What does the future hold for the NHS?
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Editorial by Hilary Brown

The following articles reflect the broad range of interests held by HSMC colleagues, but all consider the future challenges and opportunities for the NHS, and interpret leadership in a range of contexts. We are particularly pleased to include the contributions from three of our local Clinical Commissioning Groups with reflections on their own engagement in, and experience of, these issues.

The contributions gathered here address some of the most complex or controversial debates in healthcare—such as decommissioning, integration, engagement, and leadership. Some present research findings and set out the next steps for further exploration, while others are reflections on the existing evidence base and provide a critical commentary on implications for future developments.

Given the pervading issue of how we can afford the NHS in the future, it is appropriate that our first article considers the role of leadership in decommissioning. A three-year investigation of the removal and/or replacement of NHS interventions and services, funded by the National Institute for Health Research (NIHR), aims to understand what happens when decommissioning is attempted in practice. As authors, Iestyn Williams and Jenny Harlock attest, little is currently known about how leadership strategies interact with other social processes and contextual factors in the decommissioning processes.

Such processes will often require system-wide thinking in order to prevent the impact of decommissioning affecting one group of service users or one organisation indiscriminately or disproportionately. The potential of such ‘system leadership’ is certainly gaining more focus as the architecture established by the reforms associated with the Health and Social Care Act 2012 begins to bed in, and the gaps become more apparent. Against this background, HSMC is currently working with local Chief Executives to work through the strange new world where they sometimes collaborate and sometimes compete (see page 6).

Integration is a constant leitmotif in policy documents and is often presented as a panacea for the ills of the NHS, whether by reducing demand on the acute sector by providing better community alternatives for frail, older people; or reducing waste and duplication by making processes more streamlined and efficient. The Better Care Fund is seen as a significant opportunity to strengthen integration between the NHS and council services with pooled budgets worth £3.8bn nationally. Sandwell and West Birmingham Clinical Commissioning Group (CCG) reflects on its experience of delivering The Better Care Fund (page 7) and concludes that the support of local communities is integral. By developing support networks and services locally, the CCG hopes it can build community resilience and support vulnerable people to remain independent within their own communities.

The drive to engage in a more meaningful way with local communities and service users appears to be gathering pace since the introduction of CCGs, with more collaborative commissioning processes taking shape. Dudley CCG explains its work through the Building Health Partnerships (BHP) programme aimed at improving health outcomes through partnerships with the Third Sector (see pages 10 and 11). The article explores the use of PSIAMs (Personal and Social Impact Action Measurement System), an intervention and outcomes based system that identifies the key issues of people with complex or multiple needs from an holistic perspective.

A willingness to be creative and engage in a more inclusive way with communities must be fostered as we better understand the implications of living in a ‘super diverse’ region. In general, the picture around inclusion and diversity could be said to need much improvement across the NHS and Nicola Gale and Laura Griffiths explore how more can be done to address engagement through more inclusive research activities (see pages 12 and 13).

Karen Newbigging goes further upstream to consider the related themes of community engagement and co-production in her article on promoting prevention. Karen makes the point that this will inevitably require multifaceted action to build political will, inter-sectoral partnerships and practical strategies and above all it will require leaders ‘with a vision beyond the bedside and the board’ to address this fundamental challenge.

The use of telehealth to aid prevention has been much vaunted. However, the collapse of the Three Million Lives programme leads PhD student Jenni Lynch to ponder whether the NHS is asking the right questions before it provides technological solutions. A subsequent article, on where the NHS looks for inspiration, suggests that in policy transfer from other countries, the NHS is in danger of over-relying on technical solutions and failing to recognise the importance of the cultural beliefs and values that society places on it.

Though it can be argued that the relational and interpersonal aspects of health and social care have always been more evident than in other public
services, recent years have seen a shift in focus away from ‘relationships at the front-line’ as financial and performance management has taken centre-stage. Colleagues from HSMC, the Institute of Local Government and the University of Melbourne explore what it means to be a 21st Century Public Servant in the call to move from a ‘delivery state’ to a ‘relational state’, and what skills and attributes are required of them.

Perhaps more attention is likely to be given in the future to what it means to be an ‘ethical leader’. Mervyn Conroy’s contribution explores the possibilities for supporting people as they attempt to manage change in ethical and sustainable ways and in the process build their change capability and resilience. Resilience also features strongly in the subsequent article exploring the impact of emotional labour on nurses and the affect this may have on their ability to deliver compassionate care. Alistair Hewison’s and Yvonne Sawbridge’s research looks beyond the narrative of individual blame to arrive at a deeper understanding of the complexities of care.

Along perhaps with finance, compassionate care and how to achieve it has been at the top of the agenda for the last couple of years. This focus is unlikely to change anytime soon, if further instances of less than optimal care are unearthed, as seems inevitable. A formal response from the Royal College of Nursing and DH was the development of the 6Cs Framework for Developing a Culture of Compassionate Care but as HSMC colleague, Deborah Davidson, suggests in her article, it seems as though in setting out the framework, a common trap has been fallen into.

We conclude with a piece from Professor Richard Lilford, Director of NIHR Collaborations for Leadership in Applied Health Research and Care West Midlands, who in seeking to define what drives service improvement argues against top down cultural change and heroic leadership, and instead argues for a dispersed model of leadership, combined with bottom up specific improvement practices.

Whatever your own area of interest or expertise, we hope that you find this special publication an interesting addition to, and continuation of the debate on the future of the NHS. If you would like to know more about any of these topics or studies, please contact the authors directly. See our website www.birmingham.ac.uk/hsmc for full contact details.
Decommissioning and the leadership challenge in health care

Iestyn Williams and Jenny Harlock

Despite variation and fluctuation in global economics, it seems clear that nation-states are entering into a sustained period of public sector budget constraint. As a result, ‘austerity’ has cast a shadow over the planning, commissioning and delivery of services in England and elsewhere. This presents both challenges and opportunities to those working in the health and social care sector.

The challenge of resource scarcity has led to the resurgence of the rationing (or ‘priority setting’) debate in health and social care. However this debate has evolved as the health and social care landscape has evolved. For example, the controversial topic of ‘decommissioning’ has long been overlooked by social science researchers, and has instead been confined to the narrower disciplinary frames of health economics and health technology assessment (Williams et al, 2012). We have sought to address this gap through a three-year investigation of the removal and/or replacement of NHS interventions and services, funded by the National Institute for Health Research. The aim of this project is not to make the case for decommissioning but rather to understand what happens when it is attempted in practice, and what determines ‘success’ in its implementation.

A three-round online Delphi study with thirty international experts from policy, practice and academia was conducted in the first six months of the project. The aim of this exercise was to gather expert opinion on the process of decommissioning, both as it should be done and as it is currently carried out. The initial round comprised a series of open questions asking participants to identify factors which influence decisions to decommission. Subsequent rounds then measured the degree of consensus on considerations for best practice for their implementation, based on participants’ earlier responses. The results revealed a stark contrast between what experts reported should happen and does happen in practice. For example there was strong agreement amongst participants that quality and patient safety, clinical effectiveness and cost effectiveness should ideally inform decisions to decommission. However, in practice, factors such as cost/budgetary pressures, government intervention and capital costs and condition (of buildings/maintenance) were ranked as most important in driving decommissioning decisions.

Furthermore, early findings suggest that when it comes to implementing decommissioning, size matters: inasmuch as incremental changes to practices and services are more likely to be implemented than large-scale programmes of reform and/or reduction. ‘Success’ was seen as largely dependent on the presence of effective executive and clinical leadership. But what is meant by leadership and what, if anything is distinct about leadership in a context of decommissioning?

Free text comments from Delphi participants offer some clues. Firstly, it is clear that where decommissioning implies major changes, this alone creates a leadership challenge:

‘Change in the health service is extremely difficult and all involved need to have patience and persistence. Almost certainly what you will end up with will not be the same as you initially planned. You will need to be resourceful, flexible, robust and great communicators. And be prepared to deal with a googly at all stages.’

And it seems that leadership style is likely to be most effective when it is concentrated on maximising communication, sense-making and the establishing of trust with patients, staff and other stakeholders. Astuteness with regards to the political dimensions also suggests the need to engage the full range of opinion formers and authorisers:
‘If the leadership and vision is not clear, the messages and communications become blurred, leaving people with a sense of not knowing.’

‘Effective leadership that can navigate the political aspects associated with decommissioning is key. Examples include having a doctor to speak to the general public as well as engaging early on with those individuals who you need to implement the decommissioning decision.’

‘Influence political and other leaders before you start and keep going back to them as they may ‘wobble’.

So far these messages are not dissimilar to those emanating from the wider literature on health care leadership. However, as one of our respondents notes, ‘decommissioning services is a taboo subject’. This raises the required levels of courage, sensitivity and tenacity to arguably unprecedented levels, while maintaining a collaborative approach:

‘Organisations are still operating in an environment of denial. It is essential to have leaders of the organisation that are willing, able and have the courage to carry out the decisions.’

‘Ownership is the key to successful decommissioning. The more it is ‘done unto’ services, the less personally invested staff feel and the less successful the outcome.’

