Focus on quality in the NHS

Editorial by Tim Freeman and Yvonne Sawbridge

Whatever view one takes over the content of the current Health and Social Care White Paper, it is fair to say that its passage to date could have been smoother. Only very rarely is legislation deliberately postponed at such a late stage to accommodate and deflect expressed concerns, as these are more usually addressed during earlier phases of drafting. Despite recent party political sabre-rattling the general direction of the reforms, at least in terms of increased quasi-marketisation of the NHS in England, is broadly consistent with English health policy since Alan Milburn's tenure as Health Secretary in the Blair administration. The scope and scale of the proposed changes has however provoked vocal opposition from a wide range of NHS interest groups, most notably from the BMA and RCN, and the wider public, and posed difficulties for the coalition government.

The listening exercise over the summer 2011 provided an opportunity for revisions to the timetable and content of the proposed legislation, including a dual role for MONITOR in promoting both collaboration and competition between service providers and a role for clinical senates in local commissioning, reflecting an attempt to accommodate familiar tensions between partnership / competition and the role of

clinicians in service planning. Interregnum notwithstanding, the speed with which transitional arrangements are being implemented ahead of legislation is unprecedented and raises important constitutional questions for a parliamentary democracy. The general direction remains clear: a re-configured commissioning landscape consisting of local consortia and a national Commissioning Board; increased opportunities for new providers to enter the quasi-market; and clinicians charged with financial responsibility on an area basis.

Given this turbulent policy environment, we argue that academics have an important role to play in informing debate and critically engaging with the service during transition, primarily through research and policy analysis - a position underwritten by the commitment to 'rigour and relevance' which guides all of our work. Consequently, this edition of the newsletter focuses on some of our recent and current research activity which we believe the service may find helpful in actively engaging with, and reorienting to, the emerging policy landscape.

Clearly, a major change to the commissioning environment during a time of economic crisis poses further profound questions of legitimacy and public confidence in relation to service decommissioning, an aspect of service planning that the NHS has always found difficult to address. Recent work by Robinson and colleagues mapped priority-setting activity across English PCTs and explored the operation of priority setting activities in a number of case study sites, and in this edition they derive lessons to guide the future development of priority-setting within the new commissioning configuration.

Similarly, Dickinson and colleagues are exploring the operation of clinical leadership within notionally hierarchical organisations with a view to further elaborating how best to support clinicians as they face tensions between their professional and corporate responsibilities, and provide an early assessment of promising developments. With regard to the interface between health and social care, Ellins and colleagues are drawing lessons for the safe and effective transfer of vulnerable patients between health and social care settings, drawing on an innovative patient-centred research methodology. Finally, Lynch and colleagues outline an evaluation of telemedicine services, an innovation with the potential to transform services, challenging current service delivery models.

Whatever the outcome of deliberations over the White Paper, staff at HSMC remain committed to the potential of insights drawn from empirical research to inform debate and sensitive policy implementation – and we will continue to be a critical friend to the NHS community at large.

t.freeman@bham.ac.uk
y.sawbridge@bham.ac.uk

Quality in the NHS

In the immortal words of Florence Nightingale "First do no harm." The NHS has a prime responsibility to commission and deliver good quality care to patients and service users. The Darzi report (2008) defined quality as having 3 components:

- Safety
- Effectiveness
- Patient experience.

HSMC has considerable expertise in supporting the NHS in this area through our teaching, research and consultancy (see, for example, Helen Dickinson's work on medical leadership (see page 3) and Jo Ellins' evaluation of discharge from the views of older people (see page 4).

A number of current work programmes are covered below, which highlight the breadth of the topic and provide a snapshot of how HSMC is working closely with the NHS and others to support improvements in practice.

References

Department of Health (2008) *High quality care for all.* London, TSO

Call to action - nursing think tank

A number of events over the past few years have raised concerns about care experiences, particularly for older/ vulnerable patients, in acute hospitals. Each time an inquiry is launched and action plans devised but further recurrences indicate that this is not enough to make sustainable improvements across the NHS. The University of Birmingham's Health Services Management Centre (HSMC) working with colleagues in the School of Health and Population Sciences will explore these issues further by seeking the views of senior nurses working in the NHS today. This is not a new field and there is already a considerable amount of research in this area. However the problems persist, indicating that the cycle of failure; inquiry; action plan has not been successful in addressing the issues. Therefore the focus of this work will be to identify solutions wherever possible.

The work is organised into three main phases. Firstly key stakeholders at local, regional and national level were consulted to ascertain their perspective on the current situation. Then a critical literature review was conducted to explore the existing knowledge base in relation to the dimensions of poor care. The findings from

these two phases were combined to develop an 'agenda' for a focus group involving Executive Nurses. The focus was on one branch of nursing only-Acute hospital nursing-although it is likely that some of the findings will be applicable to other care settings, and other healthcare professionals

This will result in the production of an HSMC Policy Paper in November. This paper and its recommendations will be distributed widely, including to the NHS Confederation Commission on Dignity, and the Robert Francis Inquiry into Mid Staffs Hospital.

y.sawbridge@bham.ac.uk

Patient safety and Board behaviour

The formal inquiry into the poor quality of care derived at Mid-Staffordshire Trust (see following personal perspective by Antony Sumara) continues to exercise minds – and raises questions over the ability of NHS Boards to effectively discharge their duty of governance in this regard. While there is no lack of guidance on best practice, the evidence base from which it is derived is comparatively weak. In order to further develop the evidence base, the SDO have commissioned a 3-year study on the governance of patient safety from Russell Mannion (PI) and Tim Freeman at HSMC, designed to investigate the link between board governance of patient safety and clinical outcomes. The study combines national clinical and board process data together with in-depth case study analysis, and will be undertaken in partnership with Dr. Foster and the University of St. Andrews. The research objectives are:

1. To identify the types of governance activities undertaken by hospital Trust Boards with regard to ensuring safe care in their organisation.
2. To assess the association between particular hospital Trust Board oversight activities and patient safety processes and clinical outcomes.
3. To identify the facilitators and barriers to developing effective hospital Trust Board governance of safe care.
4. To assess the impact of external commissioning arrangements and incentives on hospital Trust Board oversight of patient safety.

