

“Liberating the NHS?”

Editorial by Robin Miller and Russell Mannion



The absence of an overall majority and the subsequent coalition between two parties who had campaigned on their ideological differences could have been expected to lead to a government of compromise in which policies would be watered down and lacking in radical direction. The reality to date has been quite different, with major initiatives being introduced in key policy areas and sweeping cuts to national and regional bodies. The National Health Service has once again been centre stage as a new government seeks to make its mark, with Andrew Lansley’s proposals for GP commissioning receiving particular attention and interest within both the professional press and national media. The proposed scale and pace of the changes are breathtaking, with few of the current NHS organisations being unaffected – GPs, Provider Trusts, Public Health and Community Services will all

experience enforced changes. Even the Department of Health and national bodies such as the NHS Institute and NPSA face major re-organisation or abolishment. The potential involvement of private organisations and social enterprises could lead to the independent sector becoming a major player in direct NHS delivery and commissioning and signal the end of a largely public sector service.

In any major re-organisation there is a natural tendency to become focussed on the operational details of the new arrangements and judge its success by the smoothness and pace with which new structures and working protocols are implemented and hurdles such as legal challenges are overcome. GP consortia may take over commissioning, providers may become foundation trusts and national bodies may be disbanded but these are not indicators of success. Success should instead be judged by the new health system’s ability to treat people in the community rather than in secondary care whenever possible, to tackle the growth in health inequalities, to promote health and well-being, and to ensure that health and social care needs are considered coherently and organised around the circumstances and wishes of the patient. In financial terms the new system may achieve the planned saving

of 45% of management costs, but if this leads to developments in community based care not being realised then the long-term financial costs may outweigh these savings. ‘Liberating’ NHS clinicians from the ‘control’ of managers and centrally based targets is relatively easy for the government to achieve – ensuring that the resultant ‘freedoms’ lead to more efficient and high quality patient-centred care will be a much harder endeavour that will require fundamental changes in the culture of health care organisations. In this newsletter HSMC provides an initial reflection on the White Paper – this will be followed by a series of events and more in-depth policy papers. We look forward to engaging with policy makers, clinicians, managers and patients in discussing and debating the issues that arise and in so doing influencing the national debate.

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A Tale of Two White Papers: comparing 'The New NHS' and 'Equity and Excellence'

Martin Powell



This section compares the first NHS White Papers of the New Labour and the Conservative/ Liberal-Democrat Coalition Government: 'The New NHS' (NNHS) of 1997 and

'Equity and Excellence' (EE) of 2010 respectively. While there are many important differences, this analysis focuses on the similarities....

The importance of the NHS: 'Creating the NHS was the greatest act of modernisation ever achieved by a Labour government', with its important 'historic principle' of access based on need (NNHS), while EE claims that 'the NHS is a great national institution. The principles it was founded on are as important now as they were then'.

Devolution: 'The needs of patients will be central to the new system' and 'Local doctors and nurses ... will shape local services.' (NNHS). Similarly, EE promises more control to *both* patients and professionals: 'Healthcare will be run from the bottom up, with ownership and decision-making in the hands of professionals and patients.' However, control by patients and professionals are two very different and incompatible

principles. For example, how can 'choice' for homeopathy be reconciled with 'evidence-based medicine'? Both governments' 'driving seats' are crowded with back seat drivers.

'Building' on what has worked: NNHS claimed that PCGs kept what worked about fundholding, but discarded what had failed. Similarly, EE claims to build on key aspects of the existing arrangements: for example, a number of GP consortia are likely to emerge from practice-based commissioning clusters and Monitor will become the economic regulator. 'We will learn from the past, and offer a clear way forward for GP consortia'.

Tackling 'Bureaucracy' and 'red tape': A greater proportion of NHS resources will go to the 'front line' - NNHS set out to cut £1b over the term of the Parliament, while EE wishes to find £20b in 'efficiency savings' and cut some 45% of management costs. The costs of organisational disruptions have always been under-estimated by governments, and no government has yet succeeded in the 'trick' of improving services while cutting costs.

Reconciling quality and fairness (NNHS) and excellence and equity (EE). NNHS aimed for a 'one-nation NHS', with 'fair access' and the reduction of 'unacceptable variations' Instruments such as NICE and NSFs did put the 'national' in the NHS, and reduced to some extent the post-code lottery. Apart from the vague hopes

associated with the NHS Commissioning Board and tweaking a resource allocation formula, there is little in EE that is likely to deliver greater equity. Moreover, a main feature associated with devolution is increasing local responsiveness and differentiation rather than increasing equity.

Public health, prevention and reducing inequalities. This is not the first (or probably the last) time that governments have promised to refocus upstream, but policy mechanisms have rarely matched the rhetoric.

Labour claims that EE represents a 'gamble' but it is probably no more of a gamble than NNHS. The gamble is probably more linked with the 'double whammy' of organisational upheaval and austerity. NNHS claims that it was a 'ten year programme' that would modernise the NHS so that it was prepared for the next fifty years. That turned out to be patently false, but whether the claim of EE that this White Paper is the long-term plan for the NHS in this Parliamentary term and beyond is accurate remains to be seen. Politicians remain convinced (despite all the evidence) in the 'organisational fix', and that just one more reorganisation will get it all right. However, it might be that the NHS moves not from 'good to great' but rather from 'boom to bust'.

