

Newsletter

Celebrating 40 years of HSMC

Editorial by Professor Jon Glasby

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On 1 September 2012, HSMC celebrates 40 years! As is often the case, such a birthday is an opportunity to look back at our past, but also to take stock of where the NHS is now and what the future may hold – particularly in a difficult policy and financial context. We will be celebrating throughout the year in various ways, so please keep in touch with us via www.hsmc.bham.ac.uk. However, two of the highlights include our 2012 annual health policy lecture (which will be given by one of our honorary members of staff, Sir David Nicholson) and the launch of the 'HSMC 40' website (with photos and memories from people who have worked with us and for us over the years).

In this newsletter, we have asked each of the former Directors of HSMC to reflect on the key challenges facing the NHS during their tenure and some of the ways in which HSMC responded at the time. Later in the year, a second newsletter by current staff will look at the way in which we're working with similar issues now and what they might mean for the future. Reading the contributions of my predecessors has felt very privileged – but the similarities between then and now feel uncannily strong. Several of the articles touch on issues such as the use of markets, the importance of medical leadership or the need to develop more integrated care which mirror exactly those taking place in 2012. Citing Hegel, George Bernard Shaw is quoted as saying that the only thing we learn from history is that no one ever learns anything from history – and the need for organisational memory seems as strong now as ever. While there is much good practice to learn from other sectors and other systems, we can also learn from what has gone before – and we hope this collection of think pieces is a helpful contribution to current debates as well as an opportunity for us to celebrate our past.

To find out more about our 40th anniversary, please visit www.hsmc.bham.ac.uk or email Sue Alleyne: s.e.alleyne@bham.ac.uk



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CELEBRATING
40 YEARS
HEALTH SERVICES MANAGEMENT CENTRE

HSMC as a 'reorganisation child'



Derek Williams

(founding HSMC Director, 1972 - 1986)

The Health Services Management Centre of the University of Birmingham was formed in October 1972 with an initial teaching staff of five. As children were sometimes referred to as 'wartime babies' often to explain some quirk in their physical or mental make-up, so the Health Services Management Centre was a 'reorganisation' child. Within a month of its establishment it began the first of a series of courses to explain the impending major reorganization of the NHS (planned for April 1974) to groups of senior personnel from all parts of the service: Medical Officers of Health and nursing officers from local authorities; administrators, nurses and others from the hospital; and family practitioner services. The challenge of presenting these courses at such short notice and helping in other ways to meet the shifting training needs of the reorganisation had a powerful influence upon the Centre and the thinking of its staff. Paradoxically, the Centre was also established and its early training programmes designed within the framework of some traditional assumptions about what should be taught, when, where, by whom and for whom. Historically, the NHS had tried to meet its management development and training needs primarily through the provision of a hierarchy of relatively short (up to six weeks) multiprofessional courses in management for officers in mid-career: there was no real equivalent to the investment made in the USA, for example, in postgraduate education to Master's Degree level for aspiring administrators. In 1972 these assumptions about the content, membership and purpose of the NHS management development programme had not been seriously questioned. HSMC was, therefore, in the position of having a radical father, committed to root and branch reform of the health care

management system within two years; and a conservative mother, holding the old values and methods, willing to consider change if tested and introduced cautiously and gradually. Mother and Father could live together amicably only because they shared one common belief: that the body of knowledge and influence represented by the word 'management' contained the answers to many of the problems of the NHS. Management change, management education and training, management research and management consultancy could all offer ways of increasing the effectiveness of the service. Accordingly the new unit became the Health Services **Management** Centre and its initial teaching staff were selected from disciplines traditionally associated with management matters: an organization theorist, a social psychologist, specialists in personnel management and operations research and a planning theorist.

As the Centre grew, some salient features of the Centre's work were as follows:

i. Post experience teaching

The multidisciplinary teaching team included organization and behavioural theorists, a specialist in planning and information, a health economist and an accountant. Courses varied in length from two days to six weeks and attracted senior administrators, nurses, medical and dental staff and other who exercised a significant influence on the affairs of the NHS. Specialist courses were also provided for trainee community physicians and administrators. The Centre was experimenting with novel forms of management development and approximately one third of its post experience teaching effort was made within health authorities themselves.

ii. Postgraduate teaching

The Centre co-operated with the Institute of Local Government Studies in postgraduate courses and research specialising in policy making and management in local government and the National Health Service. A 'Fellowship Scheme' enabled young administrators and nurses to be seconded to the Centre to take a Master's degree while researching a topic of interest to them and importance to the Service. John Clark, who later became Director of HSMC, was one participant in this scheme.

iii. Research

The research activities of the Centre were concerned primarily with problems of health service planning and resource allocation; management systems and roles in the NHS; methods of reviewing the effectiveness and efficiency of clinical practice; and the economics of NHS policy decisions. DHSS funded three major research projects: an investigation of the role of the Regional Health Authority in the NHS planning system; a study of alternative methods of development for managers; and the development of methods of comparing routine specialty, hospital and health authority information using micro-computers. The last of these projects led to a contract to service the fourteen English Regional Health Authorities. A number of the Centre's research interests, particularly in the health economics field, were developed in co-operation with departments in the Faculty of Medicine and Dentistry.

iv. Consultancy

HSMC began to receive an increasing number of requests from health authorities for help in solving operational problems and developed a consultancy

service offered primarily to NHS authorities in the Oxford, South Western and West Midland Regions.

v. International activities

The Centre had a particular interest in helping to meet the challenges of health care management in developing countries. HSMC staff regularly undertook assignments in Europe and Asia on behalf of the World Health Organisation and other international bodies and the Centre provided a growing number of study fellowships for overseas health care managers and policy makers. From 1984 the Centre took responsibility for the International Hospital Federation's annual ten week course for senior hospital and health service managers. Dr Don White, who came to HSMC from the DHSS, took the lead in these overseas activities.

[Looking back, our biggest achievement was to think about management in a new way]. In the early days the service wasn't really managed at all – it was administered by professional administrators who were willing to concede to almost wholly independent groups of clinicians all the major decisions about how the health service should develop. Inviting people to think beyond that towards a more creative form of management was one of the challenges.

[Part of the way we responded was by introducing new ideas and by breaking down boundaries]. Both Mike Drummond's thinking about cost benefit analysis and John Yates' thinking about performance (see pp. 4 of this newsletter) were wholly new concepts. One of the things we did well was that we created an open community.

The National Association of Health Authorities – which became the NHS Confederation – came and worked in the Centre for many years... and it did us good to have them in the building. We were also happy to provide a base for John Yates, who wanted to develop his own – at that time perceived to be rather eccentric – ideas about clinical performance. That way we undermined some of the traditional assumptions about academic boundaries – and that was a good thing.

This article has been written from original notes and papers by Derek in the 1970s and early 1980s, supplemented by an interview with current HSMC Director, Jon Glasby, in early 2012. All the text is from Derek's original papers or the interview – with only the tense changed in a small number of places.