t.freeman@bham.ac.uk
r.mannion@bham.ac.uk

Measuring quality improvement – the international dimension

The importance of a supportive environment for continuous quality improvement is widely indicated within the literature, and there are a number of ways in which such cultures have been researched. An important distinction is that between quantitative approaches which seek to develop and validate measures of culture, and those which explore them qualitatively over time. While both may be used to inform development activities, the emphasis of the former is firmly on the validation of measurement indices - so that data on the 'climate' of quality improvement may be easily compared between departments, directorates and organisations. One such measure, the Clinical Governance Climate Questionnaire (CGCQ), was developed by Tim Freeman from HSMC using psychometric scaling techniques on data collected within provider agencies in the UK (Freeman, 2003). The measure was used in a series of studies by the National Audit Office (NAO) as part of its value for money assessments of clinical governance, findings reported in Parliament to the Public Accounts Committee. The original measure has subsequently been used internationally by research teams in Australia, Italy and Ireland in assessments of the clinical quality of healthcare systems, but until recently the validity of the instrument in contexts other than the UK has not been tested. The publication of a validation study of the measure by an independent team of academics from the University of Aristotle (Thessalonica) is therefore helpful, as they were able to replicate the factor structure and attest to the validity and reliability of the CGCQ within the Greek healthcare system (Karassavidou et al, 2011). This is a welcome development, as it supports international use of the measure and confirms its value in assessments of quality improvement activity.

t.freeman@bham.ac.uk

References

Freeman, T. (2003) Measuring progress in clinical governance: assessing the reliability and validity of Clinical Governance Climate Questionnaire, *Health Services Management Research*, Vol. 16, pp. 234-50.

Karassavidou, K., Glaveli, N., and Zafiropoulos, K. (2011) Assessing hospitals' readiness for clinical governance quality initiatives through organisational climate, *Journal of Health Organization and Management*, Vol. 25, pp. 214-40.

Models of medical leadership   **Helen Dickinson**

The NHS has historically been characterised as a professional bureaucracy in which doctors and other clinicians have a large measure of autonomy in organising their work. The early days of the NHS have been characterised as a time where hospital decisions were made by 'consensus management' between administrators and clinical staff (Merali, 2003). However, since the early 1980s and the introduction of general management there have been any number of accounts of tensions between doctors and managers. As such, the issue of medical engagement in leadership remains one of the major challenges of contemporary health care management.

Recent reforms to the NHS, building on the Griffiths Report of 1983, extending through the internal market in the 1990s to the Coalition government's recent reforms centred on clinician leadership have superimposed management and business structures and processes on autonomous professionals (Dickinson and Ham, 2008). The main organisational mechanism for management at the clinical level in hospitals in more recent years has been Clinical Directorates (CDs).

Although a number of studies of CDs have been conducted, there is little up to date information about the range and types of structures that exist or how they operate in practice. At the end of the 1990s a number of academic studies set out to examine these organisational forms and found that although the language of clinical engagement was present, in practice little had changed in terms of behaviours (e.g. McKee et al, 1999). In one such study Kitchener (1999) concluded that:

> *'The fact that some hospital doctors have accepted medical-manager roles within a more integrated formal structure should not...be conflated with either a loss of their professional autonomy or a replacement of key elements of the PB (professional bureaucracy) interpretive scheme' (p. 197).*

Not only is there a lack of up to date information about these organisational mechanisms, but more recent innovations such as service line reporting in Foundation Trusts hold the potential to change the dynamics of clinico-managerial relationships and organisational forms significantly. Therefore, we set out to investigate the relationships between doctors and the organisation of NHS Trusts.

This NHS SDO-funded project is led by Chris Ham and involves Helen Dickinson, Iain Snelling and Kerry Allen from HSMC and Professor Peter Spurgeon from University of Warwick. The research is reaching its final stages of data collection and is due to report in summer of 2012. So far the project has mapped current and emerging structures of medical engagement in management and leadership in English NHS Trusts through a survey. This phase of research was followed by nine case studies which are just in the process of being completed, and where Trusts have undergone more in depth study to explore behaviours and relationships around medical engagement in leadership. In the final stage of the project we will conduct exploratory work where we attempt to match up structures and behaviours of medical leadership with routinely collected performance data.

We anticipate that this research will fill a gap in current knowledge about the engagement of doctors in leadership roles by describing the arrangements adopted by NHS Trusts in England, and by providing evidence about the effectiveness of different arrangements. This will enable policy makers and practitioners to review and strengthen medical engagement in management and leadership roles and take

forward current NHS reforms. Already one of the themes emerging from this research project relates to how ready medical leadership structures of Trusts are to engage with the new clinical commissioning groups. Those who have stable and developed structures for engaging doctors in their Trust's leadership are also finding this helpful in forging relationships with GP commissioners which it is anticipated will pay dividends in shaping the future of the wider health care community.

h.e.dickinson@bham.ac.uk

References

Dickinson, H. and Ham, C. (2008) *Engaging doctors in leadership: review of the literature.* Warwick, NHS Institute for Innovation and Improvement.

Kitchener, M. (1999) 'All fur coat and no knickers: contemporary organisational change in United Kingdom hospitals'. In: Brock, D.M., Powell, M. and Hinings, C. (ed). *Restructuring the Professional Organisation.* London, Routledge.

McKee, L., Marnoch, G. and Dinnie, N. (1999) Medical managers: puppetmasters or puppets? Sources of power and influence in clinical directorates. In: Mark, A. and Dopson, S. (ed) *Organisational behaviour in health care: the research agenda.* Basingstoke, Macmillan Press Ltd; p.89-116.

Merali, F. (2003) NHS managers' views of their culture and public image: the implications for NHS reforms. *The International Journal of Public Sector Management*; 16(7):549-63.

