and in other venues in Birmingham City Centre.

EHMA (http://www.ehma.org/?q=node/3) is a membership organisation that aims to build the capacity and raise the quality of health management in Europe. They have 170 members across more than 30 countries in the WHO region and beyond, bringing together the research, policy and management communities. The members range from hospitals to universities, from ministries of health to primary care providers, from management education schools to consultancies. EHMA membership is open to all organisations or individuals committed to improving health and healthcare in Europe by raising standards of health management.

Further information and booking will be available shortly but for further information please contact Ross Millar on r.millar@bham.ac.uk or Tracey Gray on t.gray@bham.ac.uk.
Events

Building better health: joint working between health, housing and social care
20 May 2013
Venue: Birmingham Business School
Faced with a double whammy of unprecedented financial challenges and rapidly rising need and demand, there is an urgent need for everyone involved in health, housing and social care to work together more effectively. Housing is a crucial determinant of health, and could have a key role to play in helping to deliver key health and social care priorities. Equally, health and social care commissioners have access to resources (however scarce) that could support and further develop the role that housing is already playing in improving health and well-being.

Yet all too often housing, health and social care are separate worlds, with few people understanding how each sector works or the key opportunities and barriers which exist. Against this background, the National Housing Federation has joined forces with the Health Services Management Centre to design a one day summit to explore what is going on in each policy area, opportunities for greater collaboration and lessons learned from current good practice examples.

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Leadership as performance
A choice of dates: 3, 7, 17, 18 or 21 June 2013
Drawing on her experience of theatre and examples. In this seminar, national and international experts from policy, research and practice discuss practical strategies for engaging citizens and communities.

Keynote presentations will be provided by experts from both health and local government settings. As part of the seminar, delegates will have the opportunity to:
- understand how public engagement has been carried out in other countries;
- hear from those who have led engagement processes in health and social care in England; and
- share and discuss their own challenges and experiences.

Delegates will each receive a copy of ‘Rationing in Health Care: the theory and practice of priority setting’ – a 2012 text designed to aid those leading priority setting and disinvestment processes in health care.

For further information and to register for any of the above events contact Tracey Gray: t.gray@bham.ac.uk or visit the HSMC website: www.birmingham.ac.uk/hsmc

Involving citizens in health and social care decision making in a time of austerity
4 June 2013
Chaired by Iestyn Williams, HSMC and Helen Dickinson, Public Service Academy
The current economic downturn has increased the pressure on local health and social care systems to ensure resources are used efficiently. This will involve decisions to restrict access to services and in some cases withholding them altogether. In order for such decisions to take account of the values of citizens and communities, and for the inevitable political fallout to be managed, there is a requirement for effective engagement strategies.

However, history and evidence suggests that involving the public in such processes is complex, costly and difficult to implement. In this seminar, national and international experts from policy, research and practice discuss practical strategies for engaging citizens and communities.

Understanding commissioning
This half day workshop has been developed to support member practices of CCGs who may have little understanding of commissioning and their role in supporting this process. It includes an overview of commissioning and two further sessions on the importance of joint strategic needs assessments and setting priorities for commissioning and decommissioning. The first session was delivered to 40 members of Stoke CCG (including audit clerks, GPs, nurses and some CCG staff). Dr Ruth Chambers, Clinical Director, Practice Development and Performance, at Stoke CCG commented after the event:

“Thanks so much for coming to Stoke on Trent and running the simplifying commissioning event for us. I think everyone in the audience learnt a lot - whatever stage they are at in commissioning in their role. It made me think and write some actions down on my ‘to do’ list.

So hopefully this helps to make our member practices more effective in their localities and engagement with our core commissioning cycle - and save/improve quality of local people’s lives, of course”.

For further information contact Yvonne Sawbridge: y.sawbridge@bham.ac.uk

The role of CSUs (“Steering or rowing?”)
A follow up from the national event held on 17th May was commissioned in London by the local health system keen to test out their approach to utilising the new NHS architecture - in particular the ways in which CCGs and Commissioning Support organisations will work together to develop their approach to commissioning.

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QR codes are similar to barcodes in that they store information which can then be transferred onto your smart phone/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
People at HSMC

We were sorry to say farewell to Jo Ellins who left HSMC in February to take up an appointment as Principal Consultant with the consultancy firm, GHK.

We welcome Nicola Gale who has joined HSMC as Lecturer in the Sociology of Healthcare. She has worked in both single-discipline sociology, and interdisciplinary health research where she has brought her sociological perspective and skills to projects in fields of health services research, public health and primary care. Nicola’s interests include: health beliefs and patient accounts of illness; patient and user involvement; self-management, recovery and resilience; complementary and alternative medicine; professional practice in healthcare, focusing on professional knowledge and learning; and qualitative methodologies and qualitative meta-synthesis.

Basque Foundation for social health care innovation congress

Helen Dickinson spoke at the Basque Foundation for social health care innovation (Etorbizi) congress in Bilbao, Spain on the 8 and 9 October 2012. This event was designed for those working in health and social care related services and attracted more than 700 participants from across Spain.

On the first day of the congress, Helen ran a 2 hour workshop on integrated care for about 100 participants. Then on the morning of the second day Helen gave a keynote speech on international debates on integrated care for approximately 500 participants.

Clinical governance in New Zealand

Helen also took part in an event on clinical governance in Wellington, New Zealand on 6 December. Organised by Professor Robin Gauld of Otago University, Helen presented on the English experience alongside the Minister of Health, Tony Ryall.

The meeting was to mark the conclusion of the Clinical Governance Assessment Project and attracted over 100 representatives from District Health Boards and other health organisations across New Zealand. Helen also appeared on Radio New Zealand speaking on the same topic.

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International appointment for HSMC professor

Professor Russell Mannion has been appointed a Visiting External Examiner in the Department of Health Services Management, Faculty of Health Sciences, University of Malta. He has recently served as the external examiner of doctoral students in Australia and New Zealand.

New publications into priority setting in the NHS

HSMC academics have led on two new publications which have come out of HSMC/ Nuffield Trust research into priority setting in the English NHS. The first paper reports on a national survey looking at structures of PCT priority setting activities and the second reports in-depth case study work in a number of sites across the country.

The publications:


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Understanding the mixed economy of welfare – this book, written by Martin Powell, has won an award in Korea and was translated by Ki-tae Kim who is now a PhD student in HSMC.

Selected recent publications

Allen, K. and Glasby, J. The ‘billion dollar question’: embedding prevention in older people’s services – ten ‘high-impact’ changes, British Journal of Social Work, advance online access