Overall then it seems that leadership is vital to the successful implementation of decommissioning decisions. However, as we know, the most important phenomena can also be the least tangible, and leadership is a notoriously porous and elusive concept (Spicker, 2012). What’s more, little is currently known about how leadership strategies interact with other social processes and contextual factors in the unfolding of decommissioning processes. Hopefully, the next phase of our research – in which a commissioner survey is followed by longitudinal decommissioning case studies – will help to fill some of these gaps.

References
System leadership in a fragmented system

Jon Glasby, Director, Health Services Management Centre, University of Birmingham
Dr. Andrew Coward, Chair, Birmingham South Central Clinical Commissioning Group

In the review that led to the introduction of general management in the NHS, Roy Griffiths (1983, General Observations 5), Deputy Chairman and Managing Director of Sainsbury’s, famously observed:

“If Florence Nightingale were carrying her lamp through the corridors of the NHS today she would almost certainly be searching for the people in charge.”

In very different circumstances, the reforms associated with the Health and Social Care Act 2012 seem to have created a similar sense of fragmentation and lack of direction. With the abolition of Strategic Health Authorities, commissioning split between local Clinical Commissioning Groups and a new national commissioning board (NHS England), public health transferred to local government, providers increasingly acquiring freestanding Foundation status and a complex mix of different regulatory regimes, it can be difficult to get anything meaningful done at local level. Different Chairs, Chief Executives and Directors are variously accountable to their commissioners (whether local or national), to their Boards, to Governors and members, and to elected members, and inspection regimes and measures of success tend to focus on single agency approaches. If all we were motivated by were the current incentive structures, then there is much in the current system to encourage us to keep our heads down, jealously guard our own budget/territory and focus only on internal ‘must dos.’

And yet most people know that this would be fatal. The NHS faces one of the most difficult financial challenges in its history in a complex and unpredictable policy environment, with a series of demographic and social changes that are leading to rapidly rising need and demand. Remaining internally focused is tempting in many ways – but, deep down, isn’t really an option. As a result, lots of people across the country are seeking to emphasise the importance of ‘system leadership’, albeit in a context where there is no such leadership (at least in formal terms).

Against this background, HSMC is working with local Chief Executives (of both providers and commissioners) to review the current CEO Forum and to propose new ways of working in future (if appropriate). Although the Forum has been meeting on a monthly basis over some time, it has probably never been fully clear what role and remit it has, and its work programme is felt by many not to reflect the really big challenges facing the system as a whole. In the current context, Chief Executives and the organisations they lead are in a strange situation where they sometimes collaborate and sometimes compete – and need to be sufficiently comfortable with each other to work through which it is on any given day (and for things still to be ok the next day).

As a result of the review, HSMC is facilitating an awayday in which the 17 Chief Executives will work on a scenario which maps out the key financial, demographic and service pressures that we are likely to face over the next ten years and asks participants to identify the major issues that need to inform the Forum’s work programme over the next 18-24 months. This exercise will also incorporate early messages from the three ‘Better Care Fund’ plans agreed in different localities (the formal plans that set out what local partners will be doing together jointly in the short-term as they use joint funds to further their plans to deliver more integrated care).

Next, the awayday will look at the values and behaviours which will be needed to work through these complexities, and ways in which Chief Executives might hold each other to account for these values and behaviours in the absence of more formal accountability mechanisms. In one sense, a key role for the Forum could be as a strategic ‘sensemaker’ on behalf of local NHS organisations and key partners – helping to receive policy, make sense of it on behalf of local people and implement it in ways which are in the best interests of the population we serve.

For us, this illustrates the added value which an organisation like HSMC can play when working alongside local partners. Having access to an independent ‘critical friend’ to help work through such issues is a valuable resource, and the ability for HSMC to reflect on how knowledge and expertise acquired from its research and development can help with real-life challenges makes our work feel more real. Ultimately, we have a system which lacks formal system leadership – and a potential solution can only come if enough engaged, thoughtful people (whether from academia or practice or both) want to find a solution. The British Prime Minister has responded to the current financial crisis by stating that ‘we’re all in this together’ – and this project feels a good example of this in action.

Reference
Strengthening Communities to Deliver the Better Care Fund

Sandwell and West Birmingham Clinical Commissioning Group

Background
Sandwell and West Birmingham Clinical Commissioning Group (CCG) is responsible for commissioning local health services on behalf of a population of 530,000. The CCG is a membership organisation involving 111 GP practices across the Sandwell and West Birmingham area. These practices are further split into five Local Commissioning Groups which enable the CCG to address the needs of its population at a local level. The CCG spans two local authority boundaries - Sandwell Metropolitan Borough Council and Birmingham City Council.

The Challenge
In June 2013 the Government announced plans to integrate health and social care by creating pooled budgets between CCGs and local councils. Nationally from 2015, £3.8billion will be transferred from NHS services to local councils to support health and social care. This is the biggest ever financial incentive for councils and local NHS organisations to jointly plan and deliver services, so that integrated care becomes the norm by 2018. The aim of the fund is to improve the health and wellbeing of the CCGs most vulnerable people, and to improve the resilience of the health and social care system.

Locally, the Better Care Fund equates to £34million between the two local councils. The Better Care Fund is not “new” money; and is currently committed against current service provision. The CCG will need to work with GP members, local councils and providers to reduce demand within the acute sector, in particular urgent care, to deliver the Better Care Fund from 2015/16. To do this, the CCG and its partners - Birmingham City Council and Sandwell Metropolitan Borough Council need to develop an innovative collaborative commissioning approach to the age old problem of reducing demand on hospitals.

History of Partnership Working
The CCG is committed to delivering high quality and safe services for local patients. To do this currently, the CCG works closely with local councils and other NHS services as part of the Right Care Right Here Partnership. Over the past 10 years this partnership has delivered a range of initiatives to improve services for local residents:

- Care closer to home: 110,000 people receive outpatient care (day visits to hospital), 100,000 urgent care and 40,000 bed days of intermediate care (e.g. rehabilitation) in the community
- New primary care facilities have been opened, with more under construction
- Improved stroke services to provide high quality care, quicker access to treatment and reduce the chances of long term disability for patients.

Delivering the Better Care Fund
The CCG and councils are developing proposals designed to deliver system change, in order to release resources within health and social care to invest in the community and prevention services. Broadly these solutions focus on:

- Developing place based integration – creating a place based integrated health and social care philosophy centred around primary care. This involves focused effort to build community resilience and the establishment of 35 community integrated teams
- Caring in a crisis – enabling people to stay independent as long as possible within their community by earlier identification, mobilisation of support and effective re-ablement
- Deploying system enablers – to identify the most vulnerable and to enable effective health and social care integration.

To support this shared commitment, the CCG and its partners will develop and deliver a range of projects that will enable partners to jointly decide where investment will be directed to achieve the maximum benefits. These decisions will be governed though both the Sandwell and the Birmingham Health and Wellbeing Boards.

The CCG has held a number of events with clinicians, patients and partners to gather views on how to use this budget to better integrate health and social care.

A New Approach - Building Stronger Community Networks
For the Better Care Fund to be a success and reduce demand on hospitals, the CCG needs to support local communities, each of which is different and has its own unique challenges, to act as the drivers for change. By developing support networks and services within local communities the CCG can help build community resilience and support vulnerable people to remain independent within their own communities.

GP practices are at the heart of this community approach. Over the next two to three years the CCG will support local GP practices and their communities to develop strategies to reduce non-elective activity and improve the health and wellbeing of the community. A dedicated Partnerships Team has been established within the CCG to drive forward the 35 local strategies. The team will work with eight to ten communities at a time, to provide an in-depth analysis of that
community. By focusing on individual communities, the Partnerships Team can strengthen its networks with the voluntary sector to understand the real local picture.

Throughout 2014 the CCG will refocus its approach and organisational structure to drive change at this community level.

**Anticipated Outcomes**
During the next two to three years the CCG will have undertaken an in-depth analysis of 35 communities to produce individual strategies that will reduce demand on hospitals, improve health outcomes and support closer integration between health and social care. By strengthening this community approach, the CCG can make a difference at a grass roots level to tackle the challenges in individual populations. The CCG recognises that one approach for 530,000 people is not achievable, however by developing locally led strategies real change can be achieved.

Working with all partners, the CCG aims to create an environment where integration is successful and communities are empowered to deliver support and more effectively manage people in the community.

Following feedback from members and community nursing teams, the CCG has worked towards realigning community nursing to GP practices to ensure an integrated approach to primary care. The issues were:

- Two former Primary Care Trust boundaries, resulting in two different community nursing services for the CCG's population
- Community nursing teams working across a wide area, reducing the opportunities for close working relationships with GPs
- A national drive for GPs to be at the heart of patient care, co-ordinating care around the patient's needs
- A number of GPs identified the need for:
  - Smaller, practice-aligned, named teams of community nurses
  - Contact numbers for GPs to speak to district nurses, enabling clinician-to-clinician direct interaction when needed
  - Case managers to be integrated with district nursing and part of the core team – vital to ensuring proactive case management and improved care of patients with long-term conditions
  - Monthly multi-disciplinary team meetings that the practice-aligned district nurse and case worker attend, to enable clinical dialogue on a patient's needs
  - Reciprocal cross boundary arrangements to reduce travel time
  - Sufficient staff to meet needs with the right skill mix and training.