Older people's experiences of care transitions

Jo Ellins

In recent years, there has been growing emphasis on understanding and improving the quality of healthcare as it is experienced by patients. Indeed, quality in the NHS is now commonly defined in terms of three domains of safety, effectiveness and experience. Researchers have at their disposal many different techniques for exploring people's experiences of illness and of receiving health services, ranging from large-scale surveys to individual testimonials. In a current project at HSMC, looking at older people's experiences of care transitions, the research team is using in-depth narrative interviews. In narrative approaches, participants are invited to tell the story of their experiences in any way they prefer rather than answer questions according to a pre-determined structure. This gives control to the 'storyteller' and can elicit richer and more complete accounts than other methods. A further important feature of the project is that it was carried out in partnership with more than 20 older people who acted as 'co-researchers'. We found that older people often enjoyed and were more comfortable being interviewed by a peer, somebody with whom they had a shared background or experience.

So what have we found out? The academic and co-researchers involved in the project carried out more than 100 interviews across four different sites in England, so it would be impossible to do justice to all of our findings in a newsletter piece. Instead I'll highlight one of the sites, which focused on the hospital and discharge experiences of older people from black and minority ethnic communities. One theme above all dominated people's accounts of their journeys through the healthcare system: the difficulties faced by those who spoke limited or no English. As one person told us:

"It's scary to go, to leave your home...And then suddenly, when you've got a language barrier, we can only say 'Thank you' and 'yes' or 'no'. And you don't know what you are saying to yes and what you are saying no to."

People with language barriers struggled to communicate with and understand staff, and this frequently prevented them from having any kind of involvement in their care, even in the most basic ways such as choosing their meals. Often hospital translators were not available at the time they were needed, so translation was carried out by other patients, kitchen and domestic staff or family members. Many patients were grateful for any help they received communicating with staff, but such arrangements were less than adequate when complex or sensitive issues needed to be discussed.

We found that the single biggest influence on people's experiences of being in hospital was the quality of the interpersonal care that they received. In other words, 'good' or 'bad' experiences were usually described by people in terms of how they, or their friends and families, had been treated by hospital staff. This is not to say that the technical quality of care wasn't important, but rather that the older people we spoke to seemed to take it as a given that their caregivers were clinically competent. Even small gestures by staff to connect with patients could make a big difference to people's sense of wellbeing and their ability to cope. This was illustrated by the following example, where a woman commented on how she felt just before she had to undergo a somewhat unpleasant procedure:

"The nurses was lovely nurses, there were four, five, you know. Smiling faces, and you feel like, thanks God. And you don't feel sorry for yourself, because they send you with a smile and that don't cost anything."

Help with personal care – such as washing and showering – emerged as being particularly important, as it enabled people to regain a sense of themselves and their dignity.

In terms of leaving hospital, patients and carers had very different emotions. While patients were generally very happy to be going home, carers experienced anxiety about how they would cope and where they would turn for support. Carers also felt excluded from decisions about discharge arrangements, and this made it difficult for them to plan in advance for the patient's return. The feeling that discharge was being 'sprung' on them was common for carers, as one person explained:

"It felt like the decision had been made – that Mum would be discharged at a certain point and it all seemed very abrupt when the decision is made. It's almost as if the care is taking place and the medical reviews are happening, but then suddenly someone has decided that the person is well...It's a shock to the family."

One of the main issues that patients reported was delays on the day of discharge, usually due to waits for transport and/or medicines. A problem with delays was that it could leave patients in a 'limbo' state – effectively they were stuck in a halfway point between hospital and home, unclear about who was responsible for them and their care at that time. It was during these limbo periods that slippages in care often happened, and sometime people felt they were being overlooked or neglected.

This is just a flavour of the findings from the research, but I hope they demonstrate the insights that can be derived from patients' experiences of healthcare and the important implications for quality improvement. The final report for the project is expected to be published in Spring 2012, so do keep an eye out for it on the HSMC website.

j.l.ellins@bham.ac.uk

The Research Team

Can telehealth improve quality through innovation

Jenny Lynch

Quality, Innovation, Productivity and Prevention (QIPP), the large scale transformational programme for the NHS, has grand aims of improving quality of care whilst making up to £20 billion in efficiency savings by 2014-15. NHS staff, patients and the voluntary sector have been engaged to implement and support the far-reaching changes with guidance from national workstreams.

Nothing exemplifies QIPP's eagerness for service change coupled with innovation and cost savings quite like telehealth. The Department of Health has been championing widespread adoption of telehealth technologies and services for the past 5 years. *Our Health, our care, our say: a new direction for community services* (DH, 2006) kick-started the debate on investment in preventative and community-based primary care at the expense of costly in-patient services and Lord Darzi's *NHS Next Stage Review* (DH, 2008) viewed the use of assistive technology and remote monitoring as a way of giving more control to patients and linked it directly to personal budgets for people with complex long-term conditions (LTCs).

Despite this governmental support, telehealth has had a slow start in the UK and this is largely due to the lack of an evidence base. There are reportedly only 5,000 users of telehealth[1] in the UK and most of these are on the Department of Health's Whole System Demonstrator (WSD) pilot programme (Clark and Goodwin, 2010). Uptake of the service is expected to surge after the publication of the results of the WSD project – believed to be the world's largest randomised controlled trial of telecare and telehealth, with more than 6,000 participants in three pilot sites and an investment of £31 million.

The backdrop of QIPP has provided further momentum for telehealth advocates with the launch of DALLAS. Delivering Assisted Living Lifestyles At Scale comprises an £18 million investment[2] over the next 4 years to show how new technologies and innovative services can help support independent living for older people and people living with long-term conditions. DALLAS is the final component to the

Assisted Living Innovation Platform (ALIP) which was launched by the Technology Strategy Board in 2007 to promote independent living by addressing the technological needs of future populations.

Whilst these national programmes bring publicity to the opportunities presented by telehealth, the QIPP agenda has enabled individual Primary Care Trusts to develop telehealth solutions to respond to local priorities and circumstances. The Long Term Conditions QIPP work stream focuses on access to high quality, local, community care and Sandwell PCT has recently completed a telehealth pilot for patients with Chronic Obstructive Pulmonary Disease (COPD), finding that patients were enthusiastic about carrying out their vital signs checks at home and had more positive contacts with the respiratory team as a result (Sultan, 2011).

