

# Newsletter

Focus on tough choices  
and new opportunities in a  
cold fiscal climate



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# Focus on tough choices and new opportunities in a cold fiscal climate



**Edited by Iestyn Williams and Jenny Harlock**



Some say that necessity is the mother of invention, others that being innovative requires resources. Whatever the validity of these competing claims, it seems clear that we are entering into a sustained period of public sector budget constraint brought about by both economic trends and political decisions. As a result, 'austerity'

has cast a shadow over the planning, commissioning and delivery of services. 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. The pursuit of reasonable approaches to rationing has long been a preoccupation of HSMC. However this debate has evolved as the health and social care landscape has evolved, and HSMC's research and practice has changed accordingly. For example, the controversial topic of 'decommissioning' has long been overlooked by social science researchers. In this newsletter Jenny Harlock explains how we have sought to address this gap through a three-year NIHR-funded investigation of the removal and/or replacement of NHS interventions and services. 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. Kerry Allen further explores best practice in this area by considering lessons and learning from recent care home closures.

The traditional pre-occupation of priority setting with a narrow range of health care interventions is also out-dated post Marmot, and HSMC is therefore piloting and evaluating a novel public engagement initiative for deciding between preventive interventions with Solihull Health and

Wellbeing Board. The 'REACH UK' game enables citizens to debate the merits of a range of programmes for improving health and wellbeing. Katharine Warren, a public health trainee on placement at HSMC, describes project progress to date.

As well as necessitating difficult choices, austerity arguably provides an opportunity to think in new ways about old problems and how they might be solved, in particular through the emergence of new service models. In this newsletter Robin Miller and Jennifer Lynch explain the move towards a social capital and assets-based approach to service planning and delivery in adult social care. Put simply, this means services that build on and complement what people are able to do rather than making dependency and helplessness a condition of support. Hilary Brown meanwhile explores the value of Stroke Groups in facilitating recovery and confidence and tackling isolation and loneliness for stroke survivors and their carers. Both articles make the case for expanding the narrow preoccupation

with price as an indicator of the value of interventions in health and social care - all too easy in these financially straightened times. And finally, our newly appointed Professor, Mark Exworthy, reviews the pervasive but largely unpublicised awarding of financial bonuses to NHS consultant doctors - to the estimated tune of over £500 million per annum.

These articles are supplemented by our usual project and news updates, including a second contribution from Mark Exworthy reflecting on a recent health care 'trade visit' to China.

Overall we hope that this newsletter, and the work of the department that it showcases, combine realism in relation to the financial constraints we are currently facing with continued commitment to quality and innovation in health and social care.

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# Decommissioning healthcare: early findings from an NIHR study



**Jenny Harlock**

There are very few examples of successful attempts to decommission healthcare services and/or interventions.

Decisions to

decommission are often accompanied by resistance from staff, negative media attention, and an aggrieved local public. For these reasons decommissioning has often been overlooked by social scientists: it is seen as too controversial, too difficult to implement, or simply a knee-jerk response to financial difficulties. Yet as new technologies emerge, practices evolve, and population needs shift, decommissioning is part of a continuum of activities and skills (alongside re-commissioning) that those responsible for planning healthcare services are learning.

HSMC is therefore undertaking a three year study into decommissioning – that is, the planned process of removing, reducing or replacing - healthcare services and interventions in the English NHS. The project is funded by the NIHR Health Services Delivery and Research programme and seeks to understand what happens when decommissioning 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 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 participant's earlier responses. The results revealed a stark contrast between what experts reported should happen and does happen in practice.

There was strong agreement amongst participants that quality and patient safety, clinical effectiveness and cost effectiveness

should ideally inform decisions to decommission. However, cost/budgetary pressures, government intervention and capital costs and condition (of buildings/maintenance) were cited as the top three factors that actually do inform decisions to decommission in practice. These results may not come as a surprise to some, given the financial constraints and political pressures that those in the healthcare sector are facing. Yet participants stressed that 'cost' in itself is not an illegitimate reason to decommission. Rather, it is decision-making based on expectations of short-term cost savings (so-called 'salami slicing'), instead of a whole systems perspective focused on long-term sustainability that was said to be problematic.

Meanwhile participants emphasised the time, resources and skills necessary to collect, analyse and communicate the evidence for decommissioning decisions. Healthcare providers whether public or private are not used to collecting data to prove their 'unworth' - indeed quite the opposite in a competitive funding environment - but basing decisions on a strong and robust evidence base was amongst the top five best practice recommendations for decommissioning in our Delphi exercise.

When it comes to implementing decommissioning, size would appear to matter. Related research on disinvestment and cutback management has suggested that incremental changes to practices and services are likely to be implemented far more successfully than large-scale programmes of reform and/or reduction.

The results of our Delphi survey suggest that this could indeed be the case: executive and clinical leadership were highlighted as key factors in facilitating programmes of change. Meanwhile quality of communication, clarity of rationale for change, and demonstrable benefits were reported to be crucial by participants if decommissioning programmes are to be seen as more than just another short-term cost-saving initiative, and gain the trust of patients, staff, and stakeholders.

The next stage of the study will explore these issues in greater depth through four case studies of decommissioning processes. Previous investigations of decommissioning have been heavily couched in the rhetoric of comparative health economics. Early evidence from our Delphi survey suggests there is a need to pay attention to the political and organisational dynamics of decommissioning, and the project will address both of these ambitions.

Decommissioning is likely to remain a highly contested and challenging activity, especially in a context of austerity. Yet decommissioning can be a planned process of healthcare modernisation underpinned by improved patient experience, quality of care and patient outcomes. Our research so far suggests that key to this is establishing a clear evidence base for decommissioning based on both clinical and patient experience, involving patients actively in plans and decision-making, and forecasting potential impacts on the health (equalities) of the local population.

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Protesters in front of hospital / by Labor Youth - Óige an Lucht Oibre on Flickr (CC BY-NC-SA 2.0)

# Closing care homes: managing change for positive outcomes



**Kerry Allen**

In a challenged economic context care home closures can occur for a number of reasons and take very different forms.

Closures can often be sudden, connected to a specific emergency in a single home or breach of regulatory standards. Market failure is also an inevitable risk in a private sector dominant provider landscape. However care home closures are not always abrupt and unforeseen; increasingly local authorities are decommissioning care homes as part of a planned process of modernisation and outsourcing.

The potential for negative consequences for the vulnerable people being resettled is easily imaginable in connection to care home closures. In one of only a few studies providing insight into this topic for older people, Scourfield (2004, pp. 511) points to the knock-on effects for extended social networks and to the importance of these multiple stakeholders in providing support:

*“Minimizing ‘transfer trauma’ necessitates an ongoing piece of work involving the whole system around the individual old person concerned. This would include, for example, friends, family, care staff, professionals and companions in the home.”*

Against this background, this article draws on a recent HSMC evaluation and good practice guidance (Robinson et al., 2013; Glasby et al., 2011) to explore whether effectively managed care home closures can produce better long-term outcomes for residents. It identifies some key principles and practices behind effective closure management that may be applicable across various closure scenarios.