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The courage to think and act differently

Deborah Davidson



As the NHS begins a time of enormous structural change I would like to suggest that those leading and working with the change in the NHS need to think and act differently in their approaches to

change. Grint (2005) suggested that there are three ways in which problems can be framed:

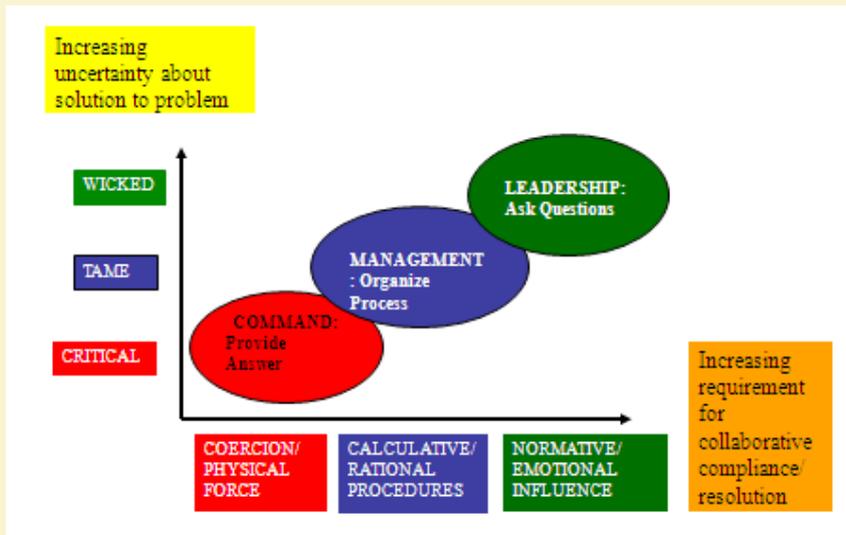
- 1. Critical:** a crisis, where there is little time for discussion or dissent or worrying about procedures that get in the way of resolution. The role taken up by leaders in crises is that of *Commander*.
- 2. Tame:** there are tried and tested procedures to resolve the problem because management can, and has, previously experienced the same thing happen. In these situations, the role taken up is that of *Management*.
- 3. Wicked:** there are "no easy answers" (Heifetz, 1994) because the problem might be a new unknown situation that people understand differently, it may be embedded in other problems which means that actions

can have consequences elsewhere that cannot necessarily be anticipated or it may be a dilemma that is not going to go away and needs to be worked with. The role taken up here is that of *Leadership* and the task is to ask appropriate questions.

Using this typology, Grint goes on to suggest that there are (at least) two ways that leaders frame situations. They understand the situation as *objective and real*, and concentrate on understanding the problem and then act accordingly:

- It's Wicked so they must Lead
- It's Tame so they must Manage
- It's Critical so they must Command

Figure 1: A typology of problems, power and authority



Source: Grint (2005:1477)

Alternatively they understand the situation as *socially constructed* and concentrate on what we do best, what resources are available, what might work best and how to persuade audiences:

- Leadership – construct the problem as Wicked
- Management – construct the problem as Tame
- Command - Construct the problem as Critical

Grint argues that leaders and decision-makers often construct the problem to match their “preferred mode of engagement, rather than what ‘the situation’ apparently demands” (2005:1467).

Quinn and Sonenshein (2008) mirror Grint’s arguments when setting out the kinds of strategies often taken when leading processes of change. They draw on the work of Chin and Benne (1969) who

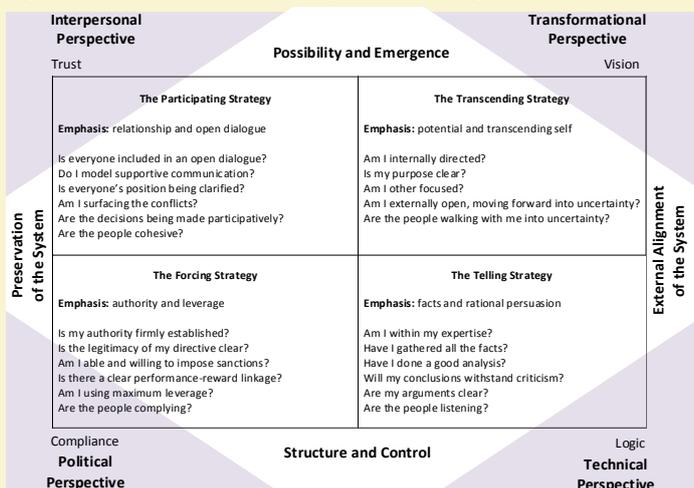
suggested there were three general strategies for change¹:

- **Empirical-rationale (telling)**: people will adopt the change if it can be rationally justified and if it can be shown to be in their self interests to do so;
 - **Power-coercive (forcing)**: people change when power is applied in some form; those with less power comply to the plans, directions and leadership of those with greater power; and
 - **Normative-re-educative (participating)**: change in a pattern of practice or action will occur only as the people involved are brought to change their normative orientations to old patterns and develop commitments to new ones.
- They added a fourth strategy:
- **Leadership agency (transcending)**: people are proactive in co-creating their

environments and futures by examining their integrity gaps (between what they say and what they do) and make a fundamental commitment to becoming more *purpose-centred* and *other-focussed*.

Their four-fold framework is shown:

Figure 2: Four General Strategies for changing human systems



Source: Quinn and Sonenshein (2008:77)

What we might take from this is that each of these different constructions of problems and strategies for change are legitimate in different circumstances and can be combined to provide a more effective strategy for change.

However, the *valency*² (Bion, 2000) in the public sector is to approach these major changes as either *tame* (Rittel and Webber, 1973) (i.e. been there, done it, got the T-shirt, or worse) or as *critical*. The challenge to those leading change in the NHS will be to avoid treating every change as if it were life and death (a crisis) because policy implementation demands this, and be mindful to frame problems and select strategies for change that are appropriate for the different challenges presented. Addressing issues as *wicked* and engaging patients, staff and other stakeholders in collaborative dialogue will enable a shared view and new solutions to be found.