The Right Care QIPP work stream has given rise to Sandwell's Right Care Right Here action plan, which has the express aim of ensuring that telehealth technologies are part of mainstream service delivery. However, this recent surge in activity around telehealth does not negate the need to tackle some reservations about developments in this service. While serious money is being invested in the development of an evidence base for telehealth, there are no simple answers to questions about the high 'up-front' costs of implementing telehealth on a large scale and whether proof of cost effectiveness will ever be agreed (Barlow et al, 2006).

Where telehealth has been implemented successfully, huge adjustments have been required by professionals and organisations, the acceptability of which is often determined by champions of the service. This is often not helped by issues relating to the quality of equipment available and the lack of interoperability between systems manufactured and supplied by competing companies.

Furthermore there are numerous ethical dilemmas, specifically around the fear that use of technology will de-personalise the care that patients get, reduce their interaction with NHS staff and thereby increase their chances of becoming socially isolated (Sorell and Draper, unpublished).

Work currently underway at HSMC aims to explore some of the challenges relating to the implementation of telehealth and telecare. In partnership with Sandwell PCT, Sandwell Metropolitan Borough Council and with co-

operation from MedilinkWM, Jennifer Lynch is carrying out doctoral research that focuses on developing an assessment and referral model for telecare and telehealth, with particular consideration of multi-agency working, patient experience and the ethical debates.

References

Barlow, J. et al (2006) 'Implementing complex innovations in fluid multi-stakeholder environments: Experience of Telecare', *Technovation*, 26(3): 396-406

Clark, M. and Goodwin, N. (2010) *Sustaining innovation in telehealth and telecare*, London, WSD Action Network.

Department of Health (2006) *Our health, our care, our say: a new direction for community services*. London, The Stationery Office.

Department of Health (2008) *NHS next stage review*. London, The Stationery Office.

Sorell, T. and Draper, H. (unpublished) Telecare, surveillance and the welfare state. *American Journal of Bioethics*

Sultan, H. (2011) *An evaluation of a telehealth pilot for patients with chronic obstructive pulmonary disease in Sandwell*, Poster at HSRN and SDO Network Annual Conference Delivering Better Health Services 7-8th June 2011, Liverpool.

j.lynch.1@bham.ac.uk

Notes
[1] Compared with 1.6 to 1.7 million users of telecare (Clark and Goodwin, 2010).
[2] With a further £5 million contribution from the Scottish Government and partners for a pilot in Scotland.

Looking back to the future: reflecting on the evaluation of healthcare reform   **Ross Millar**

Health service researchers always appear to live in interesting times as the system they study appears to be under almost continuous change. The reforms proposed by the Coalition Government are a case in point (Millar et al, 2011). Whilst the Health and Social Care Bill is likely to be revised as it goes through the legislative process, the overarching vision for the reform programme remains. It represents a controversial attempt at re-balancing a healthcare system that (according to the Coalition) was developed 'piecemeal' and became 'unwieldy' under New Labour. These new reform proposals are intended to be 'interconnected and mutually reinforcing' in providing 'levers' and 'incentives' that lead to improved outcomes (DH, 2010, p.12).

At HSMC, our experience of researching New Labour's reform programme suggests such a vision of reform put forward by the Coalition is unlikely to be achieved (Powell et al, 2011). As with the Coalition vision, New Labour also promoted a vision of 'interconnected and mutually supporting' reforms. This system reform programme presented four related streams (demand, supply, transactional and system management reforms) which were described as 'a coherent and mutually supporting set of reforms' which together provided levers and incentives to drive improvements (DH, 2005).

Our research, entitled *Comparative case studies of health reform in England*, carried out a case study analysis of six regions in England. The findings were based on a series of in-depth interviews carried out between 2008-2009 with a range of stakeholders including Board Directors, senior clinicians and service managers. The aim of this research was to understand how different policies with different characteristics interacted at local levels.

What we found was that despite the theory of New Labour's reforms being mutually supporting, for those 'on the ground' this was not the case. The theory about how the reforms worked was not clear. Furthermore, they did not interact as intended. They tended to assume 'one size

fits all' with little recognition that some contexts would be more receptive than others. For example, there was little recognition of the differences between acute and community care settings. There was limited and differential understanding and engagement from the 'street level bureaucrats' or those 'in the field' (Cabinet Office, 2007). This could be seen, to varying degree, in some differences between the perceptions of organisations (e.g. FTs and PCTs), managers and clinicians, and in levels of seniority.

Reflecting on our experience of the evaluation, it is clear that the implementation of the latest Coalition reforms is likely to come up against similar internal and external dynamics that will affect and challenge their vision as 'mutually supporting' levers and incentives. Implementation of reform is complex and contingent on a range of factors (see Powell et al, 2011). As a result, the need to understand the local dimension of delivery is important in three ways:

1. **Understanding the 'programme theory' of reform is important:**
   Simply linking all reform policies or streams to global outcomes, such as improved health, is insufficient. Greater and more specific analysis of the assumptions underpinning individual policies and streams is required. In addition, more attention needs to be paid to the interactions between the various reform policies as tensions are clearly evident (Millar et al, forthcoming).

2. **Understanding context is important**
   Much existing work tends to assume universalistic ideas about policy rather than seeing policy and its implementation as a contingent process. For example, policy tends to assume reform levers that work for acute, elective procedures will work for long term conditions. They also tend to assume levers can work in both urban and rural areas. Policy makers need to understand that healthcare systems are like complex and fragile ecosystems: changes to one area may trigger changes in other areas.

3. **Understanding implementation is important**
   Evidently, policy implementation is as important as policy formulation. 'Perfect implementation' is unlikely to occur, and

apparent 'implementation failure' is often linked to 'formulation failure'. On this basis, it is also important to be more receptive to views 'from the ground'. The main 'bottom-up' wish is to 'live in less interesting times'. While this may not always be possible, especially for institutions that are seen as not performing to expectations, it is clear that one factor contributing to the relative weakness of demand-side reforms was the organisational upheaval of PCT amalgamation after 2005. There is a need to refine policies and adapt them to changing contexts based on the feedback of those in charge of implementation.

r.s.millar@bham.ac.uk

References

Cabinet Office (2007) *Capability review of the Department of Health*, London: Cabinet Office.