Can the closure of care homes lead to improved outcomes for residents? Based on the findings of a 3-year evaluation of the modernisation of older people’s services in the city of Birmingham, the best answer is ‘Yes, but...’. This study measured health-related quality of life of older residents at:

- initial assessment (before closure and resettlement)

- 28 day review (28 days after resettlement)
- 12 month follow up (a year after resettlement)

Because of the size of Birmingham, this was believed to be one of the largest closure processes in Europe – and the City Council took the brave but unusual step of commissioning an independent evaluation so that lessons could be shared with other areas contemplating similar changes.

Despite the received wisdom that care home closures can be damaging to older people’s well-being, we found that many things stayed the same for our participants (despite the fact that they were 12 months older and frailer at the end of the study than at the start). In some cases, indeed, outcomes actually improved – and this seems a major success story given the complexities involved. However, many older people, their families and care staff were angry and upset part way through the closure process – perhaps demonstrating that service closures can be distressing and emotionally charged even if the overall outcome is positive.

Contributing factors to the success of the closure programme included:

- **A dedicated social work assessment team:** assessment provided the primary mechanism by which new services were determined and getting this right was crucial to the health and well-being of service users, both short- and long-term. A key strength of the process suggested by all stakeholders was a dedicated group of assessors, who were able to take the time to get to know people well, meet families, work alongside care staff and carry out holistic assessments.
- **Strategy and communication:** having a clear strategy and policy that could be easily articulated to stakeholder groups was seen as important. This aided subsequent communication and enabled the closure programme to take place on a phased basis (which prevented rushed decisions and overloading care staff and assessors). Being forewarned of potential risks and negatives was also seen as important, so that every possible step could be taken to overcome these. The communications approach incorporated an independent advocacy service for residents and their families.

Above all, a key factor seems to be time for adequate planning and preparation. This includes time to:

- Put in place well organised, dedicated and skilled assessment teams.
- Involve all relevant parties (especially service users) in decisions about future services.
- Get to know people well and carry out holistic assessments of their needs.
- Support service users, families and care staff through potentially distressing and unsettling changes.
- Work at the pace of the individual and give as much time to explore future arrangements as possible.
- Help residents and key members of care staff to stay together if possible.
- Ensure independent advocacy is available.
- Plan the practicalities of any moves and ensure as much continuity as possible after the move has taken place.
- Stay in touch with people and assess the longer-term impact of resettlement.
- Work in partnership with a range of external agencies and key stakeholders, managing information and communication well.

While these are easier to achieve as part of a long-term, planned process, such factors are also important when an emergency closure takes place. Given that staff may have to respond in rapid timescales, it feels important that there are accessible and practical guidance and tools available – and our subsequent national good practice guide has sought to share our learning with others (see Glasby et al., 2011).

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# Reaching Economic Alternatives that Contribute to Health (REACH) with Solihull Health and Wellbeing Board



## Kate Warren and Iestyn Williams

The Marmot review 'Fair Society Healthy Lives', published in 2010, highlighted the persistent problem of health inequalities in England and the need to invest in programmes which target social determinants of health and well-being. In order to bring about a more integrated approach to tackling these problems, the recent NHS reforms

saw relocation of public health into local government and the creation of Health and Wellbeing Boards responsible for developing strategies in local areas.

Clearly these changes have implications for how public funds are allocated, and therefore for the role of 'priority setting' in this process. Until now, priority setting has been heavily influenced by a fairly narrow range of medico-economic models and measures (such as the 'quality adjusted life year'). However, to retain its relevance, priority setting must address challenges both new and longstanding. These include:

1. How to engage citizens in decision making in ways that genuinely increase involvement and deliberation
2. How to rebalance spending from predominantly curative interventions towards preventive programmes, and
3. How to do this in a context of increased financial constraint

HSMC, along with the Institute for Local Government at the University of Birmingham, have recently devised and piloted a UK version of the REACH game, which was originally developed in the US (Pesce et al. 2011). REACH is a deliberative group exercise based on a board game, where citizens are asked to debate and select from a range of interventions that address the social determinants of health. Participants select interventions based on a simple description of their effects and an estimate of their relative costs (indicated by the size of the wedge on a pie chart). The resources held by participants are not sufficient to fund all available interventions and therefore choices have to be made. In several rounds of the exercise, people work on their own and in small groups to establish priorities for themselves, their neighbourhood, and their city.

The game was test-run in two deliberative events held at the University of Birmingham. Participants in the events were made up of postgraduate students and service users. The next step for the REACH project is to run the game with residents of the Solihull area, under the sponsorship of Solihull Health and Wellbeing Board. These events will be formally evaluated to measure and explore their value in taking forward the public engagement agenda in priority setting for health and wellbeing.

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Solihull High Street / by velela on Wikimedia Commons

# Turning the welfare state upside down?

## New approaches to adult social care



### Robin Miller and Jennifer Lynch



As the implications of the Care Bill continue to be debated, adult social care is facing significant difficulties. With major financial and demographic challenges, the system as a whole feels as if it is creaking at the seams – and maintaining even the status quo (which many people felt was not good enough in too many cases) will be very

hard. As Councils gain new responsibilities and face massive cuts (described by one Council leader as “the end of local government as we know it”), they will have to make some very tough choices.

Against this background, a number of local authorities are actively considering new approaches which draw more fully on social capital and community resources.

For all the legislative changes taking place, adult social care is still based on very negative underpinnings, with people forced to highlight the things they can't do for themselves in order to be eligible for support. Anyone with family support or keen to stress what they can do for themselves runs the risk of being penalised for not being sufficiently vulnerable and dependent. For people on the receiving end this can feel a very demeaning and disempowering process – especially if after a lengthy process you find you are still not eligible for support. At best, it means that Councils too often fail to take into account people's existing social capital and the community resources they use on a regular basis; at worst it can ride roughshod over such sources of support.

Now, in contrast, there seems a genuine appetite for a new and more assets-based approach which builds on what people can already do for themselves. This does not mean that people with less social capital would lose out – simply that Councils would try to build on whatever support already exists in individual situations and communities, wrapping any formal services around what already works for the person concerned. Thus, a number of authorities are exploring mechanisms such as timebanking, local area co-ordination and the development of micro-enterprise. Councils such as Surrey are setting up user-led citizens' hubs in high-street locations to provide advice and peer support and encouraging staff to think about the contribution social capital could make to meeting the needs of the 'Taylor family' (a fictitious but realistic family created to help engage staff and service users in creative discussion). The Shropshire social work pilot is led by a community organisation which is pioneering approaches to re-ablement based on peer support, with delegated authority from the Council to spend small

weekly sums on formal services if needed in the short-term. All round the country there are sometimes small, but often powerful, examples emerging.

In many ways, such approaches take social work back to its community development roots, moving away from a more narrow focus on care management. However, making a strategic shift from a deficit- to an assets-based approach will not be easy and Councils cannot simply reduce formal services and hope that social capital will somehow make up the difference. Instead, we need a firm commitment to a new way of working – and then we have to really mean it/be consistent when we say it. Thus, many authorities are reducing the number of neighbourhood workers they employ, cutting grants to local community organisations and/or trying to reduce the number of area offices they have, placing staff in large, central buildings many miles away from the communities they serve. These seem the mirror image of what might be needed if we were serious about a more community-orientated approach.