Markets and competition



Mike Drummond

Professor of Health Economics, University of York and Director of the Centre for Health Economics (1995-2005)

Although I'd worked at HSMC since 1979, my period as Director (1986 -1990) coincided with the second half of the Thatcher era and growing debates about competition in the public sector and the internal market in healthcare. However, not only did the NHS witness major reform. HSMC itself also had to find ways of responding to very rapid changes. Prior to this time, the majority of our management teaching had been funded by a core Department of Health/DHSS grant. This formed a large chunk of our budget and enabled us to provide a range of short courses at a heavily reduced rate. In addition, the financial stability left us free to pursue more traditional academic activities in teaching and research.

However, under the new NHS Training Authority, our previous grant gave way to a series of contracts – and our annual income declined sharply. I remember attending a meeting in Bristol where I was told the outcome of the first round of contracting. At a stroke the Centre's income had roughly halved. We therefore had to find very rapid and dramatic ways of responding, and introduced a new system where staff were given an annual individual income target to meet from a mix of research, teaching and consultancy. Almost overnight this placed staff, the majority of whom had been used to stable funding, into a more competitive and challenging environment, where we needed to be entrepreneurial, flexible and fully relevant to current NHS concerns. Although this led to a number of positives

over time, making the initial transition was very difficult – and the dilemmas we faced at HSMC seemed to mirror the changes the NHS was going through as it moved into the internal market. Like the providers in the NHS, this process made us think about our role and the unique contribution we could make. As we debated the future, it seemed as if HSMC was partly an academic department, partly a private consultancy and partly an NHS staff college – and with hindsight this might be the origins of HSMC's current commitment to both 'rigour and relevance'.

Because of these changes, much of our time was spent on internal changes and on keeping ourselves fit for purpose in a rapidly changing policy context. However, during

my four years as Director there are at least two highlights that stand out:

1. The first is the work of Peter Spurgeon (featured later in this newsletter) whose background in organizational psychology gave him and us a distinctive edge as the NHS developed new approaches to selecting and training general managers. Although this is often taken for granted now, at the time it was a key contribution.
2. The second is the work of the Inter-Authority Comparisons Consultancy (IACC) – an independently-funded group

of colleagues led by Professor John Yates based at HSMC, working with large-scale data sets (see below for further details). Again, IACC's commitment to collecting and working with routine data to analyse performance and root out poor practice is commonplace now – with the NHS Information Centre, Dr Foster and others. However, at the time, their work was groundbreaking and crucial – and has provided a key resource for NHS organisations keen to make better use of the data they collect.

Over time, the new staff that came to HSMC were attracted by what's now termed the commitment to 'rigour and relevance' – and Chris Ham (see later in this newsletter) was a good example of someone who could perform at both ends of this spectrum. Like all changes, however, this was a difficult period in the interim and both HSMC and the broader NHS family faced a tricky time as they navigated a rapidly changing policy context.

Inter-Authority Comparisons and Consultancy



John Yates

Director, IACC (1978-2003) and
Honorary Professor, University of
Birmingham (1998-2001)

John Yates was seconded to HSMC from a senior NHS management post in 1978. The initial secondment was for a two year period to help establish management training for clinicians and study for a Master's degree. He transferred to a PhD degree supervised by Professor Derek Williams and studied the uses of routine data in the NHS. This led to the creation of a number of Performance Indicator packages that were widely used in the NHS during the 1980s and 1990s. At its peak the workload necessitated a full-time team of 5-6 staff working in HSMC but called Inter-Authority Comparisons and Consultancy (IACC).

In parallel with the development of Performance Indicators, John took on a major study of NHS waiting lists and waiting times. Over a ten year period up to a dozen NHS and University staff undertook consultancy work aimed at reducing waiting times in hospitals. The work was

commissioned by both local and regional authorities as well as the Department of Health. For a period John was the government's advisor on waiting lists. The research and consultancy work resulted in over 100 publications including three books - two of which gained the Baxter prize for European healthcare literature. One of the books, "Private Eye, Heart and Hip", published in conjunction with two TV documentaries, was a controversial examination of the abuse of private/NHS practice by surgeons. The work was credited with being one of the chief factors leading to the revision of the consultant's contract. Despite initially upsetting a number of clinicians, managers and politicians, John was awarded the Naughton Dunn medal for distinction in orthopaedic surgery and an Honorary Professorship from the University of Birmingham.

As John recalls, "HSMC provided a superb independent base with very strong academic support. Without such support and independence the work on waiting times and the private/public interface would probably never have taken place. Thank you to all at HSMC. Particular thanks go to Professor Derek Williams for being prepared to take in hand an NHS manager whose only academic qualifications were 5 GCEs!"

After spending 25 years at HSMC as a 'placebo academic' John retired in 2003. He still lives in the Lickey Hills and can be contacted on jm.yates@virgin.net

Markets and competition continued – a sense of déjà vu?



Peter Spurgeon

Director, Institute of Clinical Leadership
and Professor in Clinical Healthcare
Management, University of Warwick

My period (1988-94) as HSMC Director was marked by very close and sometimes difficult, engagement with the concept of markets in healthcare and also in the education sector. The former related to HSMC's client population and re-organisation of services whilst the second was concerned more with internal arrangements within HSMC and its relationship with the University.

It is uncanny and unnerving how close the parallels are between the early 1990s and the current policy context (2012). The similarity might give all those working in the health sector pause for thought as to what has really happened in the intervening 20 years. The government paper "Working for Patients" of 1989 established self-governing hospitals, subsequently referred to as Trusts. The Health Minister at the time, Ken Clarke, also saw this as the creation of an internal market and defended his proposal (against concerted opposition from virtually all professional bodies) by saying he hoped it would usher in a business-like approach where none currently existed.

The separation of purchaser from provider was probably the most fundamental of the components of the reforms but Peck and Spurgeon (1993, p.117) noted that there were other core values at the heart of the proposed changes such as:

- Increased accountability (institutional and personal)
- Multiple providers encouraged
- Differentiation of service levels
- Greater consumer choice

Such notions could surely have been taken and with very little rewording, from the current Health Minister's (Andrew Lansley) position in support of the recent health and social care reforms!

The backcloth to the 1990 Act was a sense of frustration that previous attempts at reform had largely been blocked by strong professional bodies and the inherent inertia of the system to resist change. It was the intention of the Act to see the purchaser acting on behalf of the population/patient and offering a more powerful counterbalancing voice against the established service patterns. It was this Act too that introduced the notion of GP Fundholding - and again in 2011-12 we see the GP at the forefront of the purchaser process.

The whole notion of the viability of markets in the UK sector has been discussed, debated and largely failed to exist ever since. For Peck and Spurgeon (1993), there were four major factors that would act as a brake on the notion of markets and they largely remain unresolved (p.125):

- The interdependence of clinical specialties: this factor has weakened as medical techniques have changed
- Viability of a hospital (provider) unit: this remains a thorny issue of how far the purchaser represents the views of the local population by potentially destabilising a local unit
- Geographical considerations: the isolation of some rural communities still makes it difficult to see how a market can really exist when the only provider in the same area is threatened

- Political acceptance: markets involve winners and losers and we still have not witnessed, to quote the TV programme "Yes Minister", a large set of "courageous MPs" advocating closure of their local hospital for the greater good of the system.