Department of Health (2005) *Health reform in England: update and next steps*. London, The Stationery Office.

Department of Health (2010) *Equity and excellence: liberating the NHS*. London, The Stationery Office.

Millar, R., Snelling, I. and Brown, H. (2011) 'Liberating the NHS: orders of change?', *HSMC Policy Paper Number 11*, University of Birmingham.

Millar, R., Powell, M. and Dixon, A. (forthcoming) 'What was the programme theory of New Labour's Health System Reforms?', *Journal of Health Service Research and Policy*.

Powell, M., Millar, R., Mulla, A., Brown, H., Fewtrell, C., McLeod, H., Goodwin, N., Dixon, A. and Naylor, C. (2011) *Comparative case studies of health reform in England: final report*, Department of Health Policy Research Programme (PRP).

Postgraduate programmes

HSMC welcomed a new intake of students on 26 September 2011. The department delivers a number of UK-based Masters programmes as well as contributing to a number of interdepartmental programmes. These include:

1. MSc in Health Care Policy and Management, with an option to specialise in:
   · Quality and service improvement, and
   · Commissioning
2. MSc in Leadership for Health Services Improvement
3. MSc in Public Service Commissioning (with the Institute of Local Government).
4. MSc in Managing Partnerships in Health and Social Care (with the Institute of Local Government)

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

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

HSMC also runs a number of MScs in Healthcare Commissioning for both clinicians and managers, including:

■ A standalone MSc commissioned by NHS London, with an in-take per year (the third in-take started in October 2011). Over time, this programme has included more and more participants who are GPs and/or from a primary care development background
■ A standalone MSc and additional modules commissioned by NHS West Midlands
■ A broader MSc in Public Service Commissioning run jointly with the Institute of Local Government Studies.

In the longer run, HSMC is also working with colleagues in public health and primary care to develop additional commissioning support for clinical commissioning groups.
For further information contact Kate Vos email: **c.j.vos@bham.ac.uk**

NHS Management Training Scheme - Postgraduate Certificate in Leadership and Service Improvement.

MTS 2011 at their first Module of the PG Certificate in Leadership and Service Improvement taking place at Yarnfield Conference Centre in Stafford in September

HSMC, in partnership with University of Manchester has been commissioned by the NHS Institute to provide a Postgraduate Certificate in Leadership and Service Improvement for the NHS Management Training Scheme (MTS) which started in September 2011. The Certificate will provide a stand-alone qualification for all trainees on the Scheme and is also the first element of the General Management Masters programme in Leadership and Service Improvement. The four specialisms are General Management, Finance, HR and Health Informatics: although HSMC has worked with Manchester on MTS for many years, we have previously only worked with the General Management trainees. In the scheme, the King's Fund provide experiential learning, People Opportunities provide action learning and HSMC works with all providers to make sure the programme is co-ordinated.

The university education for the 2011 MTS was designed followed a tender exercise, and is significantly developed from previous versions. Specifically there is much more use of e-learning, both as a repository for materials but also as an interactive tool, and all the assessments are work-based, which will help trainees to apply their learning with academic rigour to their professional practice. The programme has never before included all trainees working in inter-professional groups. The high workloads of the trainees (many of whom will be doing their own professional qualifications as well as the postgraduate certificate) means that supporting them through their studies will be critical – and the changes that have been made are designed with this in mind.

The first module was a successful four day residential workshop for all 150 trainees. Subsequent learning events will be locally delivered in 5 locations around England – London, Manchester, Peterborough, Leeds and Bristol. The trainees work in group sizes of around 30, which allow for effective interactive teaching and the development of local learning networks and communities.

For further information about the programme please contact Tracey Gray at **t.gray@bham.ac.uk** or visit the NHS Institute Management Training Scheme website at **www.nhsleadtheway.co.uk** which provides details of the scheme for 2012.

National Leadership Council (NLC) Clinical Leadership Fellows

HSMC has also been commissioned, again in partnership with the University of Manchester, to provide the same Postgraduate Certificate as MTS for a new cohort of 60 clinical leadership fellows from November 2011. The first module for all fellows is at the end of January 2012, and there will be three regional groups after that.

The programme is broadly based on the programme provided for the NHS Management Training Scheme, although it will be adapted to suit the different needs of the NLC fellows, who are all experienced clinicians, and have identified work-based projects. HSMC will also be working closely with the King's Fund on this programme, as providers of both experiential learning and action learning.

For further information about the programme please contact Tracey Gray at **t.gray@bham.ac.uk**

Projects Update

INTERLINKS – modelling European long-term care systems

HSMC's Kerry Allen and Jon Glasby have helped launch the results of a 3-year EU project into long-term care and support for older people. With 15 partners across 13 countries and more than 40 researchers, 'Interlinks' explores ways of improving health and social services for older people, with a particular focus on:

- Prevention and rehabilitation
  www.birmingham.ac.uk/
  InterlinksPreventionRehabilitation
- Quality
  www.birmingham.ac.uk/InterlinksQuality
- Informal care
  www.birmingham.ac.uk/
  InterlinksInformalCare
- Governance and finance
  www.birmingham.ac.uk/
  InterlinksGovernanceFinance

In addition to a series of national reports and four European overviews, the main product is an **interactive website** http://interlinks.euro.centre.org/ of good practice examples from across Europe for policy makers, managers, practitioners and researchers to use when developing future policy and practice. **A key introductory** http://interlinks.euro.centre.org/sites/all/themes/interlinksTheme/templates/flash.php video sets out some of the key dilemmas that the project seeks to resolve.

The final launch of Interlinks took place in Austria in the autumn of 2011, with some 130 stakeholders from across 25 different countries.