In one sense, this sort of shift has been promised before – most recently via the personalisation agenda. However, the current financial crisis has to be seen as both a threat but also as an opportunity. While difficult choices will have to be made, necessity could well be the mother of invention. Many authorities have always been supportive of a more assets-based approach, but there have always been too many barriers. Now, many Councils know this is the right thing to do, but also cannot afford not to – potentially a powerful combination of drivers.

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This article is based on a recent HSMC policy paper, Turning the welfare state upside down, by Jon Glasby, Robin Miller and Jennifer Lynch, commissioned by and published in conjunction with Birmingham City Council Adults and Communities directorate. A full copy of the policy paper can be found at [www.birmingham.ac.uk/hsmc-policy-paper-fifteen](http://www.birmingham.ac.uk/hsmc-policy-paper-fifteen).



# ‘Knowing the price of everything but the value of nothing’ - Placing a value on ‘A lifeline’



**Hilary Brown**

The above quote from Oscar Wilde’s *Lady Windermere’s Fan* is given in response to the question, ‘What is a cynic?’ It strikes me as being a relevant

contemporary comment on the shift in recent years to using performance information as the main measure of the benefits of a health and social care intervention. This seems particularly the case when it comes to those services which are intended to help people to self-manage their conditions by adopting a more psychosocial approach. Without outcomes that can be easily measured, counted and costed, such services are potentially vulnerable to cuts in these financially constrained times. This is particularly unhelpful given the increasing numbers of people living with long-term conditions, and the recognition that people with long term conditions are two to three times more likely to be depressed than the general population (Haddad M et al, 2009).

There are estimated to be over £15 million people living with at least one long-term condition in England (DH, 2013), 900,000 of whom are estimated as living with the effects of a stroke (Stroke Association, 2013). A stroke is often life changing for both the patient and carer as there can be physical and cognitive impairment, fatigue, and behavioural and emotional changes. Psychological difficulties such as depression and anxiety are commonly experienced (Hackett et al. 2005). Evidence also suggests that this kind of psychological distress may be long-term and may not manifest itself for some time after the individual has experienced a stroke (Ch’ng et al. 2008).

HSMC has recently been involved in a longitudinal evaluation of a Third Sector organisation’s approach to setting up support groups for stroke survivors and their carers which has reiterated the vital role these groups play in a participant’s well-being. Third sector organisations have often been set up in response to the priorities expressed by people with long-term conditions – fulfilling their mission enables and indeed in many ways compels them to take a holistic view of people’s needs.

Our experience however is that this role is not always valued by the decision makers because it is difficult to put a price on what the groups can achieve.

## Tackling loneliness and isolation

It is not uncommon for stroke survivors and their carers to feel very isolated and left on their own after they are discharged from hospital. Stroke groups are seen by participants as a vital resource in terms of developing a support network. The simple act of attending the group provides a sense of purpose and acts as a motivator to go on and do other things. For a number of those who live alone and have limited contact with others, the groups were described as a ‘lifeline’.

The groups were seen a ‘safe’ place for participants to practise motor and speech skills as fellow members are likely to be more patient and encouraging. Participants can join in with activities and if they can’t quite manage something as well as others, it’s an opportunity for humour rather than embarrassment. In general, the ability for participants to talk about what has happened to them and what they are going through without embarrassment and feeling awkward about ‘being different’ or the ‘odd one out’ is empowering. Group members are also a good source of encouragement for each other and can provide hope that things will improve:

*‘The support group is a major part of keeping me mentally well - sharing experiences and recognising that there is life after stroke. It is easy to get down when you realise that life is irrevocably changed and you will never go back to certain things you took for granted. The group gives hope and you realise that there are other things to do - different, but equally valuable.’* (Stroke survivor)

Carers equally report that the groups provide them with an opportunity to refresh themselves providing some light relief from the usual routine and responsibility of caring for someone, and their own sense of isolation:

*‘I was feeling very alone and neglected as a carer before – I felt quite excluded from normal life.’* (Carer)

## Metrics mania

Our evaluation highlighted the social isolation experienced by stroke survivors, the vital role that support groups can play in addressing this isolation and the importance that the survivors and their carers placed on such support. Research drawn on by the ‘Campaign to end loneliness’ <http://www.campaigntoendloneliness.org/threat-to-health/> shows us that the effect of loneliness and isolation on mortality exceeds the impact of risk factors such as obesity, and has a similar influence as cigarette smoking (Holt-Lunstad, 2010). Loneliness can increase the risk of many negative outcomes including suicide among older people (O’Connell et al, 2004). The stroke support groups, which offer a means by which to tackle the loneliness and isolation often felt by stroke survivors and their carers, are surely therefore a useful preventative strategy as well as a rehabilitative one?

However, interviews with professional stakeholders highlighted differing views as to the overall purpose and approach of stroke groups. Should they be informal, allowed to develop in line with the wishes of the members and have mainly social benefits? Or should they be more structured with the principle objective to promote the integration of the individual back into the community, thereby reducing the need for statutory interventions?

We noted that because some stakeholders struggled to quantify the benefits that participants might gain, they did not always recognise the value of such groups. Management consultant and business guru, Peter Drucker, is often famously misquoted as saying, ‘If you can’t measure something, you can’t manage it,’ which many have taken as a maxim resulting in a sometimes inflexible reliance on metrics to determine the value of something. In the world of health and social care commissioning, this has resulted in a proliferation of key performance indicators in contracts and performance managing to the metric. But

life for those who attend these groups isn't about measuring the number of times they visit their GP, or the number of contacts they have with social services, it's about how they feel about themselves and their ability to carry on with what is important to them in their lives.

#### A broader view of value

The quote at the start of this article continues: 'And a sentimentalist, my dear Darlington, is a man who sees an absurd value in everything, and doesn't know the market place of any single thing.' – I trust we are not guilty of being sentimental in calling for commissioners to think very carefully about how they assess value. Instead of solely relying on KPIs on a spreadsheet, they need to get out and talk

to people who receive the service and ask them how they would assess its value. And whilst these will not easily be compared or assimilated, this evaluation suggests that the findings could provide a powerful source of evidence of real impact.

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## Paying the doctor



**Mark Exworthy**

With Paula Hyde and Pamela McDonald-Kuhne\*

In trying to find £20billion efficiency savings, the NHS will

find it increasingly hard to balance rising demand and continued public sector pay restraint. Pay is the biggest item in the NHS budget and so, it is timely to re-assess the state of pay in the NHS and especially among consultants. Following a 2 year pay freeze and the announcement of no pay increases in 2014 for staff eligible for progression-in-pay increment (BBC, 2014), current developments (such as the forthcoming new contract for doctors, reforms to Clinical Excellence Awards and the prospect of 7 day working) seem to point to a new settlement in doctors' pay (DDRB, 2013).

In 2011, there were over 47,000 consultants in England which was the highest number ever – equivalent to 4% of the NHS workforce but 13% of the NHS budget. However, these are not evenly distributed with particular shortages, for example, in accident medicine and deprived areas (PAC 2013; BMA 2014).