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Notes

- ¹ Definitions by Jean E. Neumann on HSMC’s MSc in Leading Public Service Change and Organisational Development
- ² Making decision or taking actions on the basis of assumptions, without conscious purpose or thought

Decommissioning PCTs: priority setting in the liberated NHS

Suzanne Robinson and Iestyn Williams



Whilst national debate continues about what GP commissioning will look like one certainty is that the cold economic climate requires tough decisions around investment and disinvestment. GPs are used to making individual decisions around patient care, but are less experienced in making decisions on a population level. However, considerable time and resource has been committed by PCTs and other organisations from across health and social care to develop priority setting structures and processes. Work by HSMC which explores commissioning and priority setting across England identifies some important lessons. For example, technocratic approaches including Programme Budgeting and Marginal Analysis (PBMA) and scorecard techniques have been used (with some success) to aid priority setting. However, much of this has tended to focus on allocation of additional resources rather than on core spend and/or disinvestment. Where priority setting has been most successful commissioners have used technical approaches but also recognised the importance of the non-technical aspects of priority setting. These include:

- giving priority setting groups genuine power and authority;
- having strong governance structures – this includes aspects of performance management, and the practical politics associated with coalition-building;
- strong leadership and support from across the health economy to ensure that prioritisation decisions are implemented by providers;
- having a well-resourced knowledge analysis and exchange infrastructure at local levels;
- managing the expectations of (and relationships with) the public, clinicians, industry and government.

For some time now at HSMC we have been engaged in the practical and theoretical challenges of rationing in a cold climate. Projects range from the international comparisons and NHS case studies of Chris Ham, Shirley Mclver, Penny Mullen and colleagues to more recent research into PCT priority setting and commissioning (and a forthcoming editorial in the journal *Public Money and Management*). Based on this work we would argue that whoever the rationing task falls to will need to adopt a range of strategies. Whilst we acknowledge the benefits of decision support analysis and frameworks for achieving fair processes of decision making we also consider the 'non-decision making' elements of priority setting to be of crucial importance. Managing the authorising environment and giving due attention to the *implementation* of rationing decisions are key. Of course, these challenges are not unique to the NHS and we are engaged in collaboration with colleagues

from Europe, Australia, New Zealand, the United States and Canada in order to share ideas, research findings and best practice in the allocation of increasingly scarce health care resources.

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‘The freedom to flourish’? Robin Miller and Iain Snelling



With the majority of media attention focussing on plans for GP commissioning, the general public could be forgiven for thinking that there will be little change in their local providers of health services. It is certainly true that existing foundation trusts will be able to continue as organisations, enjoy greater financial freedoms and may no longer be working to a number of the high profile waiting time targets (although these may be maintained within local contracts). But in reality the coalition is also looking for radical change in the degree of competition between providers, the types of organisations that will deliver health care and the relationship between patients and providers.

New Labour had already started down this route and a number of their initiatives will be continued by the coalition. These include major organisational changes such as the shedding of PCT provider services by March 2011 under Transforming Community Services, despite concerns by some Primary Care Trust Chief Executives that the deadline would not allow proper consultation and could lead to the main determinant being what was achievable in the timescale rather than what could provide long-term strategic benefits. The right of PCT staff to request to deliver NHS services through a social enterprise has been maintained, and whilst this has had relatively limited take up it should lead to over 50 new enterprises being developed. This includes large enterprises delivering a range of community provision as well as smaller organisations delivering discrete service areas. NHS Trusts will no longer exist as an organisational form and all current Trusts will have to become Foundation Trusts within 3 years. It is not clear as yet what will happen to those who do not meet Monitor's requirements, but 'take over' by a Foundation Trust or by a private provider may be the most likely options.

Choice and competition will continue to be used as levers for change. The principle of an 'any willing provider' approach will be extended for all elective procedures, and patients will be able to choose any provider that fulfils national price and quality standards. Competition will also be introduced for clinical teams with their peers (through for example the publication of quality accounts) and by patients having choice over which consultant team they are referred to.

Further personal health budgets pilots will be encouraged, and a possible right to a personal budget is being considered in relationship to discrete areas such as continuing health care. Outcome measurements related to patient reporting will be extended and payments (and penalties) related to quality will continue.

So will this mixture of 'carrots' and 'sticks' lead to greater productivity and improved quality? There is evidence that competition between providers can lead to improved quality and reduced costs, but only if there is the correct balance of incentives and purchasers have sufficient power (Propper, 2010). Patients have been shown to respond positively to having the option of choice over the provider, but their decision can be strongly influenced by the views of their GPs (who often also have a perception of the likely interest of the patient in being able to make this choice) and they do not often use published information on performance (Dixon et al 2010).

Furthermore pressure on provider management and finance teams will not necessarily lead to behaviour change in clinicians as they are often more loyal to their speciality and their patients than to their organisations and most have lived through numerous re-organisations.

Arguably the central issue is will the policy changes lead to a supportive and empowering culture in which quality is celebrated, errors are learnt from, patients respected and there is a spirit of co-operation between clinicians and managers, primary and secondary care, and health and social care? Developing such a culture requires sensitivity to the correct balance between

transactional and transformational management and a connectivity between Board and frontline practice (Mannion et al, 2005). The 'mutual' and 'employee-owned' models being promoted for foundation trusts and social enterprises could provide environments for such cultures to develop (Ellins & Ham, 2009) – we must hope that the need to find such large cost savings and corresponding reduction in management do not dominate the agenda to the extent that new opportunities are lost.