The community nursing project is an example of this approach and has been led by Dr Priyand Hallan, Clinical Lead for Community Nursing. Through clinical dialogue, the CCG was able to identify the barriers faced within the service and identify actions to improve outcomes for patients. As clinicians work with community nursing teams on a day-to-day basis, they have the insight and experience to support the CCG and its providers to facilitate real change.

**Clinically Led Redesign**
The embedding of clinical leadership throughout the CCG is key to the success of this project. The CCG has GPs on its Governing Body and within Local Commissioning Groups; it also took the decision to create 26 clinical leaders - local GPs with a remit to work with staff, member practices and patients to drive innovation and quality in designated specialties. Already, the clinical leaders have embarked on a series of challenging redesign projects to improve health outcomes for patients.

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**Action**
- Clinical Lead identified to drive forward the community nursing agenda
- Project governance established, including a project board and sub-groups. A collaborative approach was taken involving GPs, providers, commissioners and patients who were members on the project board and sub-groups
- Extensive stakeholder engagement with more than 800 patients as well as patient groups to find out what matters most to patients who use these services
- Development of a Best Practice Service Specification, following extensive feedback from clinicians and stakeholders, to co-design the new service using best practice locally
- A pragmatic approach tocommissioning; the CCG recognised the value of both community nursing services currently provided in the area. To retain this experience, the CCG agreed a revised contract with current providers based on the new specification (in line with procurement guidance).
This approach maintained the experience and knowledge of both providers but also led to a consistent and quality service for all patients.

- Created 35 skilled integrated nursing teams, able to connect with all services that a patient needs to provide seamless and co-ordinated care. From 1 April 2014 the teams are aligned to between one and three GP practices (based on a population of 15,000). This approach responds to the identified need for multi-disciplinary working, case management and dedicated teams.

**What was the Outcome?**

The 35 new community nursing teams were launched on 1 April 2014. Work will continue throughout 2014 to support the new approach and facilitate closer integration between GP practices and community nursing services. This work is being carried out in collaboration with health and social care partners with a further aim to integrate social care into the community teams. The new services will continue to be evaluated throughout 2014 as the service develops.

“This project was the first service redesign for us and I feel we have achieved something special. The integrated community nursing service will provide joined-up, multi-disciplinary healthcare to patients and will support GPs, who are central to the development and delivery of an individual patient’s care plan. With every decision there is a patient, and I know that this project will improve the patient experience.” Dr Priyand Hallan, Clinical Lead for Community Nursing.
The role of leadership and collaboration in the development of a social impact measurement system for use in healthcare

Paul Maubach and Mark Ellerby, Dudley Clinical Commissioning Group

Dudley, located in the West Midlands, faces significant challenges in the variation of health across the economically affluent and economically poorer parts of the borough. Coupled with the financial challenges the area faces, this inequality meant that carrying on doing things the same was not an option for the future. The Building Health Partnerships (BHP) Programme, established in order to improve health outcomes through effective and productive partnerships between Clinical Commissioning Groups (CCGs), local authorities and voluntary, community and social enterprise (VCSE) organizations, was the catalyst that brought together people interested in improving health outcomes through innovative solutions.

**Measuring personal and social impact**

The first of these innovations was PSIAMS (Personal and Social Impact Action Measurement System) - an intervention and outcomes based system that has the 'whole person' at its core. PSIAMS is a way of working that identifies the key issues of people with complex or multiple needs.

PSIAMS socially triages those needs and helps staff plan ways to resolve them. Working in a similar way to medical triaging, PSIAMS doesn’t just focus on the presenting issue; instead it takes a holistic perspective, and triages all the person’s needs. Typically, these issues include: finance, housing, mental well-being, and physical well-being. However, variations exist based on the needs of the person, e.g. a young person’s needs may include education and sexual health whilst the needs of a person over 80 may include safety.

Analysis of the PSIAMS scores allows VCSE staff to determine the appropriate support a person needs. Over time the issues are re-measured using PSIAMS to show what has changed for the person. This can be shown in a number of ways: an impact score on what has changed - "Social Impact" and a measurement of the cost savings gives the "Social Value". PSIAMS also demonstrates the legacy of that change in a community i.e. its "Social Capital" which has been described as "The web of social relationships that influence behaviour and thereby affects economic growth" (Pennar, 1997).

All data produced using PSIAMS can be applied to an individual, a cohort (e.g. age, disability) or an area (e.g. Borough wide to ward or community area). PSIAMS provides an opportunity for the CCG and Voluntary Sector to agree an approach on engagement and assessing value for money across organisations and sectors. It also provides a system for collecting evidence to ensure communities are influencing local decisions. This includes a common system to measure how far the service user has progressed, a calculated personal social impact score and a social value score on services delivered by the VCSE sector. VCSE organisations collect and appropriately share data for both soft and hard outcomes. In doing so, PSIAMS will help inform the development of sustainable services delivered by VCSE organisations, improve efficiencies and map trends, enabling them to improve the customer’s journey.

The data collected by organisations through PSIAMS is already helping to inform and shape current and future health and care commissioning interventions, especially in terms of integrated care, location of services and the efficiency of interventions undertaken in non medical settings.

From a VCSE perspective, PSIAMS is helping organisations to embed partnership working with the CCG and local authority commissioners into their practice. Staff have been able to see that the work involved in PSIAMS is not additional to the evidence they already collect and actually brings it together more effectively.

**Community Information Directory**

The second innovation from the BHP is the Dudley Community Information Directory (CID) which enables GPs and VCSE organisations to find local services that could provide alternative solutions to replace or enhance medical interventions. These include: clubs and societies, CVSE organisations that provide specialised support, care providers, self help groups and a personal assistance directory. CID provides an alternative, non-medical pathway to support patients with low level or non-medical support needs, rather than inappropriate A&E or GP visits.

The CCG is now working with the local authority, public health, Healthwatch and the library service to gather feedback on the CID and identify ways to develop this to support social prescribing within the borough.

**A collaborative process**

PSIAMS and the CID are now making commissioning a more collaborative process, leading to better health and social care outcomes in Dudley. The way forward is to ensure that people’s lives are changed with a positive
outcome and community needs are addressed in a responsive way.

Improvement needs to be measured and understood both from a clinical outcome perspective but also from the value that is derived and perceived by the patients receiving care. We need to enable genuine co-production of care plans (and shared monitoring of progress against those plans) between the patient and the clinician. This can only be achieved systematically if we have tools, like the PSIAMS tool, that are specifically designed to facilitate this kind of dialogue.

We recognise that for most people they are their own healthcare professional for the majority of the time in managing their health and wellbeing. Our philosophy as a CCG is to support individuals to do this and so by maximising their potential, reduce their demands on healthcare. In addition, our CCG is seeking to change the basis of future engagement from the ‘representative mechanism of the willing’, to a ‘participative mechanism for all’. This can only be achieved through the development of information tools that enable every single person receiving healthcare to articulate the benefits (or otherwise) of the care that they receive and the personal impact that it has had for them. We can then use actual patient feedback to evaluate the effectiveness of services as determined by the patients themselves.

Dudley CCG is investing in activities that encourage a mutual approach to healthcare – where individuals take responsibility for their health and make the best use of resources; where the NHS seeks to maximise the potential for individuals through genuine personalised care; and where we all recognise our collective responsibility to each other and to our community to work better together. So the improved working with the VCSE services and the community information database is part of this process of encouraging ‘health as a community responsibility’ - supporting integration between the voluntary sector and the NHS in our local communities.

“What has been unique is the high level leadership involved - it’s pushed it higher up the agenda” said Neil Bucktin, Head of Partnership Commissioning at Dudley CCG
Health inequalities have continued to grow since the inception of the NHS in 1948 and research has gradually identified not only class differences but other dimensions of inequality, along the lines of ethnicity, gender and gender identity, sexual orientation, geographic location, migration and age, as well as complex ‘superdiverse’ intersections of these. The challenges for the NHS include: trying to understand and develop different modes of engagement in order to deliver more effective services; developing specialist understandings of risk and prevention across diverse populations in order to allocate resources more effectively; and the challenge of reducing the existing inequalities in the incidence, diagnosis, treatment and outcome of particular conditions.

Before identifying potential solutions, it is important for researchers to understand what the causes of the problem are. It may be an unwillingness to accommodate differences; it may be a lack of recognition of diversity; or it may be a lack of knowledge and resources to challenge the status quo. There is some evidence of personal characteristics - sexism, racism, classism, homophobia, transphobia, ageism, etc. – that affect outcomes in diverse populations, but sometimes even when the intentions are not so problematic, the effects still can be. Injustice can be both impersonal and institutional, and can become embedded in the culture of an organisation and the debates around institutionalised racism across the public sector are an example of this.

The way that biomedical and public health knowledge is constructed can also be problematic; defining what “the problem” is in the first place often needs the participation of many, not a few. Outcome measures, which often help define the comparative success or failure of interventions and services, should themselves be open to debate. Outcome measures themselves would be more effective if they were actively co-produced by the diverse populations the interventions and services will be offered to. Efficacy and cost-effectiveness studies want to know if an intervention is worthwhile overall, and rarely have the statistical power to consider differential effects on sectors of the population. Indeed, often the characteristics of research participants (often disproportionately adult, white, young males in secondary care services) is very different from the population that the intervention will ultimately be used with (mixed gender, age, ethnicity and in primary and secondary care populations).