Finally it might also be worth noting that markets work when there is a degree of excess supply so that providers can expand and fight over who can capture the market. In 2012 with a 1/5th of the NHS budget to be saved, is it really the right time for markets?!

HSMC's response at the time was to work particularly with Chief Executives to understand the implications of an internal market. Two Directors (Peter Spurgeon and Edward Peck) combined to prepare a publication, "NHS Trusts in Practice" (1993), which covered most of these aspects.

Turning to the internal aspects of the markets movement, for HSMC this was the point in the history of HSMC where we continued to move from a previous system of block grant funding to a more market-based approach (as discussed by Mike Drummond in the previous article). As with NHS colleagues, this presented a major transition for many HSMC staff who had been recruited to function in a quite different environment. The creation of long term business plans and individual income targets changed the operating culture of the organisation and, as Director, prompted a number of challenging and difficult conversations with staff.

The University too was unable to buffer this new financial situation as it too was operating under resource constraints. HSMC has come through this difficult period but it remained an anxiety for many staff at the time and for those leading the organisation. The marketisation of higher education has since continued, and the debates surrounding the recent increase in undergraduate tuition fees show how deeply feelings run on both sides of this issue.

Overall in reflecting on my time as Director I am most struck by the similarity of the thrust of policy and the language of the debate. My work now is primarily with doctors and one can sympathise with their often expressed view that most policy seems a re-cycling of things tried before. This may be cynical but I think one can see the point - and in their minds patients have just continued turning up irrespective of the policies and re-structurings that have taken place. Experience of the stability of other health

systems and their largely superior performance leaves me to advocate that the political process might be better focussed on allocating a resource, setting broad parameters of performance and then doing something else themselves. Real innovation is more likely to come from good professionals feeling ownership and responsibility for their organisation than from political dictat.

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HSMC in the 1990s



Chris Ham Chief Executive, King's Fund

The internal market reforms introduced by the Thatcher Government were being implemented when I arrived at HSMC with general practitioner fund holders and 'self governing' NHS Trusts at the heart of these reforms. In a clear echo of contemporary debates, the government's opponents warned that competition would undermine the principles on which the NHS was based, and raised the spectre that many services would be privatised to the detriment of patients.

I played a bit part in this debate in my previous role at the King's Fund. Sitting in the Fund's library late on a Friday afternoon, I was summoned to take a phone call (these were the days before mobiles were ubiquitous) from Martin Jacques, then editor of *Marxism Today*. Martin had turned *Marxism Today* into the journal of choice for readers wanting to access radical thinking on major issues of the day. He had an uncanny knack of commissioning articles that challenged conventional wisdoms and offered contrary but well argued points of view from authors of many different political persuasions.

Martin's brief to me was to deliver 3,000 words by Monday morning offering a constructive critique of *Working for Patients*. The piece I wrote urged the government's opponents to avoid a knee jerk response and to embrace those aspects of the reforms that had the potential to strengthen the NHS, and improve patient care. Then as now, I was concerned that debate about reform led by powerful professional associations and trades unions risked skewing the argument in favour of the status quo ('defend the NHS' being the rallying cry), and not giving enough attention to the needs of service users.

Much of our work at HSMC in the 1990s involved supporting colleagues in the NHS and the Department of Health on implementation of the reforms. One of the earliest lessons in this work was the ability of managers, general practitioners and other staff to adapt the reforms in the course of implementation. Fund holding was a good example. General practitioners who were opposed to the idea of taking on budgets found innovative ways of influencing resource allocation decisions through

locality purchasing (as it was known) and many other mutations.

While other universities engaged in longer term academic evaluations of the reforms, at HSMC we focused more on action research and development in which we worked alongside NHS colleagues to support implementation. One of our distinctive contributions in this work was to help spread intelligence and understanding of what was happening in different parts of the country at a time when the internet did not yet fulfil this function. On one occasion I remember spending time with the South London Umbrella Group of GPs (with the unattractive acronym of SLUG) helping them to engage GPs in commissioning, and meeting for the first time a young doctor by the name of Clare Gerada who was actively involved in SLUG.

The internal market reforms were implemented at a time when NHS funding was growing very slowly. The increasing gap between the demand for health care and the availability of resources ignited a debate about rationing centred on patients

having to wait a long time for non-urgent treatments. Building on the seminal work of John Yates, whose association with HSMC over many years had established Birmingham as a centre of expertise on waiting lists, we pioneered the idea that patients should be able to book their hospital appointments along the lines of a scheme already in place in New Zealand.

The change of government in 1997 opened the door to this idea being taken forward and HSMC was appointed to evaluate the forerunner of Choose and Book. Our findings illustrated the challenges involved in giving patients greater certainty about the time of their treatment, not least persuading doctors and other staff that booked appointments were the way to go. The government used these findings to inform the national roll out of Choose and Book as a key element in the Blair Government's programme to give patients quicker access to care and choice over where and when they were treated.

Looking back, it is possible to see what a pivotal role HSMC had in the evolution of health policy in the 1990s. Located at the cross roads between government and the NHS, and between researchers and practitioners, we were able to help the NHS make sense of government policy, and in turn inform government of the impact its policies were having on the ground. We were also able to make use of research to support policy implementation and service improvement, while drawing on experience of working with practitioners to add to the literature and evidence base on health policy and management.

The experience of the last 20 years underpins my scepticism that the current NHS reforms will undermine the principles on which the NHS is based and lead to widespread privatisation. As Nick Timmins showed in an article in *The Financial Times* in January, the private sector's share of the market for treating NHS patients waiting for elective care has remained stable,

notwithstanding the efforts of the Blair Government to increase the role of the sector. Roy Griffiths memorably observed in his 1983 report on general management that the NHS often resembles a decoration which moves when it is disturbed but then resumes its previous position. The power of inertia should never be underestimated.

Two implications follow. First, reports of the impending death of the NHS should be regarded as premature, to borrow from Mark Twain. Second, inertia may make it difficult for the NHS to adapt quickly enough to address the financial and service challenges with which it is faced. All the more important therefore that HSMC continues to play its part in helping leaders avoid the danger of change occurring too slowly and supporting them navigate their way through the storms that lie ahead.

Medical leadership: from the 'dark side' to 'centre stage'



John Clark

Senior Fellow in Medical Leadership and Engagement, King's Fund and Director, Institute for Health Leadership, Western Australian Department of Health

The Griffiths Report (1983) had been published shortly after I first joined HSMC. This provided a "fundamental critique of NHS management and its failure to ensure that resources were used effectively or with the needs of patients in mind. Specifically, the report identified the absence of a clearly defined general management function as the main weaknesses of the NHS" (Spurgeon *et al.*, 2011, p.35). The reforms which followed, like so many thereafter, provided great opportunities for HSMC to facilitate learning amongst new managers and leaders and offered fertile research

opportunities. Although unaware at the time, The Griffiths Report sparked my main research and development interests for the rest of my career.

