

Newsletter

Editorial by Jon Glasby and Ross Millar

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Stop Press: HSMC is to host EHMA 2014 Conference on 24 - 26 June 2014 – see p.11

Focus on international networks

For many people, HSMC is seen as part of the broader NHS family and as a critical friend to health and social services. Most people reading this editorial will already know quite a lot about what we do in the UK – and there are the usual updates on our teaching, research and events later in the newsletter. However, HSMC is also very active globally, and this edition of the newsletter focuses more on some of our international links and networks. We feel this is crucial to our work in the UK for 4 main reasons:

1. The NHS is so large and complex that it can often be difficult to look outside of what we do on a daily basis for good practice lessons from elsewhere. However, learning from other systems is crucial (particularly as many other countries are grappling with the same issues as us). Indeed, 'broadening horizons' is a key theme of our new NHS Leadership Academy programmes (see p.8), and the ability to look for evidence of what does and doesn't work in other systems seems an important source of expertise when working with everyday issues in UK health and social care.
2. At the same time, the NHS and social care have incredible experience and expertise to contribute to other countries – and so such learning needs to be two- rather than one-way. We're really proud of the NHS, and there's lots of scope to share good practice with other systems and to make a contribution globally as well as nationally.
3. When policy makers do look abroad for new approaches they often look to the US first and foremost, and they can sometimes be guilty of identifying apparent success stories and trying to implement wholesale here. In line with HSMC's role as a critical friend to the health and social care community, we feel that this is an overly-simplistic approach to policy transfer, and that deeper understanding is required to be clear about the contextual factors that make something work/not work and the extent to which such approaches might be

- appropriate in a very different UK context. This requires the ability not just to identify apparent good practice, but also to ask difficult questions and consider what potential success factors and barriers might exist if such interventions were adopted here. There is also a key role in making sure that lessons are sought from any system that might have something to offer, not just from the US (where there are a number of high profile good practice examples, but where the system as a whole has many flaws). Later on in this newsletter, Harvard's Prof. John McDonough makes similar points when he highlights the problems that the US system faces and compares US with UK approaches (see p.5).
4. Whilst there are lots we can learn from elsewhere, detailed international links can also identify situations where there are few easy answers. This can be frustrating for policy makers keen to find a way forward, but can also be very liberating for local leaders and practitioners. Often there are no 'magic solutions' and other systems are struggling with the same problems as us. Although this can feel initially underwhelming, having confirmation that the things we find hard are sometimes just genuinely difficult can help to put current challenges in perspective. If it was easy, then someone would have solved it by now, and the fact that no one has can be a helpful lesson in itself.



In this edition of the newsletter, we hear primarily from colleagues working in and with different health systems. These are often our own staff visiting or temporarily based in different countries, but can also be honorary members of the HSMC team who are a crucial part of our international networks. Articles include 'letters' back to HSMC from colleagues overseas looking at decision-making and priority-setting in Vancouver or adolescent mental health in Melbourne; the current health reforms in China; and insights from our new Honorary Professor, Harvard's John McDonough. We are also delighted to be the founder member of the Universitas 21 (U21) health management and organisation group (see p. 9) and to be hosting the 2014 European Health Managers' Association (EHMA) Conference (see p.11).

HSMC will always continue to be part of the NHS family and to focus primarily on UK services – but we hope that our international networks continue to add value in our mission to promote both 'rigour and relevance' in health and social care.

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A letter from Vancouver: insights into Canadian disinvestment

Tom Daniels

Dear HSMC,

I have now been in Canada for just over two weeks and have already given the first presentation of my research into 'Public Involvement in Health Disinvestment Decision Making.' Having arrived fresh from the airport I was asked by our former colleague Stirling Bryan to give a presentation of my PhD findings (so far) to the University of British Columbia's Clinical Epidemiology and Evaluation group. Like any true Englishman in a foreign country I began my presentation with an apology - as this was the first departmental presentation I had attended, let alone presented at, I wasn't sure exactly what was expected. However, I needn't have worried as the issues we're facing in the UK seem to have uncanny parallels with debates in Canada.