The experiences of populations such as people with learning difficulties, sex workers, drug users, non-English speakers, prison populations or the homeless are often left out of mainstream research unless the research is specifically on that group. Research that focuses on particular groups goes some way to counteracting the myth that much mainstream research can be generalized. There are, however, some risks in this strategy because research on particular groups, such as ‘South Asians’ or ‘women’ or ‘gay men’ can sometimes reinforce stigma. It can lead to the illusion that particular issues, such as type two diabetes amongst South Asian populations, are inherently linked with the cultural and ethnic identity of that group. Populations that are still not represented in research are then identified as ‘the problem’ and frequently labelled as ‘hard to reach’. However these populations may only be ‘hard to reach’ when using mainstream research methodologies. A term which is becoming increasingly common is ‘seldom heard’ groups, which emphasizes the responsibility of researchers in designing studies that genuinely attempt to represent the whole population, rather than just the easy to reach ones.

Changing the method of engagement and crucially involving participants in the design of the research, not just the recruitment, has the potential to enhance the validity of research across the board. Redwood, Gale and Greenfield (2012) report on the many reasons why particular groups have been left out of research, many of them unintentional, but still discriminatory. Research that seeks to include groups which are seldom heard in mainstream research have often required innovative methodologies. By changing the research process and the routes of access to participation in research, researchers have also challenged the idea that particular groups are hard to recruit to research more generally.

For example, Greenhalgh, Collard and Begum (2005) report on the development of a complex intervention for diabetes education amongst minority ethnic groups who did not speak English, in this case Bangladeshi. Greenhalgh’s previous research (2002) had indicated that behavioural change, such as giving up smoking, had often been attributed by the participant to a story told to them in an informal setting by another Bangladeshi. Their action research study on experiences of diabetes was carried out by bilingual health advocates (trained by a learning set) who recorded ‘shared stories’ between the health advocate and participant. The advocate set an informal and supportive atmosphere in which to talk about diabetes and risk, which researchers felt was distinct from the type of education about diabetes that was found elsewhere in the borough.
Although the general picture around inclusion and diversity could be categorized as bad, there are pockets of good practice to be seen in collaborations between the public, patients, professionals, managers and health researchers. More will be required in the future!

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Preventing poor health and illness has been a concern for centuries and contemporary efforts have been reinforced by the financial climate, the demographic challenge of an increasingly ageing population and rise in non-communicable diseases as a leading cause of death and disability (WHO, 2010). There are four good reasons to focus on prevention (Heginbotham & Newbigging, 2013; Newbigging & Heginbotham, 2010:4):

1) The ethical case: everyone has the right to the best physical and mental health that society can afford, to enable them to enjoy their capabilities to the full and contribute to society (Sen, 2005). Emphasising strengths and abilities, rather than deficits, offers a positive alternative to the illness and disability focus of much health and social care.

2) The equalities case: health, and access to health care, is influenced by socio-economic determinants and generational disadvantage. Preventing poor health and illness requires attention to these determinants and action to reduce the social gradient in health i.e. the difference in health between low-income groups and high income groups (Marmot et al, 2010).

3) The economic case: to reduce the costs at an individual and societal level, prevention at primary, secondary, tertiary levels is needed to lower demand on primary care, hospital and community services, and achieve improvements in overall population health.

4) The evidence: there is a growing evidence base for interventions at a population, community and individual level to promote good health.

Whilst not many would argue with this, the reality is that much of the attention is on intervening downstream, particularly on individual lifestyles to reduce well-established risks (obesity, physical inactivity, smoking and alcohol abuse) rather than the socio-economic determinants and the social processes that influence their distribution (Graham, 2004). This “lifestyle drift” means that positive policy intentions of addressing socio-economic determinants of poor health upstream translate into downstream lifestyle interventions (Hunter et al, 2009).

Whist some argue that a paradigm shift is needed to move from a downstream focus on framing health as the responsibility of the individual to upstream interventions that tackle the root causes of poor health (Raphael, 2003), it has also been suggested that downstream interventions have an intuitive appeal (Exworthy et al, 2006). To make substantive progress five challenges need to be tackled; requiring assertive leadership. First, the adoption of a life course approach that recognises the long shadow cast by early disadvantage and poor childhood health, and action to ensure that children have the best possible start in life, as widely advocated by key government reports (see Marmot et al, 2010 for example). This means a move away from illness construed as episodic, to health as personal and social capital developed over the life course (Foresight, 2008). Second, results are not quickly achieved and may take several years to realise. The application of the Robinson & Horwitz’s (2012) Ten Year test (i.e. will the decisions made to day come back to haunt us in ten years’ time?) provides a potential antidote to politicians concerned with quick wins on the complex causes of poor health (Heginbotham & Newbigging, 2013). Third, the interventions required and gains achieved may not lie within the same policy or service domain and so the savings in one area, e.g. the criminal justice system, may result from investment in another, i.e. programmes to promote childhood health. Fourth, it is clear from this that upstream action is dependent on inter-sectoral partnerships, working across boundaries to implement upstream action and tackle inequalities. Finally, co-production with individuals and communities to better understand assets, possibilities and challenges is required and will have a bearing on strategies to promote health.

Addressing these challenges will require multifaceted action to build political will, inter-sectoral partnerships and practical strategies. Above all, it will require leaders with a vision beyond the bedside and the board to address this global challenge.
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Karen Newbigging is the co-author, with Chris Heginbotham, of the recently published text: Commissioning Health and Wellbeing. See http://www.uk.sagepub.com/books/Book238846?subject=W00&sortBy=defaultPubDate%20desc&fs=1
Telehealth and the NHS: are we asking the right questions?

Jenni Lynch

Telehealth has become a messy issue for the NHS. Successive UK governments have lauded the technology as providing an answer to the financial crisis faced by health and care bodies, insisting it will relieve pressure on emergency provision whilst improving the quality of the care received and the day to day experiences of patients. Yet there is still much debate about the status of evidence for these claims and investment in a national rollout of telehealth has stalled recently with the scrapping of the 3millionlives’ pathfinder programme before it could complete its objective of recruiting 100,000 telehealth users by the end of 2013. 3millionlives was developed by the Department of Health and representatives from the technology industry as a mechanism for promoting and improving access to telehealth and telecare. It was founded on the principle that at least three million people nationwide with long term conditions, or who may be in need of social care support, could benefit from the use of telehealth and telecare services.

The initiative was launched off the back of the headline findings from the Whole System Demonstrator (WSD) study, the world’s largest randomised control trial of telecare and telehealth (DH, 2011). The WSD aimed to provide a clear evidence base for investment in telehealth by focusing on equipment that could provide home monitoring for people with diabetes, heart failure and chronic obstructive pulmonary disease (COPD). The intervention was shown to be associated with reduced mortality rates – by 45% against the control group – and fewer emergency hospital admissions – a decrease of 20% (Steventon et al, 2013). However, these strikingly definitive figures belie the ambiguity of other results from the study – most notably that the telehealth intervention did not improve quality of life or psychological outcomes for patients (Cartwright et al, 2012) and that the impact on hospital costs was inconclusive (Steventon, et al, 2013).

This has left Clinical Commissioning Groups (CCGs) and other providers with some difficulty in making evidence-based decisions about investment in telehealth. The government strategy for a blanket rollout of telehealth has been criticised as unwarranted, with calls for a more targeted approach and a need for further insight into what technology, exactly, is working for whom (Car et al, 2012). Part of the problem is a lack of clarity about what is being referred to when the term ‘telehealth’ is used. The multitude of pilot studies showing positive results for ‘telehealth’ only serve to demonstrate that success is often context-specific: good outcomes rely on particular pieces of equipment being implemented in certain circumstances, and involving people with identified requirements and attributes conducive to reaping the benefits.

The Department of Health’s narrow definition of telehealth as ‘equipment to monitor people’s health in their own home... [monitoring] vital signs such as blood pressure, blood oxygen levels or weight’ (Davies & Newman, 2011) is evidently clinically-focused and suggestive of considerable investment in hardware leading to high initial implementation costs (Henderson et al, 2013). However, the teleSCoPE project, which developed a European Code of Practice for Telehealth Services, argued that approaches to telehealth ‘should not solely reflect clinically driven responses to the higher-level needs of some ‘patients’ (Fisk, 2013: 1) and accordingly adopted the definition of telehealth as ‘the means by which technologies and related services concerned with health and wellbeing are accessed by them or provided for them at a distance.’ (teleSCoPE, 2014: 14).

This is indicative of a move towards an approach to telehealth that is both more personalised and more focused on adaptable technology that can be developed for a range of uses. Crucially, this shift allows commonplace technology, such as smartphones and tablets, to form part of the solution. This is appealing not only for the fact that these devices are already user-focused by design but also because it may reduce some of the need for investment in expensive hardware. The drive towards ‘mHealth’, which makes use of mobile technology, opens up possibilities for a single device to meet multiple needs – apps on a tablet could monitor vital signs, enable video consultations with a GP, provide a dashboard of controls for managing the home environment, connect the user to a 24 hour response service, and so on.