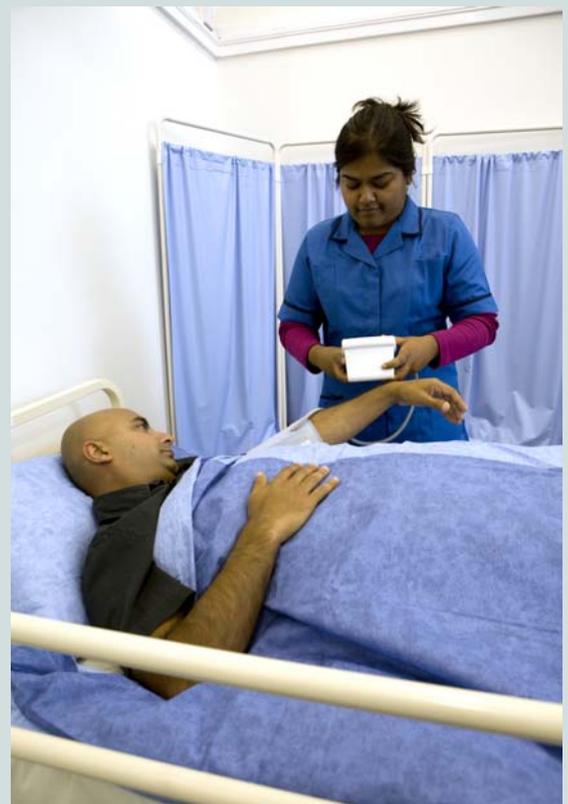
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Altogether now – where next for health and social integration?

Jon Glasby



As is often the case, the changes set out in the new White Paper represent both an opportunity and a threat. On the 'threat' side of the equation, the NHS is facing one of the biggest reorganisations and one of the most

difficult financial situations in its history. This will inevitably make it a harder partner to work with in the short-term as its attention is naturally focused on setting up the new system, making the required savings and reducing management costs by 45 per cent. All the available evidence suggests that reorganisations like this can reduce morale and productivity as well as stall positive service delivery – sometimes for two years or so after the original changes. The tone of the White Paper is also unhelpful in places – as many of the managers who will be helping to introduce these changes are feeling very unappreciated and are wondering about their own jobs and futures. We also know very little about some of the GP consortia that will emerge – while some will want to develop strong relationships with social care, it's possible that others may focus more on what they might see as core clinical business.

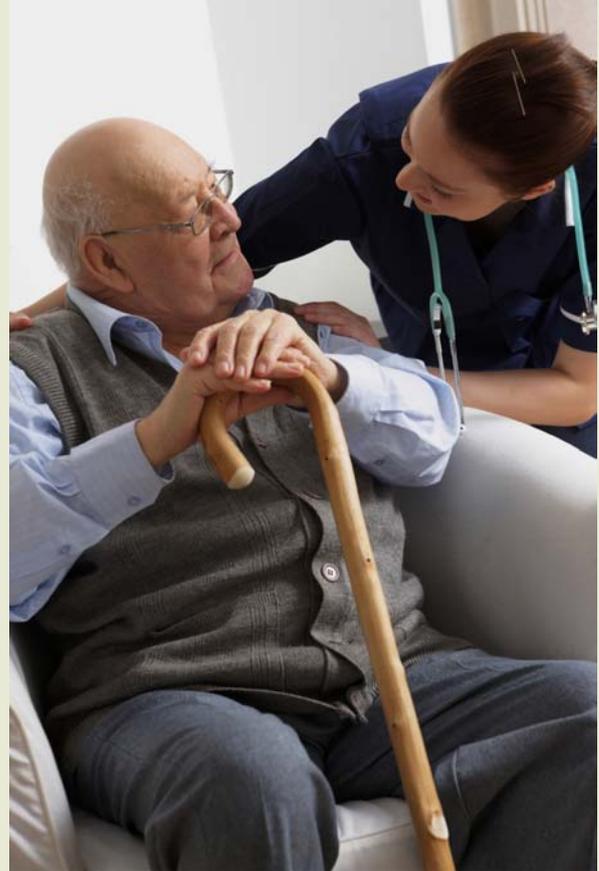
On the positive side, the White Paper offers an opportunity for local government more generally to take a greater role in promoting health, tackling health inequalities and ensuring local democratic accountability. With its accountability national rather than local, the NHS has always had an ambiguous relationship with local people and communities, and the language of democratic legitimacy in the White Paper is genuinely exciting. Of course, there is now a further consultation document to explore what this might mean in practice, and the devil is likely to be in the detail – being responsible for joint working and for promoting local accountability with very few mechanisms to actually deliver would be the worst of all worlds, and the jury is still out. Also promising is the scope to develop more locality-based approaches to health and social care, working with GP consortia, local services and neighbourhoods to join services up at more local level. This could also be boosted if we can find ways of making better use of scarce public resources across agency boundaries, rather than working in organisational silos. Probably most

revolutionary of all is the continued development of personal health budgets, which could enable people with complex and multiple needs to join up their own care and support from the bottom up in a way that makes sense to them.

What is crucial is that the current focus on systems and structures doesn't get in the way of the softer aspects of partnership and integration. Whatever structures emerge and however they work, the key issues are often to do with personal relationships, professional values and culture. This requires significant attention to the human aspects of joint working and a firm commitment to organisational development, to staff engagement and to service user and patient involvement.

In the current financial and political climate, moreover, the challenge is not to find ways of doing more of the same for less, but to more fundamentally rethink the whole nature of what we do. This will require us to engage with local communities much more fundamentally than in the past about the nature and the quality of the health and social services that people want and need. In the past we have often tried to promote joint working through the *power of ideas* (telling people it's a good idea to work together) or through changing *structures*, and the evidence suggests that this hasn't worked. A lot of the White Paper is about starting to change *incentives*, and this can be a powerful mechanism. However, some of the White Paper might also be about changing the underlying *accountabilities* – between the state and the individual, between the NHS and local government, and between services and local people. If we could find an approach where the accountabilities, incentives, structures and ideas were all aligned, then we might really start to make a difference.