#### 'Stuffing their mouths with gold'

The story of NHS doctors pay has always been highly political - with a big and small 'p'. Bevan, the founding minister of the NHS, described how he had to 'stuff doctors' mouths with gold' to join the fledgling NHS. Enoch Powell, another former Health Minister, described:

*"the unnerving discovery every Minister of Health makes at or near the outset of his term of office is that the only subject he is ever destined to discuss with the medical profession is money"*  
(Le Grand 1997, p. 14).

Likewise, Ken Clarke spoke of 'doctors reaching nervously for their wallets' when he mentioned health reforms. Latterly, attention has focused on the impact of the 2003 contracts which saw pay increases of between 24% (bottom of consultants' pay band) and 28% (top) between 2002-03 and 2003-04 (NAO, 2013). As a result, doctors' pay now attracts significant media attention. Newspapers (notwithstanding their own 'political' agenda) continue to report on egregious examples of doctors' pay (Donnelly, 2014).

#### Doctors reaching nervously for their wallets?

NHS consultants are paid in terms of basic pay, additional Programmed Activities, on-call supplements, Clinical Excellence Award (CEA), and other fees and allowances (DDRB, 2013). Three-quarters of their pay comes from basic pay. In the 12 month period ending October 2013, consultants (non-locum) earned £88,088 (mean annual basic pay) (HSCIC, 2014). If CEAs are added, the median annual total earnings of senior doctors are £109,000 (2011-12). These awards range from £3,000 to £75,000 per annum across 12 levels, are pensionable, are reviewed periodically but are rarely withdrawn. The overall cost of CEAs is £500 million per annum (NAO, 2013).

With a new contract in the offing, assessments of the 2003 contract are salutary. As the table shows, the results are mixed.

Expected benefit of 2003 contract	Realised?
Limit increase in private practice	Realised. 39% of consultants undertook private practice in 2012, down from 2/3 in 2000 but in context of rising consultant numbers
Increase consultant participation	Realised
Increase consultant productivity	Realised. Fall in productivity slowed after 2003 contract.
Improve management of consultants' time	Partly realised
Slow pay progression	Partly realised
Extend patient services	Partly realised
Secure extra work at standard contractual rates	Partly realised
Reduce waiting times	Times have reduced but difficult to attribute to contract

The DH gave the NHS £715 million (2003-4 and 2005-6) to cover additional contract costs, with recurrent costs of £400 million pa. Over 80% of Trusts said that "they now paid for work, which they had not previously paid for under the old contract" (NAO, 2013).

Given heightened media and policy interest, public perceptions of doctors' pay are noteworthy. For example, High Pay Centre (2012) asked the public whether they thought certain workers earned "too much, too little or about the right amount of money." Doctors' (not just consultants) pay (estimated at £82,962) was deemed "about right" by 73% of respondents, the highest amongst all the categories of workers. Doctors were thought to earn too much by 20% and too little by 5%. This compares with nurses (£30,742): 37% about the right amount, 1% too much and 61% too little (the second highest, after "domestic cleaner", earning £14,144).

## Challenges

In the coming years, the NHS faces four challenges in paying its consultants.

### a. Pay

The 2011 NHS staff survey found that consultants were the grade most satisfied with their level of pay. Although pay restraint may be eased for some NHS staff (Lintern, 2014), doctors will not get significant pay rises (and annual increments of 3% to 8% have been revoked (BBC, 2014)). Major reforms to CEAs seem unlikely; as 60% get a CEA, they are becoming a de facto salary ladder. As with similar health systems, doctors' pay is nationally-determined.

### b. Productivity

The working time directive, quality improvement initiatives, rising workloads, changing skill mixes and technology make evaluating improved consultant productivity problematic.

### c. Performance

Consultant pay progression in "most Trusts" is not linked to performance. Moreover, most Trusts thought that CEAs rewarded "exceptional performance" although less than half of consultants thought so (NAO, 2013).

### d. Population

The UK still has low numbers of physicians by international standards, despite significant increases during the 2000s: 2.8 practising physicians per 1000 population up from 2.0 doctors per 1,000 population in 2000 (OECD 2013). However, it is still below the OECD average of 3.2 per 1,000 population.

The resolution of these challenges will be indicative of the 'politics of the double bed' (Klein, 1990), the settlement between the state and the medical profession. Continuing the metaphor (perhaps unwisely), no-one suggests that either party is likely to fall out of the 'bed' but on-going tensions over pay will move the 'duvet' between them!

\*Mark Exworthy, Prof. Paula Hyde (Durham Business School) and Pamela McDonald-Kuhne (Kingston Business School) are currently conducting an empirical study of the ways in which clinical performance is defined, interpreted and implemented in the committees allocating Clinical Excellence Awards (CEAs). It is funded by the British Academy of Management's Researcher Development Scheme ([www.bam.ac.uk](http://www.bam.ac.uk)).

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# China crisis?

## Mark Exworthy

David Nicholson famously claimed that the recent NHS reforms could be seen from space. If he visits China, he will need to revise his analogy. My participation (on behalf of HSMC) in a health care 'trade mission' to China (led by Ken Clarke MP) in January 2014 brought home the scale of change and enormity of the challenges facing China and its health care system (Healthcare UK).

The ramifications of China's economic growth are being felt in all aspects of society, not least public services. Rising ambitions and expectations amongst the public are presenting enormous challenges to the Chinese government as it moves from a command-and-control to a mixed market economy. With inflation and unemployment remaining stable and economic growth remaining (moderately) strong (currently 7.5% pa), China may be able to meet growing demands for the time being. However, rising (income and geographical) inequality may yet threaten this.

Until about 30 years ago, 20% of China health care costs were out-of-pocket expenses, with the rest met by the state. Then, health care reforms made hospitals take care of their own finances, as commercial entities. However, such incentives led to over 50% of hospital income currently being derived from drug sales and unnecessary medical procedures.



The Chinese government is now seeking to devolve away

from the centre, to reduce bureaucracy and shift from (direct) provision to regulation. So far, the agenda seems remarkably similar to English health care reform. Indeed, many Chinese policy-makers and practitioners have a high admiration for the NHS, seeking to learn from it and even emulate it.

Yet, enormous challenges remain for the health-care system. These include:

**1. Scale of change:** In the past 10 years, over 100 million people have migrated to cities and even more will move in the next 10 years. Meeting the health needs of such a population is becoming increasingly difficult. For example, just 30 minutes from Beijing (admittedly by the very fast Harmony

train) is Tianjin, a city of over 12 million, with 304 "hospitals" and over 2000 "village health rooms." The pace of change is stretching existing capacity and capabilities here, as elsewhere.

### 2. From secondary to primary care:

Hospitals dominate the health care landscape. In China, 90% of health care contacts are in secondary care, unlike the NHS where 90% of contacts are in primary care. Although the policy rhetoric is to move away from existing funding streams at prospective payment models (similar to PbR), the shift to primary care remains problematic. For example, minor surgery in primary care has largely disappeared. Moreover, the public has expectations of seeing a 'specialist' in secondary care. The continued dominance of secondary care and the weak infrastructure in primary care might augur higher costs and reduced access in the long term. This could exacerbate health inequalities. Current investment in primary care facilities will remedy this situation somewhat but the scale of the challenge may hamper such ambitions.