I began by explaining what I considered disinvestment to be (the withdrawal, reduction or retraction of health services), before considering how decisions to disinvest are made and whether or not the public can or should be involved. Involving the public can deliver instrumental, communitarian and educational benefits, but it can also lead to a protracted decision-making process and there is no guarantee of public objectivity or knowledge and understanding. In addition to this, research has shown significant variation in the extent to which the public actually want to be involved in disinvestment or priority setting decision-making.

My presentation then moved on to discuss the research that I had carried out looking into the attitudes of health professionals and the three distinct perspectives my study has uncovered. These are 'advocates of involvement' (those who are fully behind public involvement), 'cautious supporters' (those who support involvement but recognise that it can have limitations) and 'freedom of choice' (those who support public involvement but believe that the public should have the ability to choose whether or not they take part). I concluded my presentation by noting that each of the shared perspectives showed support for public involvement and that there was no clear point of view suggesting that the public should not be involved in disinvestment decision-making. I also suggested that further research should be carried out to establish what these findings meant in practice before asking the audience for their views on whether this research could be repeated in Canada. The discussion that ensued highlighted a number of points which may be of interest to UK researchers and practitioners.

Whilst the Canadian economy is in a much stronger position than the UK and much of the rest of Europe, Canada is still facing similar healthcare funding difficulties. Discussion about disinvestment, however, has been far more limited and indeed it was suggested that 'disinvestment' was too negative a word to use in Canada, and that I would have to find a new term to define and describe service changes and cutbacks. Another potential difficulty was that I may struggle to identify enough healthcare professionals with disinvestment experience to take part in the study. Whether this was a flippant comment or not, it could be the case that, as explicit disinvestment is still rare in Canada, those individuals who have taken part may not recognise their involvement in disinvestment or may not be aware of the decision-making process.

Whilst disinvestment may be a new concept within Canadian healthcare, the notion of priority setting has become well developed across all Canadian provinces over a number of years. By definition, disinvestment is a form of priority setting; it involves tough choices between cutting and continuing funding. In the English context, disinvestment decisions, particularly around hospital closures or ED downgrades, have often caught the attention of local and national media but in Canada, either because of the implicit way in which they have been carried out, or the euphemistic 'priority setting' banner under which they have been taken, these kinds of decision have passed off fairly quietly. It isn't that they haven't been taken, it is that they have been taken slowly or incrementally or that they haven't been publicised in the same way as they may be in England and there has therefore been less of an impetus for public involvement.

In the UK, decision makers and the public have become accustomed to the language of austerity and we are reminded on a daily basis of the need to tighten our belts. The Coalition government may have come to power promising to protect the NHS and maintain its budget, but a number of apocalyptic financial forecasts, allied with a spate of high profile quality scandals, have refocused the public's attention and there is now a palpable feeling that "we can't go on like this." The time is ripe for service change and disinvestment. In Canada, however, talk of austerity is far from the lips of those in power and it remains alien to the public and decision makers - this is another reason why my study may require a significant overhaul before a Canadian rollout.

I hope that the clinicians and academics that attended my presentation learned something. I hope that, if nothing else, they went away with an understanding that public involvement in disinvestment decision-making is not necessarily a yes or no question; there are other considerations and other concerns that should be borne in mind when designing a process. As for me, I came away having learned far more from the discussion and questions than I could ever have hoped. I have gained a good understanding of Canadian thoughts on disinvestment, and the state of public discussion across the provinces and I have gained the confidence to rewrite my study for a Canadian audience. Having written and delivered the presentation, and reflected on the discussion, I am now left with two nagging questions - is the UK ahead of or behind Canada in its health disinvestment practice? Are we grasping a nettle now that the Canadians will be forced to grasp in the future, or with more implicit, slow-paced priority setting in the past could we have steered clear of the language of disinvestment altogether?

Yours sincerely,

Tom

A letter from Melbourne: providing mental health services for adolescents and young adults

Sarah-Jane Fenton

Dear HSMC,

Comparative health policy research is a developing field at HSMC. Increasingly, links and joint research projects are being established with Universities overseas. PhD researchers are also being supported to develop innovative research in multi-site, international contexts. It is an exciting time for interdisciplinary collaborations that help elucidate key issues common to health systems, in the search for pragmatic evidence and research-based solutions.