The Griffiths Report is perhaps the tipping point for the medical leadership and engagement movement which has gained momentum over the past decade. Griffiths argued that hospital doctors should accept the management responsibility which goes with clinical freedom and participate in decisions about priorities. It also perhaps marks the point at which we slowly began

to move from medical representation (the Cogwheel system) to one based on medical leadership and accountability.

As the NHS moved during the early 1980s to consensus management decision-making at the unit level, I undertook some research into what levels of decisions were permitted at the unit level. Whilst there were some encouraging examples, the general conclusion was that decision-making was still very much focused at the Health Authority level. The unit tripartite teams of Administrator, Nurse Manager and Medical

Representative provided great opportunities for HSMC to work with teams either at Park House or within the organisation. The development of Clinical Directorates in hospitals, reinforced by The Resource Management Initiative (1986), created further opportunities. By then I was a Chief Executive of an acute hospital trying to put into practice my learning from being involved in research and reviewing best practice.

My experience was probably very similar to that of other CEOs who were seeking to encourage a number of doctors to take on Clinical and Medical Director roles and to contribute to the overall running of the hospital. These roles were generally undertaken on top of busy full-time clinical commitments. Few, if any, were appointed against any leadership competence assessment framework; more based on seniority. Even fewer had had any prior management and leadership training and the vast majority did not wish to do so! When I rejoined HSMC in the late 1990s, the need for GPs in Primary Care Groups and Trusts and for doctors in positional leadership roles in hospitals to take on greater responsibility for purchasing (commissioning) and delivering to contracts respectively grew. Essentially doctors in these roles offered advice and responded to general management directives and initiatives. Nearly all were slowly beginning to move from representational to accountable roles but still within a very strong general management culture.

Over the past decade or so, there has been a shift of emphasis with a stronger recognition that significant improvements in access, quality, safety, service delivery and productivity require stronger clinical (particularly medical) leadership and engagement. This was strongly reinforced by Lord Darzi's review of the health system in England, culminating in the publication of *High Quality Care for All* in 2008. He strongly advocated the importance of clinicians, and particularly doctors, being more engaged in leading service improvements.

Historically, doctors have been criticised by their peers of moving to "the dark side" if they reduce their clinical commitments and take on greater managerial and leadership roles. However, I would contend that doctors are now seen as "centre stage" in the implementation of the current NHS (England) reforms, whether as leaders within Clinical Commissioning Groups or as Clinical Directors/Leads within a much stronger Service Line Management type of approach within hospitals.

So, is the pendulum swinging from general management to medical leadership? Some commentators argue that appointing more doctors as chief executives will lead to greater improvements in performance. To date there is no evidence that medical leaders are more effective than non-medical ones. However, there is strong evidence from studies in the USA and UK that securing greater medical engagement at all levels of any health service, organisation or system will generate greater clinical and financial performance. In the UK, the study led by Peter Spurgeon and myself as part of the joint NHS Institute for Innovation and Improvement and Academy of Medical Royal Colleges *Enhancing Engagement in Medical Leadership* project confirmed that there is a strong relationship between the extent of medical engagement and performance.

As mentioned earlier, HSMC ran many action learning sets for clinicians and non-clinical managers throughout the 1990s and early 2000s. One of the more innovative programmes included action learning sets for the duality of chief executives and medical directors. These often included learning programmes with peers in other international systems, particularly the USA. Interesting that perhaps a decade on some studies from the USA suggest that the top-performing health organisations are typified by dualities or pairings of medical and non-clinical leaders complementing each other and being held jointly accountable for the delivery of goals.

The King's Fund Commission (2011) concluded that leadership is needed from the board to the ward and should involve clinicians as well as managers. Experience

from the Griffiths Report and my career since suggests that the NHS and its patients will be better served by clinicians and managers working closely in partnership at all levels with common goals about improving quality within a much more medically engaged culture.

Back at the 10th anniversary of the birth of HSMC (1982), it would have been hard to contemplate that all medical students and postgraduate trainee doctors (and indeed now all clinical professionals) would be required to attain management and leadership competences by the time of the 40th anniversary. It is now recognised by professional, regulatory and educational bodies as well as policy-makers that being a good doctor or any other clinical professional means accepting responsibility to not only deliver, but also to lead the improvement of services.

HSMC has contributed significantly to the enhancement of leadership effectiveness during its 40 year life and has had a considerable influence on the development of graduate management trainees as well as doctors moving into management and leadership roles. Perhaps the next ten years will see HSMC offer far more joint development opportunities for postgraduate trainee doctors and other clinical professionals with not only the graduate management trainees but also other non-clinical managers and leaders? The evidence would suggest that this type of joint development provides the greatest opportunity for a more distributed and effective style of leadership to meet the future challenges for the NHS.

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Partnership and integration



Professor Edward Peck Pro-Vice-Chancellor, University of Birmingham and Head, College of Social Sciences

On the morning I had set aside to write this piece, the Chief Executive of the NHS Confederation came on the Today programme to argue that 25 per cent of hospital admissions could be avoided, in part by more integrated health and social care services in the community. He did not use the term 'partnership', but what he had to say indicated that the topic remains as salient today as it did when I was Director of HSMC, perhaps even more so as the population ages and the budgets of the NHS and Local Government tighten.

My first published article appeared in the Health and Social Services Journal (as the HSJ was then) in January 1985. The topic: the virtues of integrated community mental health teams in Nottingham. It seemed self-evident to me then – and remains so to this day – that at the practice level bringing together community nursing and social work would benefit the users and staff across a broad range of client groups. As it turned out, the field of mental health, and maybe also the imagination of local leaders in that city, gave me an unduly optimistic view of how straightforward the creation of health and social care partnerships might be. Furthermore, in those far-off days, the local NHS was managed as one service system, with more or less stable administrative boundaries that frequently mapped onto those of local government.

An insight into the obstacles ahead was brought home to me in Gateshead a few years later when I was working with district nurses and social workers on a joint assessment form – the first step to an integrated team. It faltered on two key aspects: the social workers could not understand how district nurses managed to complete the form in fifteen minutes when it took them an hour (and vice versa); and district nurses did not like asking users

about their bank accounts anymore than social workers relished enquiring about their bowel movements. The importance of 'culture' – that most slippery of terms in the organisational vocabulary – was becoming apparent.

When I arrived at HSMC in 2002, we were nearing the end of the data collection phase of research into the Somerset Partnership Mental Health and Social Care Trust, the first in the UK to transfer to the responsibility for social care – including secondment of staff and allocation of budgets – to an NHS Trust. Again the central role of 'culture' loomed large, as, echoing Nottingham, did the crucial contribution of creative and committed senior leadership. I recall that those local managers were disappointed by our main conclusions: firstly, that integrated mental health services in the county had not produced innovations that not already in place elsewhere (but they had enabled best practice to be replicated); and, secondly, that the major concerns of service users – about feeling safe in in-patient settings and being treated with respect – were as prevalent after two years of the partnership as at the outset. I was reminded of the question that Dame Denise Platt once posed at one of our conferences on the topic: "if health and social care partnership is the answer, what is the question"?