**3. Health spending:** China spends 5.2% of its GDP on health care (compared to 9.3% in UK). In the past decade, there has been a growth in social insurance coverage. In some places, it is currently over 90% whereas it was only 15% ten years ago. Packages of essential care are still provided by the state. Despite such social insurance, patients still make significant co-payments of 40-60% of the costs of their care. In such circumstances, it is understandable that the public seek to save as much of their income as they can, not least for cases of catastrophic health care costs (Li, 2012). The effect across the country is an economy unbalanced towards investment and not consumption

Corruption remains a significant challenge as, in some sectors, it is endemic. Some strides are being made to address this. The GSK case of bribery has become a notable illustration of the state's commitment to tackling this issue (Guardian, 2013). Corruption has also, some claim, had an antagonistic effect on doctor-patient relations (given the role of the former in prescribing drugs).

### 4. Social determinants of health:

Throughout the week of the visit, 'smog' pollution was ever-present. Although we visited only cities (where pollution might

be expected to be at its worst), train travel between them revealed persistent 'grey' skies. Combined with on-going urbanisation, reliance on coal fired power stations, and growing car usage, deleterious health effects will be substantial. Rising life expectancy (2.4 years increase in the last decade, for example) may not be sustainable. Moreover, policy-makers are especially concerned with models of care for the growing elderly population and those with associated conditions such as dementia.



A final word is merited about the purpose of the 'trade mission'. It was interesting to note the mix of 50 or so delegates from the UK – from IT companies, the NHS and universities. While IT companies had a particular focus on digital health, the NHS (mostly specialist Trusts) was exploring the development of education, research and commercial links which may ultimately create a new income stream for the NHS. For universities, there was interest in advancing existing research and educational programmes. The University of Birmingham has a major collaboration with Guangzhou. HSMC has won British Academy funding to conduct a learning network on health care reform in China (see HSMC latest Newsletter). To that end, my visit helped HSMC pursue yet more international links and in doing so, revealed familiar challenges of health care reform in a completely different context.

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# Postgraduate programmes

HSMC will welcome a new group of students in September. Our three programmes give opportunities for study at Master's level in:

- Health Care Policy and Management
- Healthcare Commissioning
- Leadership for Health Services Improvement

All of our programmes emphasise the application of learning to practice in policy, management and leadership. Our staff group has a wide range of expertise and experience in research and publication and in management and leadership.

Most of our students work in health and social care as managers or clinicians and undertake the programme part time over two academic years, with a dissertation taking around six months at the end of the taught modules. We also have a group of full-time students, mainly from overseas, who complete the programme in one academic year with a dissertation. The diversity of our student group adds to the learning and the HSMC experience.

In the Health Care Policy and Management programme there is an opportunity to specialise in:

- Quality
- Integrated Care
- Commissioning

Specialty programmes are based on two optional modules, as well as four compulsory modules which cover policy, management, patient and user involvement, and organisation development.

The Healthcare Commissioning programme includes modules on strategic commissioning, procurement and market management, and decision making and priority setting.

The Leadership for Health Services Improvement programme is based around an action learning programme. It is only available for part time students working in leadership roles during the period of study.

All of our programmes offer the opportunity to study flexibly, and to take qualifications of Postgraduate Certificate and Postgraduate Diploma. These are substantial qualifications in their own right, and there are opportunities for progression. We understand the pressures of professional life require some flexibility in study and make every effort to accommodate that.

Assessed work for the modules includes short assignments to support the workshop activities and a 3,000 word individual assignment for each of the modules. Dissertations may be literature based, empirical studies, or based on students' own leadership roles.

Please join us on Friday 11th April for a 'Masterclass' where you'll be able to meet staff and prospective students, and some current students, and discuss the programme in more depth.

For details of this session, and the programme, please contact Kate Vos,

[c.j.vos@bham.ac.uk](mailto:c.j.vos@bham.ac.uk)

## Nye Bevan Leadership Development Programme

Bevan is a one year programme aimed at leaders aspiring to be Board members (or National equivalent) in the next 1-2 years. The learning is largely self-directed, though guided through a series of learning events: on-line, in residential workshops, through experiential sessions (such as simulations and live press conferences) and through Self Managed Learning (SML) sets. Patients are at the heart of this programme and are present at the start, throughout the journey, and form part of the assessment of participants at the end. A unique aspect of this programme is the concept of SML, which emphasises peer review and challenge for participants. The learning sets have to agree that each individual learning contract is sufficiently ambitious and relevant. They will also assess the progress of the individual against these personal development goals, as well as the overall programme learning outcomes. Participants will ultimately decide whether the individual has attained the standard required to achieve the programme award (NHS Leadership Academy Award in Executive Leadership - Leading Care III). Six cohorts are currently on the programme with around 300 participants to date, with many more to follow.

More information can be found on the Leadership Academy web site. <http://www.leadershipacademy.nhs.uk/grow/professional-leadership-programmes/nye-bevan-programme/>

[d.c.davidson@bham.ac.uk](mailto:d.c.davidson@bham.ac.uk)

## Doctoral student achieves international recognition

Dr Ching Yuen Luk's research, **Health Insurance Reform in Shanghai and Hong Kong: Using the Lens of Historical Institutionalism** has been chosen, by the editorial team of Journal of Health Organization and Management, as a Highly Commended Award winner of the **2013 Emerald/EFMD Outstanding Doctoral Research Awards** in the Healthcare Management category.

Dr Yuk was supervised in her research by **Professor Martin Powell** of the Health Services Management Centre and by **Professor Peter Preston** of the Department of Political Science and International Studies at the University of Birmingham.

# Projects Update

## ESRC-funded projects

Catherine Needham is leading two ESRC-funded projects. The first, evaluating micro-enterprises in social care, now has its first publication, which is available as an HSMC Policy Paper (Social Care for Marginalised Communities: Balancing self-organisation, micro-provision and mainstream support, by Sarah Carr). The second, a Knowledge Exchange project on the Twenty-First Century Public Servant, has a project blog at <http://21stcenturypublicservant.wordpress.com/>. Do visit the blog and contribute to the discussion via the blog or the Twitter hashtag #21Cps. Catherine also has a new publication in Critical Social Policy, entitled 'Personalisation: from Day Centres to Community Hubs?'

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## Reducing emergency hospital admissions: a user and carer perspective

Pressures on acute care are currently intense, and there has long been a desire to rebalance the system away from hospital-based services towards care closer to home. However, the number of older people admitted to hospital on an emergency basis continues to rise. Part of the problem is that this is a multi-faceted issue, and only an equally wide-ranging response will suffice. As a result, HSMC has been commissioned by the Research for Patient Benefit programme to identify ways of reducing emergency admissions by understanding the perspectives of older people and their families and of front-line staff. Alongside a formal review of the literature, the study will work with three case study sites to explore scope for prevention from the perspective of older people as well as from different professional perspectives. The study is being conducted jointly with Prof David Oliver, the former National Clinical Director for Older People's Services and will result in national good practice guidance based on the lived experience of older people.