In a 2012 survey conducted by GP-authored website Patient.co.uk, 75% of 1470 family doctors and health professionals questioned were in favour of mobile apps to help patients manage chronic conditions (Patient.co.uk, 2013). This stands in contrast to a GP Magazine survey of 316 GPs, 61% of whom stated they did not believe that traditional telehealth had the potential to improve the care they gave to patients (GPonline, 2014). Pertinently, a key gripe of respondents was the prospect of devices increasing workload rather than reducing it.

Here, perhaps, is revealed the nub of the issue: is there clarity on the public purposes of telehealth, and if so, are they compatible with each other and the practice of health service provision? Rather than continuously search for evidence of efficacy, a technologically-advanced NHS must decide what the desired result is. Can the simultaneous
aims of cost savings, maximised resources, improved quality of care and better outcomes for patients be sincerely pursued through the medium of telehealth? An honest appraisal of intentions is required if acceptance is to become widespread.

References
Learning lessons from other countries

Mark Exworthy and Kerry Allen

International conferences, like EHMA, are an opportunity to exchange ideas about policy practices in different countries. Though valuable (and hopefully enjoyable), a more in-depth analysis is also worthwhile. Cross-national comparisons are useful because all systems face endemic challenges of improving access, raising quality and containing costs. Different systems – whether tax-based, social insurance or private insurance - are likely to benefit from policy learning. Such learning can, for example, trace cross-national influences (including causes of disease), identify what policies ‘work’ in comparable contexts and avoid what does not ‘work.’ Yet, systems may make the wrong comparisons or poor inferences and may fail to learn or adapt. So, as it is now difficult for health policy makers not to know something about what is going on elsewhere, how might English policy transfer and learning be better understood and implemented?

The NHS – leader or laggard?
Theoretically, all health systems enjoy benefits and drawbacks – none perform well on all the criteria by which systems might feasibly be compared. Table 1 shows performance of idealised health systems according to these criteria. These systems (and their performance) reflect differences in ideology, institutions and interest groups.

In the UK, political devolution to Scotland, Wales and Northern Ireland has, since 1999, created a diverse landscape of policy approaches. It is fair to say that the UK does not take the opportunity to learn as much as it could from this ‘natural experiment’.

The focus here, however, is on learning between national health systems.

How does the NHS perform?
The UK’s National Health Service (NHS) has either been hailed as the ‘envy of the world’ or too centralised and bureaucratic. According to table 1, both claims might be right. At a gross level, the UK’s spending on health (3,405 USD per capita) generates reasonable health outcomes (life expectancy 81.1 years (OECD, 2013)). Such evidence is not always appreciated in political debates or in the media!

For sure, the NHS has often been praised as a model, parts of which have been emulated. Its emphasis on primary care, technology assessment and care co-ordination have been admired and even copied. However, its apparent centralised bureaucracy has been criticised for stifling innovation and specific health outcomes have been poor in comparison to other countries, as the health ministry in England claimed:

“Compared to other countries, however, the NHS has achieved relatively poor outcomes in some areas. For example, rates of mortality amenable to healthcare, rates of mortality from some respiratory diseases and some cancers, and some measures of stroke have been amongst the worst in the developed world… But international evidence also shows we have much further to go in managing care more effectively.” (DH, 2010).

Also, its record on tackling health inequalities has, despite the political rhetoric, been moderate.

Are we converging?
Like its economy, the UK is an increasingly open health system. The import and export of ideas, policies and techniques has been widespread. With the migration of clinical staff and growth in the number of medical tourists, this has been even more evident in recent years. As with all countries, improved global communications (by air and the internet) and international networks have vastly increased the opportunity for policy transfer. It has also been facilitated by the growing role of international institutions (like WHO)

Table 1

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<th>System type</th>
<th>General taxation</th>
<th>Social insurance</th>
<th>Private insurance</th>
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<td>Example</td>
<td>Eg. UK</td>
<td>E.g. Germany</td>
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<tr>
<td>Equity</td>
<td>High; progressive taxation</td>
<td>Medium/high; near universal</td>
<td>Weak; risk-based</td>
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<td>Transparency</td>
<td>Low</td>
<td>Medium; hypothecation</td>
<td>High; payment &amp; benefit linked</td>
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<td>Choice</td>
<td>Low</td>
<td>High; choice between providers</td>
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<td>Macro-efficiency</td>
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<td>Cost control</td>
<td>Demand-led or global budgets</td>
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<td>Micro-efficiency</td>
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<td>Incentives?</td>
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and management consultants. Yet, policy ideas rarely travel alone; they come with an intellectual ‘baggage’ of assumptions and paradigms. The spread of market-based policies attests to this.

While international health policy transfer has certainly improved our (collective) knowledge of other health systems, to what extent has it led to the UK becoming more like elsewhere (or vice versa)? On the one hand, there are indications of convergence. Borrowing ideas from organisational theory (DiMaggio and Powell, 1983), isomorphism may take three forms:

- Coercive refers to institutional and regulatory requirements such as WHO policies,
- Mimetic refers to agents’ copying or emulating innovations elsewhere (such as Kaiser’s integrated care approach adopted in some NHS organisations), and
- Normative refers to the influence upon agents’ norms and routines.

On the other hand, there are tendencies for continued divergence. The notion of ‘path dependency’ policy and management can become so institutionalised that it becomes nearly impossible to break free from the established policy path (Greener, 2002). English civil society (public opinion, media) often presents resistance to change in hospital configuration, for example. Judging the balance between convergence and divergence is problematic. Specific examples can be drawn on both sides.

**How do we learn from other nations?**

Of late, the UK has had an enthusiastic interest in learning from abroad. For the most part, it has looked to the USA for ideas and solutions. There has been an indifference towards Europe and even English speaking countries (such as NZ, Australia and Canada (Walshe, 2001)). The irony of learning between two apparently different health systems has not been lost:

“**The UK learning from the US health system is like an obese person trying to advise someone on a diet,”** (Klein, 2010).

Such learning has taken the form of study tours, research projects and exchanges from the UK to the US (Hunt, 2014); much fewer have gone across the Atlantic from west to east. The UK has also recently become active in promoting UK health care abroad and not only in the life science industries. Support for ‘health’ initiatives is increasingly taking a form of ‘soft’ diplomacy.

However, the different context makes the ‘translation’ of ideas between systems difficult:

“**What are taken as policy ‘lessons’ are derived from comparison which is inappropriate, which pays little attention to evidence and evaluation, and which ignores the particular needs and requirements of different policy contexts.”** (Exworthy and Freeman, 2009)

The notion of a linear model of learning – transmitting ideas from one place/person to another – is inappropriate. Rather, policy learning is more about adaptation and contextualisation. Thus, policy ideas do not have a universal merit or value. They need to be moulded to the demands and pressures of each system. This highlights the need for better intelligence (‘smarter’ health leaders) about this process.

**Can we learn more from Europe?**

Current learning from European countries may offer the UK more nuanced and context aware intelligence for health system reform. Perhaps lacking the immediate appeal of the one-size-fits-all solutions that are becoming publicised as best practice (e.g. public-private partnerships, data analytics, precision/personalised medicine), recent EU collaborations have displayed more focused approaches to common challenges; evaluating real life interventions within their political and cultural contexts.

For example, a recent EU study of long-term care policy and practice across 13 countries (Interlinks) took a broader analytical approach to the identification of promising developments; jointly defining and conceptualising long-term care systems before reviewing current practice in each country. Acknowledgement of the complexity of transferring structures, policies or interventions into new national settings is visible in these findings (Leichsenring, Billings and Nies (eds.), 2013), which aim to provide national and local policy makers with the evidence towards decision-making. Project outputs challenged the prevailing discourse centred on the problems of demographic change and long-term care provision for older people and evidence is provided for how the construction of long-term care systems can be taken forward. Such evidence, whilst still covering an array of system types, might provide a less context-blind approach for future system and service changes.

**Conclusions**

Rudolf Klein (1990) likened health reforms to two types of models: the garage and the church. The ‘garage’ model implies that technical solutions will solve health systems’ ‘failings.’ Certainly, this has been a key feature of health policy transfer in the UK in recent years. The ‘church’ model refers to the cultural beliefs and values that society places in the health system;
reforming the system risks challenging these beliefs. Given that the NHS has been likened to a national religion (Lawson, 1992), current reforms need to take more account of the implications of the ‘church’ model. So, in so far as the NHS is looking to other countries for health policy reforms, a reliance on the ‘garage’ model, without due recognition of ‘church’ model, is likely to founder.

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A Health Workforce that’s fit for the Twenty-First Century

Catherine Needham, Catherine Mangan and Helen Dickinson

In interviews for our project exploring what it means to be a 21st Century Public Servant, we have spoken to people working and managing a wide range of public services. A recurrent theme is that the sorts of skills and values which will be needed for future public services are not necessarily those in which staff are currently being trained. Interviewing 40 people from across local government in Birmingham and the wider West Midlands, as well as people working in national stakeholder organisations, we have come across a workforce that sees a need for more generic and flexible forms of working, to cut costs but also to focus more holistically on the end user of services. As the Centre for Workforce Intelligence (2013) recently summarised – ‘we can’t integrate services without truly integrated approaches to the workforce’.