Shortly after, I became involved in the Care Trust initiative, and for a few years I had an unhealthy knowledge of the origins, intentions, implementation and impact of this novel – if ultimately rather under-exploited – organisational form. Most of my active Care Trust development work was undertaken in Sandwell, where for around four years I was also Chair of the Children and Young People's Partnership Board which oversaw the proposal for a bid for the next game in town: the Children's Trust.

By this time, most of my work on health and social care partnership had moved well beyond bank accounts and bowel movements – at least those belonging to service users – to the theatre of strategic service re-configuration. I contributed to the plans for enhanced partnership arrangements between health and social care in most parts of England; Manchester, Portsmouth and Sussex (several times) in particular come to mind.

I have little doubt that most localities made incremental progress towards more effective health and social care services for users over the twenty or so years that I was actively involved in these endeavours, but the fundamental challenges that we faced failed to excite a national policy solution, despite my best efforts with often sympathetic policy makers and ministers. It was rooted in quite a formidable list of differences between health and social care: assessment criteria; fee regimes; staff terms and conditions; financial cycles; service boundaries; governance arrangements etc. I could go on – and in the past I did, repeatedly – but towards the end of my time the emphasis was moving onto new ways of achieving integration around individuals through developments such as personal budgets. Which is not to say that there are not new structural options emerging to offer fresh prospects of enhanced partnerships; social enterprise models look particularly promising and I am sure there is someone out there as familiar with their highways and byways as I once was with those of Care Trusts – I wish you well.

Writing this piece has reminded me of the many colleagues with whom I made this partnership journey and I would like finally to mention just a few: Andrew Lowe, David Fruin, Paddy Cooney, Karen Dowman and Steve Phoenix.

Making the shift



Helen Parker
Director, Practice Partners

I joined HSMC in the summer of 2005. During my time there I was involved in very stimulating research and debate on key policy topics: the highlights including shifting care from hospitals to community settings, the development of the primary care market through choice and competition and promoting integrated care. These thorny issues areas still dominate the policy agenda today although, unlike their predecessors, the Coalition's reform language appears now to be firmly grounded in integration rather than choice and competition.

Shifting Care

The 2006 White Paper, 'Our Health, Our Care, Our Say', seems a long way off now given the scale of current NHS reform, but this described a clear vision for shifting care that could be delivered more appropriately within a community setting and 'closer to home'. HSMC was commissioned to review and evaluate NHS activity in this area and made a number of recommendations, identifying critical success factors including strong medical leadership and investment in high quality project management (Parker, 2006; Ham *et al.*, 2008b). Looking back over the last six years most agree that we have seen little progress in universal system redesign with us all familiar with the well-rehearsed barriers. Our work, plus SHA evaluations undertaken on large scale programmes to shift care, highlighted the importance of the local general practice community having a strong voice and shared strategy. Most initiatives we evaluated were partnerships between PCTs and acute trusts with little engagement or ownership within general practice of changes that needed to be made. I believe that one significant barrier (and there are many) to the lack of whole scale system change in how and where services are delivered is the current cottage industry

infrastructure of general practice with weak coherent GP leadership and control across a health economy, particularly in urban and inner city areas. If sustainable change in this area is to be achieved, GPs as *providers* have to be key players in developing their corporate organisational infrastructure in a manner that will support the scale of activity shift required.

Choice and competition in primary care

A new APMS contract and the requirement of a GP led 'Darzi' centre in every PCT were just two commissioning initiatives introduced to improve access to primary care and create some positive tension within general practice as a means to drive up quality of care. HSMC undertook an evaluation of the Darzi centre procurement process and predicted that effective use of the new capacity may not be realised and could fail to offer value for money (Ellins *et al.*, 2008). Arguably this has been the outcome with many areas now decommissioning these sites. We also haven't seen a mass takeover of general practice by corporate companies that some commentators were predicting. As the HSMC report suggested, this was unlikely unless a level playing field was created between private providers and existing practices, although HSMC agreed introducing an element of competition may be one mechanism to stimulate local provider discussions. The quality of general practice remains variable across the country and commissioners have seemed reluctant to tackle poor quality providers or develop a coherent strategy for general practice provision. It will be interesting to observe the levels of influence Clinical Commissioning Groups are able to exert and whether peer pressure rather than competition will stimulate behavioural change.

Cracking the integrated care nut

The 'NHS Next Stage Review' in 2008 emphasised the need for greater integration of health and social care services, recognising a lack of progress over time. HSMC published a number of papers in this area, one exploring the policy options that would promote this, informed by the international evidence (Ham *et al.*, 2008a). Many of our recommendations at that time are hot topic items today, specifically the development of integrated care organisations, integrating commissioning and provision and exploring the potential of the 'accountable care organization.' Like the shifting care agenda, commissioners have struggled to influence the development of integrated care and it is encouraging to see current debate that suggests we need a greater focus on provider innovation and leadership as the catalyst for reform. Perhaps the real challenge for Clinical Commissioning Groups will be to support the growth and development of their acute and community providers as integrated care champions to a point where they become capitulated budget holders and a large element of their commissioning role becomes obsolete. It doesn't take a great leap of faith to see that this is where the current integrated care agenda may be heading.

New provider model

Not surprisingly, my involvement in the above work at HSMC led to me to a career change supporting GP partnerships with a similar vision to create a new model of general practice that can deliver the future agenda and remove some of those thorny barriers. The 'Super Partnership' is a single GP partnership, replicating those of other key professions that through full mergers of practices creates a large scale integrated care provider. Working with local specialists and community partners, delivering a wide

range of services to a registered list of circa 100,000 patients, this new organisational model removes many of the barriers to shifting care and integrating services around patients; in effect 'exploiting' the patient list for maximum gain. It creates a very real alternative to hospital care and provides a firm organisational foundation, with strong medical leadership, on which to integrate social care, public health programmes and other independent contractors. It is an excellent example of provider innovation leading transformational change and potentially becomes one model for integrating commissioning and provision through capitated budgets. Which is where I would stake my reform - rather than commissioning (where we have weak evidence of system influence).

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Postgraduate programmes



HSMC holds Mastersclass

Are you considering studying for a Masters in Health Care Management in the next 12 months? If so, experts from HSMC will be holding a Mastersclass on Friday 11 May 2012 at Park House.

Please come along and sample some of our teaching, talk to current and former students and meet the experts who teach on our programmes.

Further information

Please contact Kate Vos, c.j.vos@bham.ac.uk, +44(0)121 414 3174 for more details or go to the following link: www.birmingham.ac.uk/hsmc-mastersclass-2012

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 Integration for Health and Well-Being (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
- Standalone modules in Commissioning commissioned by NHS Somerset

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.