Care Transitions project

HSMC's 'Care Transitions' project – exploring older people's experiences of transitions in care – is reaching a close. The project was funded by the NHS Service Delivery and Organisation R&D programme, and used a participatory approach. Academic researchers and older people acting as 'co-researchers' worked together to design, carry out and analyse in-depth interviews with patients and carers. The project focused on two particular types of transition: going into and leaving hospital, and receiving services for dementia for the first time. The findings cover a wide range of issues including the interpersonal aspects of care, communication and information, changing roles and relationships, social support and experiences of moving across service settings and boundaries. Currently the team are working with NHS and social care organisations in the project's four case study areas to explore the findings and identify their implications for services. The final report from the project is expected to be published in Spring 2012. See page 4 for more information.

j.l.ellins@bham.ac.uk

Local evidence on prevention services

HSMC have been commissioned by the NIHR School of Social Care Research to complete a one year study around local evidence of older people's prevention services. The study explores the prevention strategies used by Local Authorities and the evidence base around these. It seeks to build on what actually happens ('practice based evidence') and the local intelligence that has led to these strategies being adopted. The findings will be of interest to national and local policy makers as they decide how to best invest in such services in the future.

k.allen@bham.ac.uk

Integrated care

HSMC have been asked to advise the NHS Future Forum on their 'integration' workstream. As well as speaking to Forum members on the evidence base behind integrated care, HSMC have been asked to organise a one-day seminar for Forum members with a mix of research-based input and experience from local case study sites. HSMC are also linking with the social care White Paper team around the topic of health and social care integration. This policy advice builds on HSMC's Partnerships, collaboration and integration workstream:
www.birmingham.ac.uk/schools/social-policy/departments/health-services-management-centre/work/partnerships-collaboration-integration.aspx

j.glasby@bham.ac.uk

Medical Leaders in Practice

HSMC together with Manchester Business School have been commissioned by the North West Deanery to deliver a leadership development 'primer' to 150 specialist registrars. Divided into six cohorts, and over a period of 2-3 months, participants will attend 2 days of developmental and educational activities and attend 2 action learning set days, supplemented by resources and activities linked to Manchester's virtual learning system. The programme will include accreditation through a 15 credit work-based learning module.

i.n.snelling@bham.ac.uk

Social care and third sector review

HSMC have been commissioned by the School for Social Care Research to conduct a literature review in partnership with the Third Sector Research Centre. This review seeks to provide an exploration of the academic, policy and practice literature to establish the existing state of knowledge in terms of the role of the third sector in delivering social care, and identify the research agenda in this area going forward. This project should report by the end of the year and will be important in defining the research agenda in this area as well as providing helpful practical accounts of the literature.

h.e.dickinson@bham.ac.uk

Evaluating community health service provision in South Birmingham

NHS South Birmingham has commissioned HSMC to undertake an evaluation of its community health service provision. This will entail looking at the three components of the model – the rapid response service, the integrated multi-disciplinary teams and the self-care (SC) element of the model. The purpose of this work is to provide the evidence required for NHSSB to reach a decision on whether to continue to commission community health services using the current model of service developed in South Birmingham; and to provide recommendations for improvements or change, where actual practice differs from specified services.

Clearly this will require good links with the Clinical Commissioning Groups, as well as acute providers in other areas of Birmingham to ensure that the overall recommendations take account of other historical and on-going work.

d.c.davidson@bham.ac.uk

Action Learning Sets/Seminars for Human Resource (HR) and Organisation Development (OD) leads

HSMC is looking to set up a series of action learning sets or seminars for HR and OD leads in health and social care, in 2012. There is little opportunity for these senior staff to come together with others and share experiences, learning, and problems as well as receive support and ideas for challenges faced. Sessions will be co-designed so that they may be tailored to meet members learning and development needs.

d.c.davidson@bham.ac.uk

Events

Joint commissioning project:

HSMC are nearing the end of their research project investigating joint commissioning between health and social care organisations. This NHS SDO funded project seeks to explore the relationships between the practices, processes and outcomes of joint commissioning. The research team have nearly completed their 5 in-depth case studies of different types of commissioning arrangements in different localities of England. The final project report should appear in late Spring 2012.

h.e.dickinson@bham.ac.uk

Models of medical leadership

HSMC are nearing the end of their research project investigating models of medical leadership in English NHS Trusts. This NHS SDO project is being conducted in partnership with Professor Peter Spurgeon at the University of Warwick and is investigating how medical leadership is structured and operated in practice. The project is just completing data collection with 9 case study sites and has also conducted a national survey into medical leadership. The project should report late next Spring and should provide an up to date account of the state of play in terms of medical leadership in English NHS Trusts. See page 3 for more information.

h.e.dickinson@bham.ac.uk

Personalisation

Working with the Centre for Welfare Reform, HSMC have published a series of policy papers on the implications of the personalisation agenda in adult social care for broader welfare reform. Current papers in the series focus on the implications for health care, for community development, for disabled children and for criminal justice.

j.glasby@bham.ac.uk

NHS West Midlands Aspiring Programme

The NHS West Midlands have commissioned a leadership programme from HSMC in partnership with Manchester Business School, for a number of years. They have now commissioned a new programme building upon the success of these, but tailored to meet the needs of leaders in Clinical Commissioning Consortia as well as those working in NHS organisations currently. Its new name is "The Aspiring Programme" and it has attracted considerably more applicants than places. NHS West Midlands have selected 44 participants who have now completed the first module of this programme which commenced on 17 October. Key themes include:

- Management and leadership theory and practice
- Leadership impact and performance
- Organisational strategy and development
- Working with the policy context i.e. managing in transition; QIPP and integrated system plans.

HSMC warmly welcomes the new cohorts and looks forward to working with them over the next few months.

Programme Manager and Course Tutor: Yvonne Sawbridge
y.sawbridge@bham.ac.uk

Ground-breaking Integrated Care Development Programme gets underway

The Health Services Management Centre in conjunction with Finnamore Ltd (financial and business planning consultants), was commissioned earlier this year by NHS West Midlands and ADASS West Midlands to deliver a fast-track development programme for multi-disciplinary teams from GP commissioning, community health and adult social care/children's services.

The central theme of the Integrated Care Development Programme, which commenced this September and runs until next February, is to equip participants to jointly plan and implement a QIPP/efficiency savings business case, which delivers integrated care and better outcomes for service users, whilst releasing significant efficiency savings. The programme combines the use of evidence about what works with the development of essential skills required to deliver service change across organisational boundaries, as well as ensuring that participants receive personal development opportunities.