Our research has mainly focused on local government but the themes have resonance for the health sector, as it comes to terms with a period of negative publicity about poor standards of care and defensiveness in the face of complaints. An overarching theme of the research has been the need to work in more relational ways. One interviewee said: ‘We need people who are really good with people and can form relationships, who are able to learn quickly.’ According to another, ‘Authenticity is critical. We need to learn it’s ok to say I made a mistake: this isn’t car insurance – you have to start off saying you’re sorry.’ Emerging themes from our research, which is ongoing, are summarised in Box 1

Box 1: Emerging themes from the 21st Century public servant research

Future public services require a different set of workforce roles than in the past

- Citizen behaviours and expectations are changing, as citizens become more assertive and more interested in working co-productively
- Generic skills are becoming as important as professional skills, as ‘soft skills’ around communication, organisation and caring become more highly prized
- Career paths and incentive structures are becoming more fluid. People are unlikely to stay in one sector or service area for life and need portable skills that are valued in different settings
- Ethics and values are changing as the boundaries of public service shift, with notions of the public sector ethos being eclipsed by a narrower focus on individual values and a wider focus on social value
- Perma-austerity is inhibiting and catalysing change, as organisations struggle to balance short-term cost-cutting and redundancies with a strategic vision for change

Organisational structures need to change to accommodate and support 21st Century public servants

- Hero leaders aren’t the answer. Rather than emphasising the charisma and control of an individual, new approaches to leadership assume that it is dispersed throughout the organisation.
- Relational and reflective practice is essential. People need opportunities to learn and reflect on new skills, which may be through action learning, mentoring, job shadowing and sabbaticals rather than formal training.
- The role of place in public service needs to be recognised: public service workers often have a strong loyalty to the neighbourhoods and towns/cities in which they work as well as an organisational loyalty.
The relational and interpersonal aspects of health and social care have perhaps always been more evident than in other public services. However in recent years there has been a sense that financial and performance management has shifted focus too far away from caring relationships at the frontline. The call to move from a ‘delivery state’ to a ‘relational state’ as a recent IPPR report put it, therefore seems, just as applicable to health as it does to other public services (Cooke and Muir, 2012). The King’s Fund has argued that the growth in numbers of people with multi-morbidities that span mental and physical health creates new workforce challenges: ‘Current staff...need to develop the skills to act as a “partner” and “facilitator”, rather than an “authority” and this will require significant cultural change’ (Imison and Bohmer, 2013). Mulgan (2012) suggests that we ‘make healthcare more like education, deliberately aiming to raise the skills of the public through, for instance, courses or e-tutorials’.

These more relational ways of working are vital for the future health workforce. But there are a number of challenges to working in this way, as we set out in our literature review for the project. These include:

1. Lack of appropriate skills training
In the rush to endorse relational approaches to public services there can be a sense that public service workers have a natural ability to relate and emote which is being constrained by bureaucratic and market-oriented systems. We just need people who behave like "real people", as the recent IPPR report on the ‘relational state’ suggested (Muir and Parker, 2014, p.35). If we can transfer more autonomy to the frontline and encourage more multi-disciplinary working, this line of argument suggests, then we will set staff free to build these relationships. But of course for staff who have been trained in more transactional and technological types of service those relational skills may be underdeveloped. Too much focus on professional development ignores the generic skills which underpin relational work (for example the ability to be a navigator of systems, a weaver of resources and a storyteller helping citizens to communicate what they want).

More attention needs to be paid to how the interpersonal skills for relational working will be developed in the public service workforce. Higher education and other training and development and support continue to offer highly specialised and professional pathways that lead to particular professional qualifications. Post-qualification training remains focused on particular sectors, except at a leadership level. There is a tendency to assume that public service careers are linear and specialised and therefore predictable.

2. The emotional labour of caring
The emotional labour of deeply relational public service work is also an area where more attention needs to be given. For those who are engaged in relational forms of support, relating can take its toll. In the care sector, for example, personal assistants have more opportunity than other care workers to build intimacy, spending sustained periods of time with an employer in a home setting, but may experience difficulties in establishing boundaries and appropriate working practices when they are treated as ‘one of the family’. Migrant workers in particular have found it difficult to set boundaries around their relational work. In its response to the Francis Report into events at Mid-Staffordshire NHS Foundation Trust, the government explicitly evoked the concept of ‘The Emotional Labour of Care’, writing: ‘Working in health and care is inherently emotionally demanding. To support staff to act consistently with openness and compassion, teams need to be given time and space to reflect on the challenging emotional impact of health and care work’ (Department of Health, 2013, p. 31). Recruitment needs to focus on the extent to which people have a set of competencies which will enable them to behave with compassion in high-stress environments and to cope with the emotional labour that care entails (Sawbridge and Hewison, 2011).

3. The pressures of authenticity
Public services which are relational and responsive to the ‘whole person’ seem to place a demand that ‘authentic’ connections be made between people using and providing services. New communication technologies allow people to blog and tweet in real time about their work and ideas, and again authenticity seems to be very much valued here. On Twitter, people are expected to engage in authentic interactions, defined in a recent article as ‘spontaneous, unrehearsed discourse’ (Margaretten and Gaber, 2012).

A recent article in The Conversation highlighted how recent management thinking which has encouraged workers to be authentic and spontaneous in the workplace has also brought new pressures:

Because employees are asked to bring themselves to work, there is a very blurry line between personal issues and professional issues. Because you should be passionate about what you do, it is not clear when you are working and when you are not. This often means work begins to bleed out into people’s personal lives—often quickly taking them over and leaving
little room left for non-work related pursuits. But it also means we come to have unrealistic expectations of what we might get from work or indeed our workplace (Spicer, 2014).

Similarly in public services more relational ways of working create challenges for traditional notions of professionalism. Professional detachment has been associated with ‘self-care’ and emotional resilience for public service workers and workers may struggle with relational approaches which appear to demand that they give more of themselves.

For updates and discussion about the themes of the research, go to our 21st Century Public Servant blog at http://21stcenturypublicservant.wordpress.com/ and contribute to the debate on Twitter #21Cps. More details about the research project are given in Box 2 below.

About the project
The project is a partnership arrangement between the University of Birmingham and Birmingham City Council and aims to establish a knowledge portal to support other public servants and public service organisations. It is funded by the Economic and Social Research Council and runs for a year from October 2013 http://www.esrc.ac.uk/my-esrc/grants/ES.K007572.1/read

Research questions
- What is the range of different roles of the twenty-first century public servant?
- What are the competencies and skills that public servants require to achieve these roles?
- What are the support and training requirements of these roles?
- How might central and local government better support and promote public service careers?

Work plan
- Rapid evidence appraisal, through desk-based research, October-December 2013
- Exploratory research, through interviews, January-June 2014
- Disseminating findings, through project blog, portal and events, July-September 2014

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Keep schtum or whistle: what makes some health and care managers resist corruptions to practices?

Mervyn Conroy

It is easy to say that if health professionals had resisted some of the changes that resulted in corruption to care practices at Mid-Staffordshire then the impact would not have been quite so serious or may not have occurred. However, have you ever felt something is not quite right or something is definitely wrong but not done anything about it? Well you are not alone and research shows that it is difficult in our work lives for us to stand up and blow the whistle on practices that might be different to what others seem to be accepting as normal. The call by the new NHS CE, Simon Stevens, to speak out when staff see or experience something that could be damaging to patient safety will be encouraging for staff. However, research suggests many are unlikely to follow his call. This article examines why it is so difficult to resist and also how some people do resist health practice corruptions and what interventions might help them to do so and encourage a corporate ethical and sustainable approach for the future.

Recent scandals in the health and social care sector (and many other sectors) emphasize the need to gain a better understanding of the ethics of healthcare practice. In particular, the responses of staff who feel or see something is not right yet take no action. The Francis enquiry into Mid-Staffordshire Hospital Trust found shortcomings in the ‘care, compassion and humanity’ shown by staff, that staff showed a lack of ‘respect’ for patients’ dignity, showed ‘callous indifference to suffering’ and demonstrated ‘a lack of candour in reporting poor standards of care’ due to fearing repercussions or victimization (Francis 2013). So fear plays a role in keeping us schtum but what else might be going on in the complex dynamics of organizational life? Anand et al (2004) argue that middle managers use rationalisations or mental strategies that allow employees and others around them to view corrupt acts as justified. They found that corporate scandals have some features in common. In most instances, the fraudulent acts involved knowing cooperation among numerous employees who were paradoxically trusted and upstanding community members, givers to charity, and caring parents. Employees may collectively use rationalizations to neutralize any regrets or negative feelings that emanate from their participation in unethical acts. Further, rationalizations are often accompanied by socialization tactics through which newcomers entering corrupt units are induced to accept and practise the ongoing unethical acts and their associated rationalizations. Some of the comments from employees involved in their research are presented in the box below.

"What can I do? My arm is being twisted.”
"No one was really harmed.”
"It could have been worse.”
"They deserved it.”
"You have no right to criticize us.”
"Others are worse than we are.”
"We answered to a more important cause.”
"I would not report it because of my loyalty to my boss.”

They found that ‘When using this rationale, individuals do not regard themselves as perpetrators of unethical acts; rather they view themselves as morally responsible individuals being forced into unethical acts’ (ibid:42)

So we can convince ourselves into believing we are being ethical when in fact we are acting unethically. This chimes with Foucault (1983) who argues that we have an internal policeman that polices in accordance with the prevailing discourses into behaviours seen as acceptable and normalised in specific contexts.