The next student intake to HSMC MSc programmes will commence on 17 September 2012.

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

Postgraduate programmes *continued*

Where are they now?

I was a student at HSMC in 2007-09 on the MSc Managing Health and Social Care course. After graduating I returned to social work practice with young people in transition with learning disabilities in Dudley. I remember the community care role play and taking on other roles; the research project and how challenging it is; and the piece of work at the hospital regarding the changes there. Mainly I remember one thing more than any of the above in terms of user perspectives; who do you respond to first thing in the morning, your managers or your service users? This led in part to my change in role because I can now make sure it is users that I see first.

Daniel Keeler

I was at HSMC from September 2002 to December 2003 as a Chevening Scholar from El Salvador studying a Master degree in International Health Management and Development. I am now the managing editor for the International Journal of Integrated Care (<http://www.ijic.org>). I did enjoy my masters degree especially the link between HSMC and the International Development Department, and our field trip to South Africa. **Lourdes Ferrer**

I was a practicing children's speech and language therapist when I went on the Managing Partnerships in Health and Social Care programme at HSMC in 2006 - 2008. I am now a children's speech and language therapist for 3 days of the week; a student coordinator for speech and language therapy (adults and children) for 1 day a week and visiting lecturer for another day a week at BCU. HSMC was committed to putting service users at the centre of its teaching and ethos of policy development and its teaching staff had a positive attitude and provided support to its students. **Raman Kaur**

I joined the University of Birmingham as a student from Zanzibar, Tanzania to do a Masters programme in Health Services Management. I completed my studies and was admitted to the degree of Master of Social Science (Health Management for Developing Countries) at a congregation held on 10 December 1992. My Master's dissertation was on "AIDS and Women in Zanzibar" which was a new disease and there was a lot of fear of this disease at that time globally and in my country. I decided to do my research to get more information that would help prevent women, men and children from being infected with HIV.

"The knowledge and skills gained after my studies at the University of Birmingham have changed my life and that of my family to a better quality of life. I managed to get very good jobs of international standard soon after my return home and was able to educate my children up to the university level".

The course of health management, especially for developing countries, was very important and relevant for health professionals who come to UK to get more knowledge. As an alumni the knowledge and skills gained has helped me to be a critical thinker with a vision, health planner, researcher and multidisciplinary team player. I was able to contribute with confidence very positively in health sector reform, prepared funding proposals for health programmes at the national, district down to village level and got funds.

"When I was doing my Masters in Health Management at the University of Birmingham we were about 25 students in class. Two thirds of the students in that year were Medical Doctors, a few were Hospital Administrators and I was the only nurse in the class. It was challenging but the team spirit of studying and brainstorming together gradually changed me from being slightly shy. I gained confidence and ended up leading some group discussions with constructive ideas. This was also the result of good instructors who were committed to changing the students to become health managers and leaders which we actually are in our countries".

Amina Ali



National Leadership Council (NLC) Clinical Leadership Fellows

Following interest from more than 1,000 clinicians across the country the NHS Leadership Academy's Clinical Leadership Fellowship programme 2011-12 is now underway. The Fellowship has been designed to develop the next generation of

leaders in the healthcare profession, so they are best equipped to take on a central role in improving services for patients.

The 60 healthcare professionals commencing the Fellowship, all from a range of clinical backgrounds, will receive high quality clinical leadership and management training underpinned by sharing best practice. This year's Clinical Leadership Fellows include Doctors, Dentists, Nurses, Pharmacists, Psychologists, Social Workers and Allied Health Professionals.

HSMC, in partnership with University of Manchester and the Kings Fund, have been commissioned to provide a Postgraduate Certificate in Leadership and Service Improvement for the Fellows. The first module was a four day residential

workshop at the University of Warwick in January 2012. Speakers included Professor David Colin-Thome and Professor Chris Ham as well as a presentation by Andrew Lansley, Secretary of State and Sir David Nicholson, the Chief Executive of the NHS.

Modules 2 and 3 will be locally delivered in 3 locations around England – London, Manchester and Birmingham. The Fellows will work in group sizes of around 20, which allow for effective interactive teaching and the development of local learning networks and communities, which itself is an important contributor to the programme.

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

Projects Update

Social enterprise within health and social care

Robin Miller and Ross Millar have been commissioned to facilitate an event in Wales exploring the potential of social enterprise within health and social care at the end of March 2012. Organised by the National Leadership and Innovation for Healthcare Agency, the event will bring together representatives from across Wales to learn of the experiences of leading social entrepreneurs and reflect on the learning from the Social Enterprise Investment Fund in England.

r.s.miller@bham.ac.uk;
r.millar@bham.ac.uk

Chronic kidney disease home therapies research

Despite international evidence to suggest that home dialysis can increase life expectancy, improve quality of life and provide cost savings, the uptake of home therapies in the West Midlands remains very low (around 5% of all patients needing dialysis). HSMC are working in collaboration with the School of Health and Population Studies to examine approaches to renal home therapies in four West Midlands Acute Health Trusts. This research forms part of the West Midlands Health, Education and Innovation Cluster (WMC HIEC). It seeks a greater understanding of how and why innovations, such as renal home therapies, become embedded in health services and what blocks this process.

k.allen@bham.ac.uk

SDO joint commissioning project

HSMC's SDO-funded Joint Commissioning project is now in the reporting stage following 2 years of research aiming to better understand the processes, practices and outcomes of joint commissioning. The research answers longstanding calls to better understand the workings and outcomes of joint commissioning. The research is particularly concerned with examining whether any distinction might be made between joint commissioning and more general collaborative endeavours. The research has involved over 180 staff and service users / carers across five case study sites that each exemplify a different type of joint commissioning, with the aim of better understanding how joint commissioning is being implemented across the country and the difference these arrangements have made to service user and carer outcomes. Phase 1 was based on a unique on-line survey known as POETQ, which aimed to surface the range of different meanings associated with joint commissioning. Phase 2 then checked out

these meanings with staff and service users from across the five sites and analysed what sorts of impacts joint commissioning has had locally.

Another SDO funded project - Models of Medical Leadership – is also coming to a close in June 2012

h.e.dickinson@bham.ac.uk

NHS West Midlands Aspiring Programme

The Aspiring programme commissioned by NHS West Midlands and run with Manchester Business School is well underway. 44 participants have just completed their organisational consultancy module, where they visited local businesses for 2 days and worked on an identified issue. Module 3 convenes on 6th March when Sir David Nicholson will provide a keynote speech.

y.sawbridge@bham.ac.uk

Time to Care

Yvonne Sawbridge is the lead author of a new University of Birmingham HSMC policy paper, which makes a series of recommendations to improve nursing care in the NHS and argues that change needs to focus on supporting nurses not blaming them. This paper, "Time to care?", has received considerable interest and Yvonne and co-author Dr Alistair Hewison from the School of Health and Population Sciences, have been invited to speak at two conferences; one in East Midlands to RCN members on 10th April and another on 30th March in Haydock as part of a series of workshops for Non-Executive Directors.