Seven teams have been accepted onto the programme - the composition of which varies widely covering both commissioner and provider roles, and practitioners, clinicians and managers. Teams are working on projects which include: community intervention services, frail elderly services, child and adolescent mental health transitions, integrated locality community teams, early intervention for people with dementia and delayed hospital discharges. It is anticipated therefore that the programme will also help to forge strong and sustainable collaborative working relationships across health and adult social care/children's services across the region.

h.i.brown@bham.ac.uk

Altogether now? The future of joint commissioning in Birmingham

As debates continue around the Health and Social Care Bill, policy continues to stress the importance of joint working in general and of joint commissioning in particular. As clinical commissioning consortia are set up and authorised, there is an expectation that they will demonstrate significant engagement with the local authority and that existing good practice around joint working will continue. Against this background, Birmingham's Health and Well-being Board is running three half-day workshops to explore the nature, challenges, opportunities and future of joint commissioning between health and social care. The programme includes:

- Learning from joint commissioning in Birmingham to date
- Joint commissioning at micro-level - the implications of direct payments and personal budgets
- What this means for Birmingham - joint commissioning in an era of clinical commissioning (exploring opportunities for aligning budgets and staff more fully at clinical consortia level).

For further information on the above please contact Ann Thomas:
a.d.thomas@bham.ac.uk

People at HSMC

We welcome Emma Pender who has recently joined HSMC as Post Award Administrator to support funded HSMC research projects and Lauren Evans who has joined HSMC's PG/MTS administration team.

HSMC Academics debate the nature of Ambiguity in Policy at ECPR's 6th General Conference in Reykjavik

Reykjavik, Iceland formed the beautiful backdrop to a stimulating and innovative debate about the nature of ambiguity in policy at the 6th European Consortium for Political Research, General Conference in August 2011. The panel entitled: "Using Critical Approaches to Make Sense of Ambiguity in Public Policy" was chaired by HSMC academic **Dr Tim Freeman** and co-chaired by HSMC Research Fellow, **Alyson Nicholds**.   It was proposed in response to Alyson Nicholds' recent Doctoral research which explores the value of interpretive and critical approaches to making sense of ambiguity in urban policy outcomes and sought to act as a platform to showcase HSMC colleagues' work to develop alternative approaches to policy analysis in the face of persistent socio-economic problems.   The panel was accepted as part of a larger conference 'section' exploring the recent 'interpretive turn' away from traditional policy analysis with its 'instrumental, a-theoretical, technocratic character' towards a broader 'argumentative turn' which accounts for the broader context in which policymaking takes place and the wide range of actors involved. Building on established work around partnerships in Health and Social Care, HSMC's **Dr Helen Dickinson** kicked off the debate with a presentation of her recent work with Professor Helen Sullivan to explore the symbolic nature of partnerships through a 'cultural performance' lens. **Dr Ross Millar** (HSMC) presented a co-authored paper, with HSMC Senior Fellow **Robin Miller** and Research Fellow, **Kelly Hall**, involving a unique 'narrative analysis' of staff involved in

becoming a social enterprise following the introduction of the NHS' 'Right to Request' policy. Dr Tim Freeman (HSMC) explored the leadership identity of an MTS trainee through a dialogic, cultural performance lens. Drawing on her recent empirical research with over 50 UK regeneration specialists, Alyson Nicholds (HSMC) highlighted the value of critical approaches in surfacing the contradictions and tensions in urban policy outcomes. Katharina Paul presented a co-authored paper with Roland Bal (Erasmus University, Rotterdam) to explore the framing of organ donation as a matter of governance. Following the panel presentations, all 5 paper givers responded to questions from a range of academics from across Europe, all steeped in interpretive and critical policy analysis.

New role for HSMC professor

Professor Russell Mannion has been appointed to the Commissioning Board of the National Institute for Health Research Health Services and Delivery Research (HSandDR) programme. The newly formed programme will replace the SDO and HSR programmes from January, 2012. The HSandDR programme will have two main work streams – one on health services research (HSR) and one on healthcare delivery research (HDR). The former will focus on research into the quality, appropriateness, effectiveness, equity and patient experience of health services. The

latter will focus on evaluating models of service organisation, delivery, and interventions, which have the potential to improve service effectiveness, efficiency and productivity. In keeping with the existing programmes, the audiences for this research will be the public, service users, clinicians and managers. The budget of the new programme will be the total of the two existing programmes at £16m per year.

Hong Kong

Professor Russell Mannion gave an invited plenary (with Professor Jeffrey Braithwaite) - "New Data illuminating culture change: a story of two health systems at either end of the world" - at the International Society for Quality in Health Care conference held in Hong Kong in September. He also presented a one day workshop on Organisational Culture and Health Care Quality at the Conference.

HSMC down under

Professor Russell Mannion presented a keynote address "Measuring hospital quality and performance: salutary lessons from the UK NHS" at the Great Healthcare Challenge: achieving patient centered outcomes conference held in Melbourne. He also presented a one day workshop (with Professor Jeffrey Braithwaite) on Organisational Culture and Healthcare Quality and participating in a Breakfast with the Experts session and plenary debate at the conference.

Dr Helen Dickinson and **Dr Suzanne Robinson** were also contributors at the conference presenting their recent work on leadership and health care. Helen's session was entitled "Medical leadership: a survey of structures in English Trusts", whilst Suzanne's session focussed on "resource scarcity and priority setting: the role of leadership in the rationing of health care." The conference is the largest annual health care meeting in Australia and attracts over 800 delegates. Following the Melbourne conference, Russell travelled to New Zealand where he had been invited to present a series of lectures in the Faculty of Medicine, University of Auckland. Suzanne travelled on to Sydney to present the findings from a recent study "setting priorities in health: a study of English Primary Care Trusts" at the Australian Institute of Health Innovation, University of New South Wales.

Details of the conference in Melbourne can be accessed from the following link: **www.healthcollab.org.au/**

A personal perspective on Mid-Staffordshire NHS Foundation Trust Inquiry into Patient Safety   Antony Sumara

Following a two year secondment to Mid-Staffs NHSFT I am now housed at HSMC doing a piece of work to understand why such appalling failure was allowed to happen.