Further concurrence comes from Ricouer (1985) who argues that we mimic through enactment the narratives that circulate our community and restore narrative to action (and possible suffering). The case is that ethical resistance is uncommon in organisations yet from time to time, despite such dynamics and pressures, people do ethically resist – but not always in their actions. Propp’s (1928) ground-breaking study of the people’s folklore (stories, songs, ballads, stories, jokes etc.) under Stalin’s rule demonstrated the powerful resistance contained in their form and construction. The folklore provided a cathartic expression of underlying feelings of discontent against oppression, exploitation and social injustice. An outlet that would not evoke violent repercussions as would have been the case if they had acted out their frustrations.

Back to the NHS, what do we find if we study the folklore of clinicians and managers on the receiving end of reforms? In a recent study (Conroy 2010), NHS folklore in the form of frontline manager and clinician stories, a pantomime and comic narratives about changes to mental health services expressed an underground resistance (similar to what Propp found) and contained the paradox of being ethically torn between what they
know is right for the people they care for and rationalisations that carry them along with corrupting practice changes (Conroy 2010). From a virtue ethics perspective (MacIntyre 1981) keeping schtum or rationalising corrupt acts as justified would both be at one pole of the virtue continuum of courage with whistleblowing at the other pole. Both are extremes that from a virtues ethics perspective are unlikely to benefit the individual, the collective or the practice.

In virtue ethics ‘phronesis’ or ‘practical wisdom’ is seen as the ability to find the median point on a virtue continuum for any particular context that will bring (internal) goods for the individual (e.g. job satisfaction), improve outcomes and experience for patients and contribute to practice excellence. That NHS folklore research was just the start of a continuing dialogue with senior clinicians and managers about how to improve services in ethical and sustainable ways and in the process build their change capability and resilience. So how did those practitioners find a median point on the courage continuum at which they could still find a way of resisting the corruption to practices but not risking all with an act of whistleblowing?

John Anderson, the Australian philosopher, urges us not to ask of a social institution: ‘What end or purpose does it serve?’ but rather ‘Of what conflicts is it the scene?’ (Passmore 1962) In other words, the individual and the meaning of individual action are framed by the wider culture in which the action takes place.

By working with the clinicians and managers, mainly in seminar learning sets and taking a participative action research approach, they tracked their paradoxical practice dilemmas back to their ideological roots and differing standpoints. Once they understood that they were unwittingly or unwittingly supporting practice corruptions then they became angry at becoming ‘emplotted’ in an ongoing and emergent narrative that they did not identify with. Courage to resist was found through externally facilitated peer group reflection, moral debate and collective action rather than individual whistleblowing.

This approach tallies with the recommendations made by Anand et al (2004). They found that when corruptions come to light there is a tendency to ‘blame rogue individuals or isolated groups, arguing that they do not represent the otherwise pristine organization. In cases of collective corruption, such scapegoating misses the point that individuals and systems are mutually reinforcing’ (ibid: 50). They suggest the involvement of external change agents to support education and connection between staff and external networks because insiders are often part of the system and continue to be susceptible to the rationalizations associated with corrupting influences on practices.

Anand et al (2004) do not elaborate on the nature of the education and connection so virtue ethics offers an option to gain clarity on the type of connection and education that would contribute to maintaining ethical practice. These findings suggest a reframing of ‘whistle blowing’ health and social care policy with its emphasis on individuals towards externally facilitated peer group reflection and ethical debate.

References:
Nursing is hard emotional work- why is this ignored?

Alistair Hewison and Yvonne Sawbridge

Researchers at UoB are actively exploring the impact of emotional labour on nurses and how this may affect their ability to deliver compassionate care (Sawbridge and Hewison 2011, 2013). Isabel Lythe Menzies (1960) was asked to help reduce the rates of student nurses leaving a London Teaching hospital, and observed: “Their work involves carrying out tasks which, by ordinary standards, are distasteful, disgusting and frightening” (p97). This statement is as relevant today as when it was first made, though it is rarely expressed. The recognition of care giving as anxiety-provoking is at the heart of our work, which explores the factors which can contribute to the lack of compassionate care given to patients. The evidence for the absence of compassion in some organisations is stark (Francis 2013), and our work looks beyond the contemporary narrative of blaming the individual, to a deeper understanding of the complexities of care.

The term “Emotional Labour” is used to describe the effort involved when working with feelings. “It requires workers to suppress their private feelings in order to show desirable work-related emotions” (Mastracci 2012 p4). Whilst our focus has been on nursing work, the relevance of emotional labour as an important consideration in public sector organisations has been demonstrated (Mastracci et al 2012, Hochshild 1983 Ryen et al 2012, Mannion 2014). Nursing is a profession which involves considerable emotional labour as a role requirement (Gray and Smith, 2009). At times this can be particularly exacting. For example, a nurse seeking to reduce the anxiety of a patient waiting to undergo a serious operation, whilst reliving the experience of her own mother who had a similar operation, and did not survive; or dealing with unpleasant bodily fluids whilst portraying a calm, caring and matter of fact demeanour.

The Boorman report (2009) made a clear policy statement about the importance of staff well-being. West et al (2011) used a variety of data to review NHS staff experience and concluded: “Engagement is shown to be particularly important: having significant association with patient satisfaction, patient mortality, infection rates…as well as staff absenteeism and turnover” (p2). However we found that this knowledge was not reflected in the practice setting where there was no formal recognition of the toll of emotional labour on nursing staff. Similarly there were no systems for supporting nurses in this aspect of their work. Whilst boards accept responsibility for reducing the risk of injury from physical labour (by endorsing the provision of manual handling training and equipment to prevent back injuries among staff for example), there is no corresponding recognition of the emotional cost of caring. Indeed the Care Quality Commission’s Chair stated that “Kindness and compassion cost nothing” (CQC 2011 p4) which seems to summarise the prevalent view that compassion is ‘free’. However it takes no account of the emotional investment required. Dealing with death, dying, distress, and vulnerability, day in day out in the absence of any formal system of emotional support, can overwhelm staff with anxiety and impair their ability to care for others. This is one of the complexities of caring that has received relatively little research attention.

As a department concerned with the practical application of our research findings - rigour and relevance being our raison d’être - we were keen to take action, because unless emotional labour is recognised and results in organisations providing systematic support for staff, it is more difficult to deliver compassionate care. With this in mind we undertook an action research project to develop a model of support which an enlightened board could then implement. Whilst models such as Schwartz rounds (Goodrich 2011) and Restorative Supervision (Wallbank and Preece 2010) have been implemented in some Trusts, they rely on the release of staff from their duties for short periods of time, which often prevents ward based nurses attending.

In view of this we sought a model which could be adopted more readily for this staff group. The one we introduced was based on the Samaritans model - a voluntary organisation established in 1953 to help individuals with nowhere else to turn and to stop the isolation and ignorance that leads people to suicide. They provided the first 24-hour helpline in the world and currently 20,665 volunteers answer a call, email or text every six seconds. Listening to people express their feelings and concerns about often distressing personal situations, the volunteer call handlers are engaged in emotional labour. However in contrast to the NHS this is recognised by the organisation which values its volunteers and has a systematic debriefing process in place (see box 1).

Our work to explore the feasibility of implementing this model on six wards across three Acute hospitals is now completed, and the difficulties encountered in this project provided some rich learning (Time to Care report 2014 - available on HSME website - link below) and has been used to inform the design of a second research project (Set to Care) which commences in Summer 2014.

In addition, to help raise awareness of the importance of addressing emotional
Each volunteer undergoes a period of training prior to taking calls. Each shift is between 3 – 5 hours, and the volunteers work in pairs. The callers are often in highly distressed state, and the volunteers are actively encouraged to share the last call with their partner in the “down times” in between calls. If the volunteer needs longer to debrief, the telephones will be turned off to enable this to happen (in this situation calls will be directed to other centres).

At the end of each shift, the volunteer “offloads” to the shift leader. This process involves a summary of the types of calls taken by the volunteer and how the volunteer is feeling. The leader will make a judgement about the emotional health of the volunteer, and may call them the next day to see how they are.

Box 1

The Samaritans

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References


Links


http://www.birmingham.ac.uk/schools/social-policy/departments/health-services-management-centre/events/2014/06/developing-a-compassionate-organisation-day3.aspx
Developing a culture of compassionate care: lost in translation

Deborah Davidson

Since 2009, healthcare leaders in the UK have heard repeated calls for a culture of compassionate care, following a public inquiry into deaths at the Mid Staffordshire NHS Foundation Trust. Sir Robert Francis said that "This is a story of appalling and unnecessary suffering of hundreds of people" and that the NHS had to develop "...a patient-centred culture...with fundamental standards...[and] caring compassionate nursing...."

One response in 2012, initiated by Jane Cummings, Chief Nursing Officer and supported by Viv Bennett, Director of Nursing for the Department of Health was to develop a strategic vision for Nurses, Midwives and Care. They engaged and consulted over 9000 nurses, midwives, care staff and patients in the development of this strategy. From this process, they identified six fundamental values central to developing a culture of compassionate care, and called these the 6Cs, with six corresponding areas of action (NHS England, 2012).