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An HSMC policy paper, *All in this together? Making best use of health and social care resources in an era of austerity*, will be available shortly via the HSMC website (www.hsmc.bham.ac.uk)



Choice and control – the dilemmas of responsibility

Jo Ellins and Shirley McIver



The focus on patient choice, shared decision making, personalised care, patient rating of care, and strengthening the collective voice of patients and the public, all suggest a continuation of pre-existing policy. The drawback is it also means the current government is likely to face the dilemmas inherent in this direction of travel towards greater patient responsibility for health. These dilemmas are particularly apparent at the level of the individual, which is the focus here, but there are similar implications for the collective patient voice and public involvement which will be mentioned at the end and which will be examined further in a HSMC Policy Paper to be published early next year.

Increased patient choice

The White Paper makes it clear that the Government intends to travel both further and faster down the road to greater choice and control, but what evidence is there that patients want greater choice and/or control over treatment and care decisions? Research suggests that while there are *some* circumstances in which *some* patients want choice and control, there are other situations where patients would prefer not to have choice or control but will accept it because they are reluctant to cause trouble.

Auerbach (2001:192) clarified the behavioural rationale for why people want to be involved in healthcare as “*a desire to impose active control over a situation with potentially aversive consequences*”. He drew attention to a useful distinction between three major ways in which people can exercise control:

- Cognitive (informational) control – to reduce ambiguity and uncertainty
- Decisional control – to identify preferences for different choices
- Behavioural control – to be involved in treatment implementation

The evidence suggests that while patients across many health care settings desire detailed information about their condition and treatment, they are less likely to want to make decisions about their care. They are only likely to want control if they feel it will improve the outcome or help avoid an aversive outcome.

A study reported by Taylor, Hall and Salmon in 1996 illustrates Auerbach's findings and points to some of the current dilemmas in assessing and measuring patient desire for control, and for staff involved in implementing policy relating to control. Taylor and colleagues (1996) examined the finding that patient controlled analgesia (PCA) results in greater patient satisfaction compared with traditional analgesic regimes even though this produces a relatively small and variable improvement in analgesia - the assumption being that improved satisfaction reflects patients' preference to have control over their pain relief.

The researchers carried out interviews with patients after they had received PCA following surgery. They found that not only were negative experiences relating to ineffectiveness and side effects such as nausea reported, but also only one patient out of the 26 interviewed reported the control provided by PCA as one of the benefits. The majority saw it as better than the alternative which was delay due to nurses being unavailable. PCA was a way of avoiding the embarrassment of showing distress and seeking help from the ‘busy’ nurses.

When control is disempowering

Similar complex and mixed evidence can be found in studies examining patients' experiences of self-management and coping with chronic conditions. This has led some writers to suggest that this type of empowerment is a way of transferring responsibility from the health professional to the patient in situations that are difficult for the health professional (e.g. Salmon and Hall, 2004). This evidence suggests that whilst moves towards better information should be as fast as possible, a more cautious approach should be taken towards greater patient control and responsibility, because in some situations it may bring responsibility without the power to prevent unwanted effects, such as poor quality care, suffering and death - a situation which is disempowering.

So what is the relationship between increasing individual control and strengthening the collective patient and public voice? The answer again is the risk that responsibility will be transferred in situations where control is either impossible, unwanted or not given. The fact that for the third time in ten years the mechanism for collective voice is to be dismantled and reformed into a new organisation (Health Watch) is open to several interpretations ranging from conspiratorial (to keep the collective voice from becoming organised) to pragmatic (to keep pace with changing health policy and structures).

Luckily there are sources of evidence that can inform this debate and help in the goal of strengthening collective voice. These lie in the experiences of other countries which have structures representing the patient and public voice as well as in the UK experience of CHCs, Patients' Forums and LINKs. HSMC will be examining these, carrying out a number of focus group discussions with health professionals about PPI, and reporting our findings in the near future.

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Postgraduate programmes

HSMC delivers a number of UK-based Masters programmes as well as contributing to a number of interdepartmental programmes. These include:

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

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

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

For further details of this or any of the above programmes, please contact Kate Vos, 0121 414 3174

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MSc in Healthcare

Commissioning

NHS West Midlands and Commissioning Support London have separately commissioned HSMC to deliver MSc programmes in Healthcare Commissioning. Run part-time over two years, the programmes aim to provide a comprehensive single course that helps to develop the competencies that health and social care commissioners require in an era of world class GP-led commissioning, and to support the ongoing development and professionalisation of the commissioning function. In particular, the programmes explore:

- The policy context and political environment in which strategic commissioning has become a core element of public service management;
- How commissioning and procurement have emerged in the context of wider public sector reform and modernisation, and how they are likely to develop in the future;
- Key theoretical models underpinning strategic management and procurement in the public sector;
- Different approaches to decision making and priority-setting in the allocation of public resources, and their strengths and limitations;
- The different reasons for and approaches to involving the public in strategic commissioning activities, and the evidence regarding the impact of such involvement.

For further details contact

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NHS Graduate Management Training Scheme – update and new alumni website

In 2007 HSMC was chosen (following competitive tender) to lead the provision of the educational component of the NHS Graduate Management Training Scheme (MTS) for the third time in a row - the first time this has happened in the Scheme's 50 years history. The current provision is a partnership between HSMC, University of Birmingham and Manchester Business School, University of Manchester. The training scheme, managed by the NHS Institute for Innovation and Improvement, is a leadership and development programme for trainees in England. In 2010



HSMC Graduates celebrating their success at the Summer 2010 Graduation

the general management programme will also be joined by six Medical Leaders from the North West deanery and for the first time, six Clinical Fellows.

New Alumni Website Launched

All alumni from the three leadership programmes run by the NHS Institute for Innovation and Improvement – the Graduate Management Training Scheme, Breaking Through and Gateway to Leadership – now have access to an exclusive website: www.institute.nhs.uk/alumni

Launched mid-September, alumni who register on the site can create their own personal profile, access news and events pages, join a discussion forum, and search for people, organisations and projects that might be of interest. As John Boileau and Rebecca Ball, who have been instrumental in getting the site live, say: "The website provides fantastic networking opportunities and is monitored daily to ensure that you are receiving relevant and up to date information. If you know anyone who has completed any of the programmes please spread the word, as the more people who join the alumni website the greater the benefits."