**j.glasby@bham.ac.uk**

## Aspiring Directors Leadership Programme for the West Midlands

HSMC and Manchester Business School, in conjunction with Hay Group have been awarded the contract to deliver the Aspiring Directors Leadership Programme for the West Midlands. Health Education England, West Midlands (HEEWM) are the commissioners and 50 participants started this 10 month programme in

March 2014. The usual mix of experiential learning, organisational consultancy and improvement projects will be enhanced this year with a more explicit focus on patients/service users. We look forward to welcoming the new participants to Yarnfield Conference Centre, and are delighted to be back running this programme once more.

**y.sawbridge@bham.ac.uk**

## Integrated care and chronic disease

From early 2014, Jon Glasby will be leading a five-year research project to evaluate interventions to support people with multiple long-term conditions. This is one of four substantive service areas within the new West Midlands Collaborations for Leadership in Applied Health Research and Care (CLAHRC), and a number of emerging service models in participating health economies will be evaluated and/or supported to develop the evidence base.

The CLAHRC represents a key partnership between HSMC and the University's Medical School, as well as between the Universities of Birmingham, Warwick and Keele.

**j.glasby@bham.ac.uk**

## Leadership programme for West Midlands GP mental health commissioning leads

HSMC has been chosen to deliver a leadership programme for the GP mental health commissioning leads in CCGs within the West Midlands and East of England. Procured by NHS England, this programme will support participants to develop their knowledge and understanding of the commissioning process and to act as local leaders for mental health services.

**r.s.miller@bham.ac.uk**

**k.newbigging@bham.ac.uk**

## Whole system leadership in a 'liberated' NHS

One of the key concerns expressed during the recent health reforms was that we could create a system lacking system leadership, and where all the incentives encouraged silo-based working. Against this background, HSMC has been asked to work with the Birmingham and Solihull Chief Executives' Forum to look at whether current service models are fit for purpose in an era of long-term conditions, and the potential role of the Forum in providing the whole system leadership required to make any necessary changes.

**j.glasby@bham.ac.uk**

## British medical tourists seeking treatment overseas without sufficient information and advice

This research was funded by the National Institute for Health Research Health Services and Delivery Research (NIHR HS&DR) Programme. A team of researchers (including Russell Mannion and Mark Exworthy from HSMC) has found that British people travelling abroad for medical treatment are often unaware of the potential health and financial consequences they could face and that this can, in some cases, have catastrophic effects for individual patients. The researchers recommend that more information and advice is provided to potential medical tourists. This, they say, needs to be packaged and disseminated so it will reach those who may not consult their GP or a specialist website before travelling.

The researchers found that decision-making around outward medical travel involves a range of information sources, with the internet and information by informal networks of friends and peers playing key roles. They concluded that medical tourists often pay more attention to 'soft' information rather than hard clinical information. They also found that there is little effective regulation of information – be it hard or soft – online or overseas.

Professor Mark Exworthy, who recently joined the University of Birmingham from Royal Holloway, University of London, said: "The rise of 'medical tourism' presents new opportunities and challenges in terms of treatment options for patients and health policymakers in all countries. This study helps clarify the scale and nature of these challenges for the UK. Whilst there remains much doubt about the extent and impact of medical tourism, it is likely that these issues will become more salient in the coming years."

**m.exworthy@bham.ac.uk**

## Healthtalkonline project: Service users and carers' experiences of ECT

This Research for Patient Benefit funded project examined qualitative accounts of having (or refusing) electroconvulsive therapy. The research was carried out by Laura Griffith and Bruce Gorrie. It is now nearing the end of its funding and drafts of the final website pages have now been written. The website, hosting video, audio and written accounts of people's experiences should be online July 2014.

**l.griffith@bham.ac.uk**

### Promoting integrated working

HSMC has been funded by the West Midlands Academic Health Science Network to develop an innovative training package to promote better integrated working between GP practices and adult social work teams. The project will last 12 months and will produce free training materials that can be adapted by local areas.

[r.s.miller@bham.ac.uk](mailto:r.s.miller@bham.ac.uk)

### Development of a culturally adapted weight management programme for children of Pakistani and Bangladeshi origin

Laura Griffith, Lecturer, HSMC, is co-researcher on this project which is lead by Miranda Pallan and funded by the HTA. During the three years of this project Laura will be supervising community researchers and advising on the analysis of focus group and interview data.

[l.griffith@bham.ac.uk](mailto:l.griffith@bham.ac.uk)

### SPCR funded project: Meeting the healthcare needs of recently arrived migrants to the UK - the perspectives of primary care providers

As co-researcher on this project Laura Griffith, Lecturer, HSMC, will interview and run focus groups with GPs, nurses and practice managers and reception staff, asking what they know about the rules stating who can access different types of healthcare (e.g. hospital treatment); whether there are particular barriers to migrant patients accessing primary care, what they believe the greatest problems are in communicating with patients. Charities working with migrants and NHS staff whose role it is to make the health service more equal will also be interviewed.

[l.griffith@bham.ac.uk](mailto:l.griffith@bham.ac.uk)

### Building better partnerships between academia and the NHS

Researchers at the University of Birmingham hope the findings of a newly published study will help academics and health care professionals work more closely together in the future.

The five-year Birmingham and the Black Country CLAHRC Theme 1 project set out to look at how NHS Trusts redesign services, and how these changes affect patients' experiences and clinical outcomes. In the process, researchers also looked at new ways of working together with managers and clinicians, in the three NHS Acute Trusts involved in the project.

The CLAHRC Programme, which stands for Collaborations for Leadership in Applied Health Research and Care, is funded by the National Institute for Health Research with matched funding from participating NHS organisations. The second phase of the programme was launched at the start of the year with HSMC's Professor Jon Glasby leading the Chronic Disease theme.

Read the full report – [CLAHRC Theme 1: Health Service Redesign](#)

### British Academy funded project: Health and Wellbeing in the era of superdiversity (health histories project)

Co-researchers: Laura Griffith, Antje Lindenmeyer and Jenny Phillimore. Based at the Institute of Research into Superdiversity (IRiS), the aim of this study is to pilot and develop an approach which can fill these gaps in knowledge. The proposed method involves the collection of narrative 'health history' data from 20 recently arrived migrants (between 18 months and 5 years of arrival to the UK) by community researchers. [l.griffith@bham.ac.uk](mailto:l.griffith@bham.ac.uk)

### Set to Care - Enhancing Compassionate Care in Practice: An Action Learning Approach

In view of the emerging findings from the Time to Care project, and the wider evidence which suggests that an organisational approach is required if compassionate care is to be provided (Dixon-Woods et al 2013, Jacobs et al 2013, Kitson et al 2013, King's Fund 2011), a programme of work centred on enabling staff teams to support each other in placing care back at the heart of practice has been developed. This research has been funded by Health Education West Midlands and will focus on nursing staff in two large organisations - an Acute Trust and a Community Trust - helping them to identify the best approach for them to implement a system of staff support, in recognition of the impact emotional labour can have on nurses. They will be supported to implement this by **Yvonne Sawbridge** and **Alistair Hewison** as co-researchers, and it will link with the Community of practice being established at HSMC to develop compassionate organisations. [y.sawbridge@bham.ac.uk](mailto:y.sawbridge@bham.ac.uk)

### Commissioning for Better Outcomes

The Care Bill, Better Care Fund (BCF), transfer of Public Health to local government and the comprehensive re-organisation of the National Health Service has renewed the focus on the importance of effective commissioning to improve the experience of social care users and their families. HSMC, in partnership with INLOGOV, at the University of Birmingham have been commissioned by the Local Government Association (LGA) to develop commissioning standards to support effective commissioning practice.