I am one of a number of PhD students who are looking at health services research in a comparative context.

The research I am undertaking explores mental health policy and the delivery of mental health services to older adolescents and young adults, those who are between sixteen and twenty-five years of age. The research is comparative between Australia and the UK, with three field sites in the UK (in Scotland, Wales and England) and three sites in Australia.

Currently in the UK, a complex picture is presented in relation to adolescent mental health and mental health policy generally. Strides have been made in relation to developing Early Intervention services in the UK. These services have been founded based on a strong clinical evidence-base from research into practice, and as a policy response to problems with service transitions. However, practice remains subsumed within CAMHS (Children and Adolescent Mental Health Services) and AMHS (Adult Mental Health Services). Policy has, in practice, meant that groups of young adults aged 16-25 fall through the gaps in care arrangements and do not receive adequate, or sometimes even any, mental health services.

The opportunity to look at Australian policy and systems that are arranged slightly differently (in part because of the federal system) could offer unique insights into the many layers of policy and how this impacts on service. Through qualitative interviews with staff, patients and policy makers, the study examines whether young people falling through the gaps who are at a vulnerable stage developmentally in terms of mental health, are consequently negatively affected by the present policy framework. The choice of Australia for comparative analysis centres on the pioneering work in the field of mental health done academically and practically throughout the 1990s. For example, models of early intervention that target this age group specifically were developed synchronously in Australia and the UK during this period. Research into early intervention generated reciprocal practice learning that significantly contributed to service developments in this area. Australia has also been particularly instrumental in their articulation of young people's needs in national health policy. The comparison does not involve service evaluation or directly comparing clinical skills or individual service outcomes; rather it focuses on the policy and practical settings through which these services are delivered, the barriers to care that young people face and the implications this has for them and for wider society.

The research is focusing on the ways in which policy sculpts mental health systems and services in the different country contexts. To aid the comparison between the UK and Australia, the experience of service users will be used to highlight both gaps and strengths in policy and service arrangements. This study hopes to better understand what improvements should be adopted in each setting and vice versa as well as how policy creation, implementation and transfer affects people experiencing mental illness and disorder. This work is crucial at a time where wellbeing is increasingly appearing in policy agendas alongside mental disorder as a policy objective in its own right. With heightened economic pressures and scarce resources it is important to examine how policy, and consequently services, fit the current needs and demands of populations.

There is much to be gleaned from taking an internationally comparative perspective and using policy as a lens through which to view practice. Not only can this lens illuminate the difference between models, but there are also useful lessons to be learned from a federal system like Australia as we move post-devolution to a quasi-federal system in the UK. The management of patients and equity of access to services across national borders is but one of the related issues. Different funding structures and the impact that these have on policy and practice also make research in international contexts exciting, with policy change and transfer shaping knowledge in both directions.

I'll be in touch over the coming months as I arrive in Melbourne and the Australian component of my data collection begins in earnest.

Yours sincerely,

Sarah-Jane

Reforming health and social care in China



Ross Millar

It has become a widely held view shared by politicians, academics and journalists that the 21st century will be characterised as

'Asia's century'. These perspectives suggest that as the axis of political and economic power moves increasingly from West to East, China is emerging as the global superpower. Jacques (2012), for example, argues that current trends suggest that China 'will rule the world' with a new and distinctive brand of modernity. This new world will not simply be a continuation of Westernisation but will represent a new paradigm experienced in economic, political and cultural terms.

Whilst the growing power and influence of China brings opportunities, friends and enemies, such rapid growth also brings with it many of the social and economic problems that often characterise the industrialisation of nation states. Increasing societal pressures associated with growing inequalities, urbanisation and the demands of an ageing population mean that China, like everywhere else, is looking for solutions to some of the intractable welfare problems facing the world today: how to manage population demands with ever diminishing resources.