As with most policy related initiatives, the sceptical question that arises with professionals is 'where is the evidence to show this will work?' Delivery of this strategy commenced early summer 2013, however, no public evaluation data is available, other than a consolidated national update. So, for the purposes of this article, the Compassion in Practice Strategy's Theory of Change (ToC) (Stame, 2004) was examined, to see if this question could be answered.

Theory of Change looks to identify the explicit and implicit theories that govern the way change programmes and initiatives are described and thought about, while acknowledging that existing evidence does not provide enough information to be confident about the nature or extent of causality between the intervention and its intended effects. It is therefore necessary to rely on theory to make some of the links between the intervention and its outcomes. In this way, we can examine and identify the underlying theory to make links between the 6Cs intentions and potential outcomes.

Mapping the theory of change
In mapping the 6Cs’ theory of change we first need to establish the impact, outcomes and activities that form the causal pathway to be examined. This can be done using logic models and the University of Wisconsin offer a number of resources that are useful for mapping (see figure 1).

The first mapping to be done is to define the long term impact and the medium to short term outcomes. The key question that is being answered here is what is the rationale for this intervention and what does it seek to address. A qualitative content analysis (Graneheim and Lundman, 2004) was employed to analyse the Compassion in Practice vision and strategy to ascertain its impact and outcomes. A ToC map is shown below in figure 2:

Figure 1: University of Wisconsin - Extension Logic Model
The next step is to identify and examine the activities and associated actions to ascertain whether they address the desired impact and outcomes. Drawing on the Effective Practice and Organisation of Care (EPOC) taxonomy of interventions (Davies, Nutley and Smith, 2000) actions were coded according to type of intervention, and cross-referenced against the levels of intervention identified in the Compassion in Practice Strategy. This exercise was then repeated, but this time, actions were coded according to type of intervention, and cross-referenced against the six levels of actions identified in the Compassion in Practice Strategy. Finally, a qualitative content analysis was employed to analyse the coded actions for indicators of compassionate care.

Exploring activities and actions
When examining type of intervention with levels of intervention, not surprisingly, most actions for national bodies were found to be professional and structural interventions and most actions for local organisations were organisational, structural and professional (educational) interventions, consistent with their roles. What was disappointing was to see more organisational interventions (local structural and procedural) than patient oriented interventions at the level of the individual, with patient-oriented outcomes accounting for only four out of a total of 108 actions. When examining type of intervention with the six areas of action, the two areas where one might expect to see more patient oriented interventions - working with people to provide a positive experience of care, and supporting positive staff experience – between them accounted for only two of the total of 108 actions.

Discussion
We know that the main precipitant for the call for compassionate care was the Mid Staffs scandal, specifically as a result of the appalling suffering of many patients. So one might argue that this is what this intervention seeks to address. Looking to the dictionary for a definition of compassion, it was interesting to note that meanings offered included one of the same words used by Francis - suffer – albeit used differently: suffer with; participation in another’s suffering; fellow-feeling; and feeling or showing compassion for others. These meanings suggest that the desired impact might be for care-givers to be alongside patients, and being emotionally in tune with that person’s suffering.

For some care-givers, this is part of their everyday practice, and is what makes them good practitioners and clinicians. However this is no easy task and it is difficult to sustain in the long run without a good space in which to make sense of and process these emotions with others, and channel them back into the work effectively. For others, actively working with emotions may challenge their ideas of professional distance, boundaries and objectivity which have been key educational concepts for health and social care professionals: “… professional objectivity was valued as the quality that allowed the helper to divorce him or herself from subjective feeling, attitudes and beliefs.”

However, if staff divorce themselves from their feelings, how then do they remain emotionally in tune with a person's suffering? The answer may lie in the mapped outcomes; the 6Cs suggests that compassionate care is given through relationships, which can be defined as an emotional association between two people; a connection, in other words, a care-giver needs to have an emotional connection with patients, to be emotionally in tune with that person’s suffering. The 6Cs builds on their idea of relationship by stating that it should be based on empathy, respect and dignity. However what helps to more clearly define the nature of the emotional connection is the reference to intelligent kindness.

Ballatt and Campling (2011) argue that kindness “indicates the quality or state of being kind … a condition in which people recognise their nature, know and feel that this is essentially one with that of their kin, understand and feel their interdependence, feel
responsibility for their successors and express all this in attitudes and actions towards each other... real acts of kindness emerge from this state."
It seems that while the intention of this strategy was to set out a framework for defining and systemically embedding a culture of compassionate care, actions have been professionally distanced, and fallen into the usual policy-professional trap of being defined by the need to be measured quantitatively and demonstrated through evidence of procedures and reports. In doing so, the translation of the desired impact and outcomes into actions seems to have got lost.

References
University of Wisconsin http://www.uwex.edu/ces/pdande/evaluation/evallogicmodel.html
Evaluating the future of healthcare: where does the truth lie?

Prof Richard Lilford - Director of NIHR Collaborations for Leadership in Applied Health Research and Care West Midlands

The Francis Report (Francis, 2012) has had a great influence on British public life – from the Cabinet, through the boardroom and down to the shop floor. The report will be widely quoted for many years to come. The report is 1,782 pages long and contains no fewer than 290 recommendations. But how much can one really learn from such an in-depth analysis of just one site?

Contrast the Francis Report with the systematic overview of the evidence on quality improvement from the Agency for Healthcare, Research and Quality (AHRQ) in Washington. Summarised in Annals of Internal Medicine (Shekelle et al, 2011), the study is based on a systematic and intellectually grounded analysis of the entire high quality, world literature. It builds on a similar review conducted on behalf of AHRQ by the Stanford Evidence-based Practice Center over a decade ago. And a very interesting and active decade this has been with an exponential increase in research in the areas of quality and safety of healthcare.

Service delivery interventions to improve quality and safety can be divided, from a methodological point of view, into two classes (Lilford et al, 2010). Interventions applied close to the patient, with a specific objective in mind, are ‘targeted interventions’. Interventions applied more upstream of the patient, with multiple objectives in mind are called ‘generic interventions’. Generic interventions have much broader or diffuse effects on quality. An example of a targeted intervention is the use of ultrasound to guide the placement of intravenous cannulae. Examples of generic interventions include improving the nurse-to-patient ratio or changing the human resources policy.

Targeted interventions are much easier to study – for example they are much more amenable to evaluation through randomised trials. The AHRQ report shows that a number of targeted interventions are effective, including use of preoperative checklists, outlawing use of hazardous abbreviations, medication reconciliation and various types of guideline such as those concerned with ventilator-associated pneumonia, prolonged use of urinary catheters and thromboembolism prophylaxis.

Generic interventions, with diffuse effects, are more difficult to study than targeted interventions. Nevertheless, a compelling case for or against generic interventions can often be built systematically by triangulating various sorts of evidence between and within studies (Ibid). It is in this way, for example, that the authors of the overview conclude that improving the nurse-patient ratio leads to better outcomes (including hospital mortality).

The AHRQ report also produces reasonably convincing evidence in favour of rapid response teams, which can be called out from the intensive care unit to attend patients who are deteriorating on the wards. There is very strong evidence for simulation training, especially for complicated technical procedures, but the case for specific team training (as opposed to training in teams) was somewhat less convincing. There is evidence that surgical ‘score cards’ – that is to say a system where surgeons collect detailed data on their cases – leads to improved care when this is owned by the surgical societies and where individual hospitals are put in charge of improvement efforts.

This result would seem to vindicate my belief that outcomes of surgical procedures should influence practice. One ‘old chestnut’ is a question of top down cultural change. The evidence that top down cultural change can be produced through ‘heroic’ leadership is extremely unconvincing. A dispersed
model of leadership, combined with bottom up specific improvement practices, seems to be the way to go. The AHRQ report does not treat safety interventions as a black box, but seeks to understand what makes an intervention work or fail. For instance, rapid response teams are dependent on both good monitoring of patients’ conditions on the ward (the afferent arm) and a rapid, efficient response (the efferent arm). Many guidelines, such as checklists, will merely elicit ritualistic displays of compliance unless practitioners have first been convinced of their rationale.

The above are just a small sample of the extensive evidence in the overview. It is a rich source of high quality evidence, based, wherever possible, on comparative studies. It is evidence such as this, rather than findings from one site, that should be essential reading for clinicians and health service managers.

The other obvious benefit is that this body of knowledge does not stand still. In NIHR CLAHRC WM we are collaborating with NHS partners, seeking to embed applied research and service change in the same structures. By the end of the five year project we aim not just to achieve positive change, but most importantly to develop a self-sustaining system where every pound of the public’s input goes on services that use the best evidence of what works.

This is where the truth lies for better health and a better NHS.

(The views expressed are those of the author and not necessarily those of the NHS, the NIHR or the Department of Health.)

References

NIHR Collaborations for Leadership in Applied Health Research and Care West Midlands

NIHR CLAHRC West Midlands is a five-year programme funded by the National Institute of Health Research (NIHR) and matched funds provided by local health and social services. The programme builds on the successful CLAHRC for Birmingham & Black Country pilot with a mission to create lasting and effective partnerships across health and social care organisations, and research teams at the Universities of Birmingham, Keele and Warwick.

For more information see http://www.clahrc-wm.nihr.ac.uk/