The aim of this work is to provide Local Authorities, and their partners, with a basis for improving commissioning practice in order to deliver better outcomes for people requiring social care. The standards are intended to support the implementation of the commissioning element of the Care Bill once it comes into force in 2015. The standards will provide a focus for sector led improvement developed by the LGA and Towards Excellence in Adult Social Care (TEASC). They will therefore support a local dynamic process of improvement in commissioning, and through self-assessment and peer review, challenge



"Elderly Care" by Mark Adkins on Flickr (CC BY-NC-SA 2.0)

commissioners, with their partners, to innovate and develop new ways of combining resources to support people requiring social care.

The work on the standards started in February and they are scheduled to be launched by the end of 2014 at a national event. The development process involves:

1. A literature review to identify good practice and the evidence base for effective commissioning;
2. Interviews with key stakeholders at a national level, to explore the main

dimensions of commissioning to support the ASCOF and Making it Real outcomes.

3. Seminars and webinars to develop the content for the framework through the facilitated use of scenarios on key commissioning challenges for social care (e.g. personalisation in the context of strategic commissioning; integrated commissioning, market shaping, decommissioning, commissioning to tackle inequalities etc.).
4. Testing the draft standards in eight - ten local health and care economies, selected for their diversity in terms of their demography and geography.

Oversight of the project is being steered through TLAP's National Market Development Forum. A Project Steering Group has been established, chaired by Bill Mumford, with a wide range of stakeholders, including people with care and support needs themselves.

#### Further information

Further information on the project is available from the project lead Dr Karen Newbigging [k.v.newbigging@bham.ac.uk](mailto:k.v.newbigging@bham.ac.uk). You can contribute by Twitter #outcomes4people and regular updates about the project will be posted on the LGA and ADASS sites.

## Events

### 'Turning the welfare state upside down?' Developing a new approach to adult social care

07 April 2014 (09:30-16:00)

HSMC, University of Birmingham

'Turning the welfare state upside down?' Developing a new approach to adult social care: A one-day workshop focusing on ways to build on social capital and community resources.

A provisional programme is available at: <http://www.ehma.org/index.php?q=node/1748> and the social programme at: <http://www.ehma.org/index.php?q=node/1834>

Bookings can be made on the online registration link at: [http://shop.bham.ac.uk/browse/extra\\_info.asp?compid=1&modid=2&deptid=34&catid=101&prodid=819](http://shop.bham.ac.uk/browse/extra_info.asp?compid=1&modid=2&deptid=34&catid=101&prodid=819)

and the wider voluntary sector shared their perspectives and insights on where housing associations as providers and landlords should fit into the developing vision for integrated care. Key speakers included: Paul Burstow MP, Former Care Minister and Chair of the Care Bill Committee; Shaun Gallagher, Director of Social Care Policy, Department of Health; Richard Humphries, Senior Fellow, Social Care, The Kings Fund.

### Developing a compassionate organisation: An Action Learning Set Approach: Day 3

02 June 2014 (09:00-16:30)

This is the third day in a series of four events. The format is a combination of expert input and facilitated learning sets to help people to put the evidence into practice in their own organisations.

### European Health Management Association (EHMA) Conference 2014: 24-26 June 2014

University of Birmingham



This prestigious event will be hosted by the Health Services Management Centre and held on the University of Birmingham campus as well as other venues in Birmingham City Centre.

### Some recent events:

#### Developing and supporting the role of Nurse board members in CCGs

Yvonne Sawbridge, HSMC Senior Fellow, lead a session on the skills and competences and role of Nurses in Clinical Commissioning Groups at an event entitled "Developing and supporting the role of nurse board members", chaired by Stacey McCann, Commissioning Lead - Nursing, NHS England. This one day national event was held at Austin Court, Birmingham on Thursday 20 March, looked at the importance of this new role of nurses on the CCG board and addressed current challenges facing them and offered the solutions and support these nurses need.

#### HSMC director, Jon Glasby, chaired the National Housing Federations Care Bill Conference: Simple steps to system change?

The conference provided the latest learning, expert advice and focused debate on the extent to which the Care Bill will give us the framework needed to make person-centred integrated care a reality. High profile speakers from across government, housing

This conference built on HSMC's previous work with the National Housing Federation, following which HSMC have published a **special edition on health, housing and social care** in the Journal of Integrated Care.

#### Integrated Healthcare - Interactive academic engagement with policy stakeholders: Knowledge Exchange Trials

The Health Services Management Centre hosted a knowledge transfer event with policy makers from the Department of Health in late February. The workshop aimed to raise awareness of the policy-making process, how research can influence policies and how academics can engage and collaborate with the 'user community' in policy and program development and implementation, for demonstrable impact. Speakers included: Ed Moses, Deputy Director, Strategic Partnerships, Public Health England, **Professor Jon Glasby**, Director, HSMC, John Garrett, Deputy Chief Executive, Sandwell Metropolitan Borough Council, Graham Beaumont, Chief Executive, Health Exchange CIC Limited.

### Commissioning for Mental Wellbeing

HSMC held a free seminar on commissioning for mental wellbeing in March which explored the current policy emphasis on prevention and improving the mental health of the whole population with input from Gregor Henderson, Director of Wellbeing and Mental Health for Public Health England. Drawing on work undertaken by Prof Chris Heginbotham and **Dr Karen Newbigging**, the seminar provided an opportunity for commissioners and their partners to identify what they can do to translate current aspirations of public mental health into tangible commissioning strategies. A book launch of the new title from Sage by Prof Heginbotham and **Dr Newbigging** entitled **Commissioning for Health and Wellbeing** followed the seminar.

### Selected publications:

#### HSMC professor raises concerns about the use of payment for performance schemes in health care

**Professor Russell Mannion** in a new article published in the International Journal of Health Policy and Management warns of the dangers of expanding payment for performance schemes in health care in the absence of a robust evidence base. He comments:

"Many countries are turning their attention to the use of explicit financial incentives to drive desired improvements in healthcare performance. However, we have only a weak evidence-base to inform policy in this area. The research challenge is to generate robust evidence on what financial incentives work, under what circumstances, for whom and with what intended and unintended consequences"

[r.mannion@bham.ac.uk](mailto:r.mannion@bham.ac.uk)

Mannion, R. (2014) Take the money and run: the challenges of designing and evaluating financial incentives in health care, International Journal of Health Policy and Management, Vol 2, first published online 5 February 2014.