In addition Yvonne has been working with Clinical Commissioning Groups (CCG) to develop their quality strategy and she is also working with Russell Mannion to deliver a workshop on creating the right culture for patient safety.

y.sawbridge@bham.ac.uk

Talent management

HSMC's Professor Martin Powell and Dr Joan Durose are part of the team that recently published a report on Talent Management in the NHS Managerial Workforce. In 2004 Talent Management was introduced into the NHS. Although Talent Management was already undertaken a more systematic approach may contribute to the three main leadership problems of the NHS: recruiting and retaining Chief Executives; a more diverse or inclusive leadership or an 'NHS of all the talents'; and benefits in terms of organisational performance, as organisations can achieve competitive advantage through people.

The aims of study were to explore and document the Managing of Talent and Talent Management approaches that assisted a group of administrators and managers from 1970s to 2000s; provide an examination of the facilitators and barriers to talented individuals achieving their potential; evaluate the impact of different schemes on individuals; to explore how values, motivations and beliefs link with managerial careers; and to examine how Talent Management links with organisational success.

To read the full report please visit:

www.netscc.ac.uk/hsdr/projdetails.php?ref=08-1808-247
m.powell@bham.ac.uk

Local evidence for social care prevention

Research funded by the NIHR School for Social Care continues into how local authorities plan, invest and deliver preventative services. Over the last months the research team have been working closely with Directors of Adult Social Services, commissioners and managers who lead on preventative interventions. With a particular focus on evidence, the project looks at how services monitor activities and demonstrate impact. The next phase of the research will be to add to this evidence-base, incorporating new findings into formal reviews of the three most common approaches identified.

k.allen@bham.ac.uk

Bespoke leadership development for individuals and groups

As a result of service re-configurations, the demand on staff to lead and manage new organisations, and new ways of working for clinicians, our leadership development programmes have been hugely oversubscribed, and those that have missed out are coming to us with requests for personal development support. For those displaced by the changes, they are also seeking some help with preparing for the future through requests for assessment centre and interview practice. As a result, we are currently designing tailored packages for individuals and/or groups.

d.c.davidson@bham.ac.uk or
y.sawbridge@bham.ac.uk

Social care and third sector review

The HSMC/TSRC review of the third sector in social care is now in its final phase. The review has compiled contributions from policy, practice and academic literature, exploring the role of the third sector over the last 20 years from these varied standpoints.

Projects Update *continued*

Several high level interviews have also been undertaken in order to validate the review's messages, highlight challenges for the third sector and raise potential areas for the future research agenda. The review should be finalised and published in Spring 2012.

k.allen@bham.ac.uk

Making the case in safeguarding: enhancing safe practice at the interface between hospital services and children's social care (2012-2013)

Recent high-profile cases of children such as Peter Connelly (Baby P), Victoria Climbié and Kyra Ishaq and her siblings have focused attention on the neglect of vulnerable children. The interface with paediatrics is a useful place to start to identify the most vulnerable children and hospital contacts can provide opportunities to assess and act whilst the children are in a safe place.

Russell Mannion is co-applicant and co-researcher on a newly funded NIHR HSR funded study which is exploring safe practice between hospital services and children's social care. Kerry Allen is research fellow and Sue White is PI on the project which aims to develop a tool-kit of transferable methods, based on clinician-led innovation in one hospital (Pennine Acute Trust), extending and adapting extant PSF

tools. The aims of the tool-kit is to help foster a safeguarding culture within the hospital environment that will detect children at risk of abuse and devise appropriate protective actions before discharge, typically involving other agencies.

The research will, through careful inter-agency follow-up, rigorously appraise hit, false positive and miss rates, enabling 'signal detection' performance to be robustly appraised. An action research methodology will be followed, with three main phases. Current design work on the tool-kit will be completed in Pennine, using user-centred methods, including interview, observation and design workshops. Evaluation will then be carried out, focused on the quality of decision-making regarding safeguarding. This will involve an analysis of complaints to help to detect any increase in false-positives, and follow up with external agencies (e.g. GP and statutory children's services).

The third phase will comprise an evaluation of the transferability of the tool-kit, by implementation in new sites, namely particular clinical settings within Birmingham Heartlands and Solihull Trust and Birmingham Children's Hospital.

Consultations with clinicians and managers in the new sites will take place, to adapt the tool-kit, which will then be implemented in

specific sites and evaluated. Further redesign work to produce a robust and portable 'transition package' will then be carried out, which will assist any hospital seeking to adopt the approach.

r.mannion@bham.ac.uk

Staff satisfaction and organisational performance: evidence from the NHS Staff Survey

Professor Martin Powell and Dr Jeremy Dawson (University of Sheffield) are leading this 18 month SDO funded project. The main aim of this project is to exploit existing data to test part of the overall model that hypothesises a positive link between Human Resource Management (HRM) and organisational performance. The study will make use of existing (secondary) data from within the NHS in England. This will include the NHS national staff survey and a variety of other, routinely collected data sources.

The objectives are:

- To examine the links between staff attitudes and behaviours with individual and organisational performance in NHS Trusts
- To use this knowledge to develop actionable recommendations for national stakeholders and local managers

m.powell@bham.ac.uk

Bespoke leadership development for individuals and groups

As a result of the abolition of PCTs and SHAs and the development of CCGs and clusters, our leadership development programmes have been hugely oversubscribed, and people who have missed out are coming to us with requests for personal development support. For those displaced by the changes, they are also seeking some help with preparing for the future through requests for assessment centres and interview practice. As a result, we are currently designing tailored packages. Development can be offered on an individual basis, and where there are several requests for the same thing, we can bring people together to benefit from group workshops.

Psychometric tests

Leadership Impact Profiles
Developmental 360° Feedback
MBTI (Step I or II)
Thomas Kilman Conflict Handling

Executive Coaching

Elective placement
Leadership x-change
Action Learning

Assessment/Development Centre

Group exercise (scenario)
Panel Interview (videod)

Development Days

Board development
Influencing /political skill
Leadership performance
Time management/delegation

For further information please contact

d.c.davidson@bham.ac.uk or y.sawbridge@bham.ac.uk

Events

Meeting the 'Nicholson Challenge' – how to disinvest in health care services

14 May 2012

The current economic downturn, allied to the government's QIPP agenda, has increased the pressure on local health care systems to ensure resources are used efficiently. David Nicholson, Chief Executive of the English NHS, has challenged the service to find £20 billion in efficiency savings by 2015. In this context it is increasingly important that the nettle of disinvestment (or decommissioning) is grasped. However the NHS, as with health care systems across the world, has traditionally struggled to both make and/or implement disinvestment decisions. Whilst recent structural changes to the NHS have created uncertainty and upheaval they also provide an opportunity to tackle the disinvestment challenge.