Remarkably, the further you go from Stafford, the less is known about what happened there, and the more people feel it was exaggerated. There is no doubt in my mind that there was significant, serial, appalling and repetitious harm to patients. For those who still feel unsure please read the Robert Francis Inquiry report into Mid-Staffordshire NHS Foundation Trust, 24th February 2010 Vol. 2. Even recently former bosses appearing at the Public Inquiry into the failure of regulation at the hospital, while giving evidence said the events had been over stated. They are wrong.

My current task is in 3 parts;

First, to reflect on what I found when I arrived and to put this in the context of organisational failure in the wider public sector. Hopefully to understand what happened.

Secondly, to understand what works and what doesn't when trying to "fix" organisational failure. This might take the form of developing some tools that could be applied to failure.

Finally, I will want to "kick some tyres". That is to develop the learning into practical things that are helpful to leaders and they can readily use. Too often the development of improvement tools can take years. Patient harm and safety lives in a world where time is a very limited resource. I will also offer to help leaders use the tools.

Maybe the real exam question is, "How can you be sure it's not happening in your organisation?"

The current Public Inquiry into Mid-Staffs is another in a long line of Inquiries into NHS (Ely, Bristol, Epsom etc). All have recommended similar actions. The NHS has not taken them up and patients continue to be harmed. When the Inquiry into Shipman concluded that GPs should be subject to revalidation I am sure no one expected it to take 5 years to implement a system. Patients can't wait.

antonysumara@mac.com

Selected recent publications

Setting priorities in health:
A study of English primary care trusts

Colleagues at HSMC and the Nuffield Trust recently reported findings from one of the most extensive reviews into how PCTs in England have undertaken priority setting, wanting to distil lessons for the future when increasingly difficult choices will have to be made about what to fund (or not).

The report from this work *Setting priorities in health: a study of English primary care trusts*, examines how PCTs make decisions about funding priorities. Alongside the report the Nuffield Trust has published a related policy briefing on the implications for current reform proposals: *Setting priorities in health: the challenge for clinical commissioning*.

One of the most striking messages from the study was that PCTs focused much of their priority-setting activity on new and marginal spending, such as how to invest additional resources, or whether new and emerging treatments should be approved for funding. What was much less in evidence was a focus on the core resources available to the PCT and how these should be used to meet the full range of local health needs.

Another concern was that disinvestment was rarely tackled as part of PCT priority setting, despite formal recognition of its importance. And even when disinvestment decisions were agreed, they were often difficult to implement in practice, especially in relation to changes to secondary care.

Findings from this work have been discussed in a number of academic and practitioner based publications, including:

- Beavers, N. (2011) Setting priorities in health. *Primary Care Today*. (online) Available at: www.primarycaretoday.co.uk/?pid=4216andlsid=4216andedname=29676.htmandped=29676 (Accessed 12 October 2011)

- Tasker, F. (2011) Commissioners struggle to cut back on services. *BMJ*, (343): d5961

- Health Canal (2011) NHS commissioners admit to more weaknesses than strengths when it comes to setting priorities. Health Canal. 16/09/2011 (online) Available at: www.healthcanal.com/public-health-safety/20842-NHS-commissioners-admit-more-weaknesses-than-strengths-when-comes-setting-priorities.html (Accessed 12 October 2011)

- Pulse Magazine (2011) Commissioners failing to make 'difficult' disinvestment decisions. Pulse Magazine. September 16 Sep 2011

- Stephenson, J. (2011), CCGs setting spending priorities urged to 'be brave'. Health Service Journal, 121 (6274): 13

- Smith, J. (2011) Health and efficiency: from PCT to CCG, *Public Finance* , 15 September

- Dickinson, H. Freeman, T., Williams, I., Robinson, S. (2011) Resource scarcity and priority-setting: from management to leadership in the rationing of health care?, *Public Money and Management*, 31(5): 363-370

- Robinson, S., Dickinson, H., Freeman, T. and Williams, I. (2011) Disinvestment in health: the challenges facing general practitioner (GP) commissioners, *Public Money and Management*, 31(2): 145-8

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

New Books

Kellet, M. (2011) *Children's perspectives on integrated services*. Basingstoke, Palgrave Macmillan (series editor, Jon Glasby).
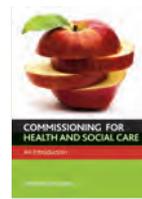
Glasby, J. (ed) (2012) *Commissioning for health and social care*. Bristol, The Policy Press (forthcoming) The book is available for order at 20% discount on The Policy Press website: **www.policypress.co.uk/ display.asp?K=9781847427922**

Exworthy, M., Peckham, S., Powell, M. and Hann, A. (Eds) (2011) Shaping Health Policy. Bristol, The Policy Press.

Robinson, S. (2011) Financing healthcare: funding systems and healthcare costs. In Walshe, K. and Smith, J. (Eds) *Healthcare Management* (2nd Ed) Maidenhead. Open University Press, pp 37-64

Williams, I. (2011) Allocating resources for healthcare: setting and managing priorities. In Walshe, K. and Smith, J. (Eds) *Healthcare Management* (2nd Ed) Maidenhead. Open University Press, pp 65-81.

Dickinson, H. and Glasby, J. (2011) Social care. In Walshe, K. and Smith, J. (Eds) *Healthcare Management* (2nd Ed) Maidenhead. Open University Press, pp 259-274.

McIver, S. (2011) User perspectives and involvement. In Walshe, K. and Smith, J. (Eds) *Healthcare Management* (2nd Ed) Maidenhead. Open University Press, pp 356-376.

Braithwaite, J and Mannion, R. (2011) Managing change. In Walshe, K. and Smith, J. (Eds) *Healthcare Management* (2nd Ed) Maidenhead. Open University Press, pp 429-453.

Dickinson, H. and Sullivan, H. (2011) Managing strategic collaboration. In Walshe, K. and Smith, J. (Eds) *Healthcare Management* (2nd Ed) Maidenhead. Open University Press, pp*538-557.*