#### HSMC contributes to Birmingham Policy Commission report Health Ageing in the 21st Century: the best is yet to come

As the Care Bill 2013/14 reaches its final stages in the House of Lords, a Birmingham Policy Commission report makes a series of recommendations for future policy, practice and research. Launched at the Houses of Parliament with the support of Baroness Cumberlege, Gisela Stuart MP and former Care Services Minister Paul Burstow, the Commission focused on ways in which people can thrive in older age and sought

to counter the common perception of an ageing society as a 'problem.' Chaired by Prof Steve Field, the Commission focused in particular on the experience of older people from black and minority ethnic communities, urging policy makers to "recognise and accommodate super-diversity" when planning services for an ageing population.

The report also found that some communities and faith groups draw on the huge contribution older people make to society and that "sharing this good practice presents a real opportunity for communities of all kinds". It also stressed the importance of drawing on relevant equalities and human rights legislation, with potential for a statutory Commissioner for Older People.

#### Download the full report

HSMC's **Professor Jon Glasby** was one of the Policy Commissioners and research for the report was undertaken by PhD students Sarah-Jane Fenton and Jennifer Lynch. [j.glasby@bham.ac.uk](mailto:j.glasby@bham.ac.uk)

#### Providing effective preventative services for older people

An article by HSMC's **Robin Miller** entitled 'Providing effective preventative services for older people' was recently published in 'The Guardian'. Robin writes:

"The potential to provide preventative services for older people has been promoted by the third sector as one of its unique selling points. This has been reflected in national policy on the basis that key characteristics commonly attributed to the sector suggest they have an advantage over public and private organisations. These include a connection within local communities, the trust that older people often place in their brand, and their willingness to work holistically and flexibly to achieve better outcomes for their beneficiaries.

There are many examples of third sector organisations successfully providing innovative preventative support that

are valued by older people and also by commissioners. But as with any such discussion it must be remembered that this is a diverse sector in terms of size, scope and organisational missions. Factors beyond the organisation will affect the impact it can make, in particular its relationship with the commissioners who provide an increasing proportion of their funding.

A study funded by the **NIHR School for Social Care Research** explored the perspectives of the two sectors in regards to preventative services for older people. In contrast with the tensions that are often described, it found that third sector organisations and their commissioners enjoyed positive relationships and had shared understandings of their respective roles which were largely met. Commissioners' priorities were preventing older people needing **social care** services in the future, while for third sector organisations the emphasis was on improved quality of life for individuals. But this difference was reconciled in practice... "  
[Read the full article in the Guardian](mailto:r.s.miller@bham.ac.uk)  
[r.s.miller@bham.ac.uk](mailto:r.s.miller@bham.ac.uk)

#### Building Better Health - Why Society Needs Joint Working Between Health, Housing and Social Care

HSMC's **Jon Glasby** and **Robin Miller** explore the relationship between health, housing and social care in this special edition of Journal of Integrated Care. With a balanced mix of case studies, research and expert viewpoints, the issue explores how the complex interaction of deprivation factors can and should be addressed through the collaboration of agencies.

This special issue, as well as an introductory video from Jon Glasby, can be accessed by visiting <http://www.emeraldinsight.com/tk/housing> - See more at: <http://www.emeraldgroupublishing.com/about/news/story.htm?id=5253#sthash.IsL64EkV.dpuf>



## People at HSMC

We are pleased to welcome Hayley Stevens who has joined HSMC as a member of the NHS Leadership Academy administrative team.



**Karen Newbigging** attended the 4th international WHO conference on service user and carer empowerment in mental health in Lille on January 31st

2014. The focus for the conference was to share good practice and discuss potential indicators to promote empowerment experiences for service users and carers in Europe. Karen, and fellow researcher Laura Able, presented the findings from their research into experiences and outcomes from statutory mental health advocacy in England.



On 1 January HSMC welcomed **Mark Exworthy** who joined HSMC as Professor of Health Policy & Management from Royal Holloway, University of

London where he was Course Director of the MSc 'Leadership and Management in Health'. He has previously held posts at Southampton University, London School of Economics (LSE), University College London (UCL) and Oxford Brookes University. He was a Harkness Fellow in health care policy, based at University of California-San Francisco (UCSF) (funded by the Commonwealth Fund of New York) and is currently a Visiting Professor at the University of California-San Francisco.

Prof Exworthy's research interests fall into 3 themes:

- (a) Governance and implementation relating to policies to tackle health inequalities and other social 'problems',
- (b) Professionals and managerialism in health care organisations (especially relating to management of clinical performance), and
- (c) Decentralisation in health care organisations including a focus on organisational autonomy and localism.

His research has been funded by the ESRC, NHS (Dept of Health and NIHR), Joseph Rowntree Foundation, NHS Confederation and the Commonwealth Fund of New York and he has been involved as PI or co-PI on research grants totalling £2.5m.

He has written 3 books and has authored 50 articles and advised NHS organisations, the Department of Health, NICE and the World Health Organisation among others.

### New HSMC Policy Papers:

#### Is integration or fragmentation the starting point to improve prevention? Policy Paper 17

This policy paper is based on a discussion paper which was commissioned by the Institute for Social Change at Manchester University as part of a series of Knowledge Exchange Trials workshops which brought together academics, policy makers and programme stakeholders to facilitate exchange of ideas, expertise and research.

The importance of health, social care and other sectors working together has been recognised for many decades by governments of all political persuasion. This is true within the current policy environment, in which integration has been proposed as the binding force to connect an increasingly diverse range of providers around individual patients and their families. This integration is being encouraged not only in respect of statutorily funded clinical, public health and social care services but also with other policy areas such as housing and leisure and other sectors (in particular the third sector).

Despite this continued belief in policy that integration will lead to a more preventative focus there is not a strong research base to support this view; however, accepting

the limitations of the evidence base, this Policy Paper looks at five key lessons which can still be drawn for national policy makers with responsibility for promoting integration and prevention.

Read the full [Policy Paper 17](#)

#### Social care for marginalised communities: understanding self-organisation for micro-provision Policy Paper 18

Although adult social care works with some of the most disadvantaged and marginalised people in society, for various reasons mainstream services don't always get it right for people. That's why there are different forms and sources of care and support developing outside the mainstream. HSMC is currently doing some Economic and Social Research Council-funded research on the difference micro-providers can make in adult social care and the team wanted to know more about how very small providers could meet the needs of people who can be marginalised in large, mainstream services. So we reviewed some of the UK research on how small, local community organisations are already working with BME people, LGB people, people from different faith communities and refugees and asylum seekers. The review has been published as [HSMC Policy Paper 18](#).

HSMC is now on Twitter! So, if you want to keep up to date with all of the latest news from across the Department, including upcoming events and research being undertaken at HSMC, then follow us at [@\\_HSMCentre](#)

### HSMC Viewpoint

Visit the new HSMC blog at <http://hsmcviewpoint.wordpress.com/> for regular commentary on health and social care issues and research. We are encouraging staff and friends of HSMC to write contributions. If you would be interested in writing a blog post contact Catherine Needham [c.needham.1@bham.ac.uk](mailto:c.needham.1@bham.ac.uk) or get in touch via Twitter [@DrCNeedham](#)



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