If you have any queries or suggestions please do not hesitate to contact John or Rebecca at alumni@institute.nhs.uk

Projects Update

A Beveridge Report for the 21st Century

At the end of June, HSMC was the venue for a two-day think tank entitled 'A Beveridge Report for the 21st Century', organised by Jon Glasby and Catherine Needham from HSMC and Simon Duffy from the Centre for Welfare Reform. The event was funded by the Advanced Social Sciences Collaborative at the University of Birmingham. With a small invited audience of leading policy makers, managers, practitioners, policy analysts and researchers, the think tank sought to explore the implications of personalisation and self-directed support for: local government, children's services, the NHS, criminal justice and the tax and benefit systems. Participants considered whether a new Beveridge Report or process is needed to clarify thinking and options around the relationship between the state and the individual in the twenty-first century. Papers from the conference will be published later this year by the Centre for Welfare Reform/HSMC.

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Aspiring Director Programme

HSMC is continuing to lead the development and delivery of the Aspiring Director programme commissioned by NHS West Midlands. The 44 participants on cohorts seven and eight begin their four module programme in October 2010 and will complete in May 2011. The programme includes several themes which are proving challenging and useful to participants in their current roles as well as preparing them for future changes. Evaluations of previous programmes say that the short Organisational Consultancy experience which takes place in non-NHS organisations such as Wolverhampton CAB, the New Vic Theatre in Newcastle-under-Lyme and Birmingham Airport, has been particularly valuable.

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European modelling of long-term care

HSMC make a continuing contribution to INTERLINKS, an EU study into long-term care for older people in 14 European countries. Recent activities have involved HSMC as co-ordinators of a work package focused on the governance and finance of long-term care. National reports from 11 European countries feed into an overview report on contextual factors that influence sustainable good practice in LTC systems. The report, due to be finalised at the end of the year, considers the overlap between preventive approaches, informal care and ensuring quality from a finance and governance perspective. Detailed European overview reports on these three

areas have also been produced by the INTERLINKS consortium and are available at the project website

www.euro.centre.org/interlinks

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New Project on medical tourism

Russell Mannion was co-applicant with colleagues at the University of York and the London School of Hygiene and Tropical Medicine on a two year NIHR Health Services Research programme funded project exploring the policy implications of inward and outward medical tourism. The study will seek to identify the number of overseas patients visiting the UK each year for the purposes of accessing medical care as well as the number of self funded UK patients travelling overseas for treatment. It will also explore the quality and safety of services provided to medical tourists and provide an estimate of the economic costs to the NHS.

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Priority setting: an exploratory study of English PCTs

Priority setting in health and social care continues to be a difficult task with tough choices around resource allocation needed to be made. Staff at HSMC are currently conducting a study which explores priority setting across English PCTs. The study maps out the different types of priority setting activities which are currently taking place within PCTs, and provides an in-depth investigation into the experiences and perceptions of those involved. This work is funded by the Nuffield Trust and results will be reported in the autumn. Dissemination will involve publications and a national event which will include representatives from a number of commissioning organisations as well as policy makers and other experts from the arena of priority setting. If you would like more details on the forthcoming publications or the national event then please contact Suzanne Robinson.

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Feasibility study into the transfer of commissioning of forensic service examinations for sexual offences

The outcome of this study is to help the Department of Health and ministers reach a decision on where best to locate responsibility for commissioning forensic medical services for sexual offences, and to provide evidence to support service improvement in local delivery.

There is currently great variation in how forensic medical services are provided in rape and sexual assault cases in the UK, and there is little consistency between police forces in terms of how services are commissioned and medical examiners employed. Key issues are the availability of a 24 hour service, the need for more female forensics examiners (preferred by both female and male victims) and the provision of follow-up health services around infection and STDs.

Currently commissioning responsibility and budgets are held by the Police, but following a number of reviews, it has been recommended that this responsibility is transferred to the NHS. A key challenge will be to ensure that the feasibility study not only takes account of the economic considerations, but most importantly the case for change in relation to victims' experiences of services.

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Talent management in the NHS

Professor Martin Powell is leading a multi-centre NIHR SDO funded research project into Talent Management in the NHS in England. Co-collaborators include colleagues from the University of Surrey and Royal Holloway, University of London. The two-year project, due to complete at the end of February 2011, has involved a literature review, focus groups, and detailed interviews with national experts and leadership/talent management leads at the ten SHAs. The project is in the process of completing a national survey of NHS managers and detailed interviews with 60 managers throughout England, and is currently setting up data collection on talent management at what have been defined as 'five high performing trusts', before concluding with a second focus group. Further details can be obtained from Phil Moss (project Research Fellow):

p.j.moss@bham.ac.uk

High impact changes in older people's services

HSMC have produced a review of emerging evidence around prevention in older people's services. The paper builds on HSMC's ongoing contributions around prevention and rehabilitation within long-term care as part of an EU research project. The work identifies and reviews ten high impact changes, addressing the acknowledged need to embed prevention into older people's services. HSMC will present their findings at Healthy Aging events at the King's Fund and the International Centre for Life later this year.

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Projects Update continued

HSMC contributes to report on incentives and performance in primary care

HSMC's Professor Russell Mannion is part of the team that has recently published a report on the impact of incentives on primary care. The team, led by Professor Ruth McDonald from the University of Nottingham, was funded by the National Institute for Health Research (NIHR) Service Delivery and Organisation Programme to undertake a three year study investigating the impact of a range of incentives on primary care professionals' behaviour and performance.