In this seminar, international and national experts from both service and research settings discuss practical strategies for achieving savings in a context of limited health care budgets. It will be of interest to local health care organisations attempting to increase efficiency, drive service change and 'manage the message' of potentially unpopular funding decisions. A keynote presentation will be provided by Dr Craig Mitton and Ms Diane Schmidt from the University of British Columbia. Craig and colleagues have worked with many health care decision makers across the world, helping them to achieve expenditure savings and improve service outcomes. This will be followed by sessions in which NHS leaders and researchers in the area of disinvestment exchange insights and good practice examples. Key domains of the NHS 'Authorisation Process' will be explored, such as meaningful engagement with communities and delivering the QIPP challenge.

As part of the seminar, delegates will have the opportunity to:

- Understand how disinvestment has been tackled in other health care systems
- Hear from those who have led disinvestment processes in health and social care in England, and
- Share and discuss their own challenges and experiences

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

"Time to Care" exploring solutions to poor nursing care

11 June 2012

There have been a series of high profile scandals over the past few years relating to the quality of nursing care. These failures illustrate longstanding issues which can be traced back to the 1960s. Previous solutions do not seem to have succeeded. We can't go on trying the same things. We need to be able to respond positively to the CQC "Nutrition and Older People report" and the numerous poor stories emerging via the Patient Association and others. The Public Inquiry into Mid Staffs will make detailed recommendations relating to the system. However history would show that general solutions to these problems are harder to embed. So what can we do?

The HSMC Policy Paper "Time to Care?" (December 2011) identified that nursing is hard, emotional work. However this is rarely discussed and often overlooked in current management practice. Consequently, there is no systematic support for nurses as part of their daily routine. Perhaps it's time to move away from blaming individual nurses and look at how to develop systems which support them to care?

This seminar will draw on key research from this work with nurse leaders and other examples of good practice. It will explore case studies from policy and practice perspectives and aims to contribute to the national debate, widening it out from the popular "good/bad nurse" or "too posh to wash" sound bite discussions which dominate the media.

This one day seminar will be of particular interest to nurse leaders, but is highly relevant for all Board members (Executive and Non-Executive); Governors of Foundation Trusts; and senior managers across acute trusts in particular, who collectively hold a statutory duty for the quality of care delivered to their patients.

Independence pays? What do personal health budgets mean for the NHS?

11 October 2012

Following longstanding success in social care, both direct payments and personal budgets are being piloted and evaluated in the NHS. These ways of working were reaffirmed in the *Equity and Excellence* White Paper and promoted as a means of extending public and patient involvement and choice in the NHS.

Described by some as one of the most significant reforms of the welfare state since the Second World War, personal budgets have the potential to revolutionise the way in which services are provided and to transform relationships between patients and clinicians. However, there have also been concerns expressed that this might undermine public sector services, create additional bureaucracy, lead to people using unproven treatments and place patients at greater risk.

As work begins to honour the pledge to roll out to all continuing care recipients, this one day seminar explores:

- The nature of direct payments and personal budgets – what they are, where they have come from and what they mean for future policy and practice
- Outcomes and lessons from early personal health budget sites
- The experiences of patients and families receiving personal health budgets
- What this means in terms of implementation and future service provision

With a mix of inputs from research, policy and practice, the seminar is aimed at anyone with an interest in personal health budgets. It is likely to be of particular interest to those working to implement this new way of working, clinical commissioners, continuing care leads, strategic commissioners and to service providers from the public, private and voluntary sectors.

For further details/booking form for any of the above events please contact Ann Thomas on a.d.thomas@bham.ac.uk

Joint HSMC / Nuffield Symposium on Commissioning

1 and 2 October 2012

HSMC are partnering with the Nuffield Trust to put on two events focussing on the topic of commissioning to take place in early October. The first day is designed to appeal towards academics and will focus on the 'limits of market-based reforms'. The second day is designed to appeal primarily to a practice audience on the theme of 'the future of health care commissioning'. Individuals may attend either day or pay a reduced price for both days and the events will be held at HSMC, University of Birmingham. Further information on these events will be released over the next few months but if you are interested in finding out more then contact Helen Dickinson. h.e.dickinson@bham.ac.uk

People at HSMC



Hilary Brown recently elected to FTGA Board of Directors

HSMC Fellow, **Hilary Brown**, who is the University of Birmingham's representative on the

Council of Governors for Birmingham Children's Hospital, was recently elected to the Board of Directors of the Foundation Trust Governor's Association (FTGA) – the only national representative body for FT Governors. The FTGA works alongside Monitor and the Foundation Trust Network to support governors. Members benefit from a bespoke website resource, policy publications and briefings and development activities such as workshops and seminars.

'The FTGA's aim is to provide governors with the knowledge and confidence they need to make an impact. I'm keen to use the knowledge and experience I and my HSMC colleagues have gained to contribute towards the development of governors to ensure they can fulfil their current statutory duties, and any future ones,' explains Hilary. www.ftga.org.uk



Robin Miller becomes TSRC health and social care lead

Robin Miller is now the health and social care lead within the delivery stream of the Third Sector Research Centre (see www.tsrc.ac.uk). Robin's initial work will be exploring different policy approaches to social enterprise across the UK and exploring the relationship between commissioning and the Third Sector.



Professor Russell Mannion gives his Inaugural Lecture

Recent high profile reports into serious failings in hospital quality, most notably the standard of care

provided at Mid Staffordshire NHS Foundation Trust, have reawakened concerns over the quality and safety of care provided in NHS hospitals. Drawing on Professor Mannion's own research, this lecture explores the organisational determinants of hospital quality and discusses the key theoretical and practical challenges in measuring, assessing, and delivering good quality health care.

This lecture entitled "Hospital Quality: the Good, the Bad and the Ugly" will take place at 5.15pm on 28 June 2012 in the Lecture Theatre, Barber Institute of Fine Art with a reception to follow in the Barber Foyer.



Director of new Public Service Academy

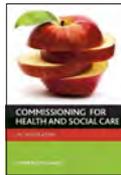
Helen Dickinson has been appointed as the Director of the Public Service Academy.

This role is part time and Helen will spend 50% of her time on this new cross-College role and the remainder will be spent with HSMC. The Public Service Academy (PSA) is a new initiative that seeks to coordinate public service activities across the University and will also provide the basis for collaboration

between the University of Birmingham and Birmingham City Council. Although there is a range of established links between the University and the City Council, the PSA will provide a better structure to build on these and facilitate a more strategic relationship between the partners. The PSA is part of a wider University agenda to develop its city and regional role. Building on the recent Policy Commission into the future of public services, the PSA will explore the changing role of local government and public servants.

Selected recent publications

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HSMC academics **Helen Dickinson** and **Russell Mannion** have edited a new publication entitled '**The reform of health care: shaping, adapting and resisting policy developments**', published by Palgrave Macmillan. This book examines how healthcare organisations shape, adapt and resist developments in healthcare policy and practice.

This edited collection of conference papers is put together from the Organisational Behaviour in Healthcare (OBHC) Conference which was hosted by the Health Services Management Centre at Birmingham Business School in April 2010. This is an international text bringing together contributions from around the globe and covers a wide range of different discussions in relation to the policy/practice gap.



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