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The report can be downloaded from the SDO www.sdo.nihr.ac.uk/projdetails.php?ref=08-1618-158

Joint commissioning in health and social care commissioning

HSMC is involved in research to explore the impact of joint commissioning on service users. This 2 year SDO funded project seeks to explore the processes, practices and outcomes of joint commissioning in health and social care, across 8 case study sites in England. So far sites 5 out of 8 have been recruited involving 2 Care Trusts; 2 Health and Wellbeing partnerships and a 'Connected Care' project. The project team are currently in phase 1 of the research which involves a unique on-line survey, specifically designed around Q Methodology. This analyses participant attitudes to a series of outcome statements based around joint commissioning. This data will be supplemented by the experiences of service users in phase 2. The project team, led by Jon Glasby, involves Helen Dickinson and Alyson Nicholds from HSMC and Stephen Jeffares and Helen Sullivan from the School of Government and Society.

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Leicestershire County and Rutland Community Healthcare Services

HSMC and Leicestershire County and Rutland Community Health Services are currently involved in a research and development partnership programme, to build the infrastructure, skills and capacity of the provider, to become a research and development based organisation. The overall purpose is to improve patient care, transform community services and embed a culture of learning from evidence within the organisation.

A number of planned activities have been on-going since last autumn including:

- Establishing five multi-disciplinary research and development groups linked to the Transforming Community Services agenda;
- An annual programme of days to develop primary research skills;
- Four seminars, focussing on the application of evidence into practice;
- Eight half day masterclasses to front-line services and teams on topics/foci of their choice linked to Research into Practice;
- Developing a research and development portal to support staff learning about research and development;
- Establishing an organisational development *Task Force* to support the embedding of a research and development culture; and
- Undertaking a multi-level evaluation looking at outcomes from the programme.

The research projects are well underway and due to present some of the findings at a final national event on 23 November at the Leicester Racecourse and Conference Centre.

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Evaluating the impact of the Social Enterprise Investment Fund: progress to date

An HSMC evaluation team has been commissioned by the Department of Health Policy Research Programme to assess the effectiveness of the Social Enterprise Investment Fund in supporting social enterprise entry into health and social care. The research comprises three phases which broadly run sequentially over the two year period from July 2009-June 2011. 'Phase One' (July 2009 to January 2010) of our research interviewed policy makers and other actors involved in formulating the SEIF in order to understand the 'programme theory'. Both the Phase One report and an extended stakeholder analysis will shortly be available on the TSRC/HSMC website.

'Phase Two' (February 2010 to September 2010) of our research undertook a survey of all the social enterprises that were successful and unsuccessful in receiving SEIF investment. A Phase Two report will be submitted to the Department of Health later this month and will then be available on the TSRC/HSMC website.

We will shortly be starting Phase Three of our research (October 2010 to June 2011) which will be carrying out in depth case studies of successful and unsuccessful SEIF organisations.

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Older people and care transitions

The second stage of an SDO funded research project examining the experiences of older people undergoing transitions in care has begun. During this stage 80 older people in Manchester, Leicester, Solihull and Gloucestershire will be interviewed by a researcher accompanied by a trained service user co-researcher. The interview will include questions about their experiences at different stages of their transition, what would have made it easier and what messages they would like to send to care providers. The project also includes an analysis of the literature, follow up interviews after a six month interval, and development work with the case study sites linked to the dissemination of findings.

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Responding to the White Paper

HSMC has been asked to address a range of local, regional and national organisations on the implications of the 2010 White Paper and related topics, including the Local Government Association, the National Skills Academy for Social Care, the Social Care Association and the National Association of Primary Care.

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Personalisation in learning disability services

HSMC have been commissioned by a provider of services for people with a learning disability to evaluate their support for people with complex needs and identify how well placed they are to provide 'personalised support' for people living in residential care homes.

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Events

The liberation of NHS Commissioning: how will we cope with freedom?

Wednesday 24 November 2010

HSMC is holding a seminar entitled 'The liberation of NHS Commissioning: how will we cope with freedom?' The aim of the workshop is to provide an opportunity for participants to feel that they are fully au fait with current policy, share their views with their peers and be able to consider what support would be helpful over forthcoming months. Keynote speakers include: David Colin Thomé and David Martin, both of whom have been involved in the planning and delivery of local and central policy for a number of years, and Judith Smith, policy analyst from the Nuffield Trust, who will share her expertise and views on the current reforms. The seminar is aimed at senior NHS leaders involved in commissioning including: PCT CEOs, Directors of Public Health and senior GP commissioners.

The **non-residential registration fee is £150** with a reduction of 25% for representatives of voluntary sector organisations.

To book a place please contact Ann Thomas on 0121 414 7058, email: a.d.thomas@bham.ac.uk
For further information contact Suzanne Robinson on 0121 414 3011, email: s.m.robinson@bham.ac.uk



Biennial Conference in Organisational Behaviour in Health Care

HSMC hosted the prestigious 7th Biennial Conference in Organisational Behaviour in Health Care (OBHC) from the 11th to 14th April. The theme of the conference, which attracted over 150 academics and practitioners from across the globe, was 'Mind the Gap: policy and practice in the reform of healthcare'. Visiting academics were invited to share their expertise, and present and discuss papers that explored the behaviours of healthcare organisations in shaping, adapting and resisting developments in healthcare policy and practice.



The Conference was held in the lecture room in the University of Birmingham Business School

In addition to the academic programme, delegates also had the opportunity to tour the Barber Institute of Fine Arts, the University's own renowned art gallery, and had dinner at Birmingham Council House,

preceded by a private viewing of the Staffordshire Hoard - an exciting, newly discovered treasure trove of Anglo-Saxon artefacts.

The academic conference was complemented by a one-day practitioner seminar attended by senior NHS managers and clinicians, who took the opportunity to discuss the conference theme with academics. Over the course of the event HSMC were delighted to welcome three distinguished Keynote speakers: Dr Peter Hupe from Erasmus University, Rotterdam; Ben Page, from Ipsos MORI and Professor Michael West from Aston Business School.

Here are just a few of the many comments from attendees:

- "It has been the highlight of my conference year" – academic from University of Southampton
- "An excellent conference. The organisation was first class and the kindness and helpfulness of everyone made it special. The programme had really good quality papers and the overall content was well-structured" – academic from Aberdeen
- "I very much enjoyed it, and really loved Birmingham" – research officer – Canada
- "How fab I thought the conference was. It was really superb - we have a lot to live up to. I was particularly impressed by your team and how positive they were" – academic from Dublin and hosts for next conference in 2012
- "On behalf of the Executive and Trustees of SHOC I am writing to thank you for a very enjoyable 2010 conference in Birmingham.

We were particularly pleased with both the streaming of papers and the opportunities to meet old and new friends within such interesting locations and with such delightful catering. Birmingham has made a lasting impression on us all" – Chair of SHOC

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Ben Page, Chief Executive of Ipsos Mori, keynote speaker on the 3rd day of the Conference

People at HSMC



Collaboration with the Australian Institute for Health Innovation

A formal research collaboration has been set up between HSMC and the

Australian Institute for Health Innovation (AIHI) and the Centre for Clinical Governance Research at the University of New South Wales (UNSW), Sydney, with the purpose of developing a joint portfolio of research in the area of health care quality and patient safety. As part of the collaboration **Russell Mannion** has been made a Visiting Professor at UNSW and Jeffrey Braithwaite, director of AIHU has been appointed to a similar post at HSMC (see below). UNSW is a leading international centre for health systems research and is consistently ranked among the top 50 universities in the world.



Professor Jeffrey Braithwaite

who is currently Professor and Foundation Director of the Australian Institute of Health Innovation and Professor and Director of

the Centre for Clinical Governance Research Faculty of Medicine, University of New South Wales, Australia has recently joined HSMC as Honorary Professor. Professor Braithwaite is a leading health services organizational researcher with an international reputation for his work in health systems improvement, particularly investigating the culture and structure of acute settings, leadership, management and change in health sector organizations, quality and safety in health care, accreditation and surveying processes in international context and the restructuring of health services. He is well known for bringing management and leadership concepts and evidence into the clinical arena and he has published extensively (more than 400 total publications) about organizational, social and team approaches to care which has raised the importance of these internationally.



Academic study tour update

Since July of this year, **Iestyn Williams** has been in North America writing up research for publication and making links

with colleagues from the University of British Columbia (Vancouver) and City University of New York. As part of this he has delivered the following seminars:

- Maximizing the value of England's NHS: What is the role of the public? (Sophie Davis Medical School, New York)
- Implementing rationing decisions in health care (Vancouver Coastal Health Authority, Canada)
- Organising for innovation in health care: strategies and approaches (Centre for Health Care Management, UBC)

A number of joint-papers and research bids are currently underway between Iestyn and colleagues from the Centre for Health and Clinical Epidemiology (UBC, Canada) and Community Health and Social Medicine (CUNY, New York).



University recognises Professor's policy contribution

Professor Jon Glasby has won the University's Charles Beale award for influencing

national policy. Jon was presented with his award at the annual Vice-Chancellor's dinner by Michael Collie from BBC Midlands Today.

The prestigious award is granted to an academic who is judged to have made a significant contribution to policy debate, in this case, the White Paper on long-term care for older people, issued in March 2010. Jon was recognised for his report, *The case for social care reform – the wider economic and social benefits*, which concludes that without a radical rethink of current priorities, the real cost of providing social care will double in the next twenty years.



Building on this work, Jon and HSMC colleagues continue to exert their influence and inform ongoing policy debates in this arena with the current coalition government.

Jon has also been appointed as a Non-Executive Director of Birmingham Children's Hospital, having previously served as the University's representative on the Council of Governors.



Prestigious national award for HSMC Lecturer

HSMC Lecturer Helen

Dickinson has won the 'best newcomers' award at this year's Social Policy

Association (SPA) conference. Helen was presented with her award by Nick Timmins from the Financial Times and President of the SPA, at the annual conference dinner. The prestigious and hotly contested award is granted to a lecturer/researcher who is judged to have made a significant early contribution to the field of social policy in terms of research, publications and teaching. Her selection was based on 3 areas of outstanding achievement:-

1. Helen's extensive and impressive publications record. She has co-authored 7 books and 20 articles in (mostly) refereed journals. In addition, she has contributed to numerous research reports and practitioner journals. Her publications record is truly outstanding for such a new researcher.
2. Her record in securing external research income and her developing research leadership role. As principal investigator, Helen has secured nearly £200K external research funding. She also leads the health and social care component of the service delivery research stream for the ESRC Third Sector Research Centre.
3. Helen's teaching and administration roles. As well as being recently appointed as HSMC's Director of Teaching, Helen is responsible for several HSMC MSc modules targeted at practitioners and managers. She also led the organisation for the international conference in Organisational Behaviour in Health Care, which was held in April.

Of her achievement, Helen said, "I'm incredibly proud of this award though I don't consider this to be a solo effort - rather, it is a testament to the support I've received at the Health Service and Management Centre in the School of Social Policy. Being an early career researcher can be challenging, but I guess I'm really lucky. I'm in a Department and a School that is really supportive, and there's something about early career researchers supporting each other that has been really helpful. You can't underestimate the importance of networking."

Some sad news

HSMC were saddened to hear of the sudden death of Dave Doyle from Knowsley Council/NHS Knowsley. Dave has worked with HSMC on various projects over the last decade and was a tireless champion of integrated working. HSMC are very grateful for all his contributions to our work and send our condolences to Dave's family and colleagues.