Over recent years, the Chinese government has been undertaking significant reforms of health and social care to meet these welfare demands and dilemmas. These reforms have been summarised by Yip *et al* (2012) who suggest that China's 3 year reform plan, launched in 2009, marked the first phase towards achieving comprehensive universal health coverage by 2020. The reform proposals have centred on the financing of healthcare together with priorities for prevention, primary care and redistribution of finance and human resources to poor regions. Reflecting on these developments, Yip *et al* (2012) suggest that there has been impressive progress towards universal insurance coverage. However, they also point to the implementation difficulties being encountered in the translation of funding and insurance coverage into cost-effective, high quality

services. Yip *et al* (2012) conclude that work is still to be done in relation to providing effective incentive structures, improving hospital governance and developing appropriate regulatory arrangements if China is to realise its ambition of a universal health system.

When we compare these developments to our experience in England, we find clear differences between the organisation and delivery of these health and social care systems. However, these recent developments in health and social care reform across China also point to similarities between the countries as both turn to 'quasi market' approaches to improve their healthcare systems. These reform efforts are being documented individually, yet a comparative focus on how reforms such as Payment by Results have been introduced remains a significantly underdeveloped issue.

Over the next 12 months, HSMC has received funding to develop and enhance a learning network for the study of health and social care reform across England and China. Our funding intends to build on an earlier visit to Peking University Health Science Center in Beijing back in October 2012 by myself, Robin Miller and Helen Dickinson, and is intended to look to develop common areas of research interest. The learning network will have the following aims:

- To analyse, assess and explain the nature and impact of quasi market reforms in health and social care systems
- To analyse what lessons can be learnt from how policies and practices 'transfer' across contexts

- To look at how approaches to reform could be improved and developed for the betterment of service users and society

To achieve these objectives, HSMC and the Peking Health Science Center will be hosting seminars with case studies of how different reform policies have been introduced in the respective countries. We plan to visit Beijing in July 2014 to contribute to a seminar that focuses on reforms to improve the performance of hospital care. In November 2014, we will invite colleagues from Beijing to a seminar that will focus on reforms to improve and integrate the primary and secondary care interface. We hope these events will further develop relationships between the two institutions and facilitate a wider network for policy and practice across the UK and China, building on the existing relationship between the University of Birmingham and the city of Guangzhou (see <http://www.birmingham.ac.uk/international/guangzhou/about/index.aspx>), as well as look to facilitate further collaboration between universities that include Guangzhou Medical University, Sun Yat Sen University and Fudan University.

References

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- Yip, W. C-M., Hsiao, W.C., Chen, W., Hu, S., Ma, J. and Maynard, A. (2012) Early appraisal of China's huge and complex health-care reforms, *Lancet*, 379, 833-42.



Harvard's Professor John McDonagh is a new honorary member of staff at HSMC and is part of the team delivering the new NHS Leadership Academy Nye Bevan programme - see p. 9

Facing the challenges of improving our health care systems



John McDonough

At the Harvard School of Public Health in Boston, Massachusetts, we are proud to partner with the University of Birmingham and

other academic institutions to support the NHS Leadership Academy and its mission to improve the quality and patient focus of health care delivery in England. This is a fundamental moment of opportunity for England and the U.S. Though our systems differ in crucial ways, both sides face some similar and compelling challenges.

The key difference between our systems is guaranteed coverage. Since the creation of the NHS in the late 1940s, Great Britain has provided full access to essential medical services for all your people, with no cost barriers. In the United States, more than 60 years later, we are still fighting to create that guarantee and assurance. The passage of the Affordable Care Act (ACA/Obamacare), signed by President Barack Obama in March of 2010, is our major opportunity to overcome this societal disgrace. Of all the leading advanced nations, the U.S. is the only one that permits our citizens to suffer financial ruin because they or a family member gets sick. Indeed, less advanced nations such as Mexico, Turkey and Thailand are ahead of us in establishing universal access.

The British established a national health system in the aftermath of the terrible scourge of World War II, when citizen solidarity and unity were quite high. That sense of solidarity has never been as strong in the U.S. and has weakened considerably in the last 30 years as libertarian cultural and political instincts have become much stronger. So even though the ACA is now more than three years old, the fighting is hardly over.

The conflict is especially intense right now as we head toward January 1 2014 when the new system of guaranteed coverage comes into full effect. ACA opponents were unable to repeal the law in our Congress,

unable to get our Supreme Court to declare it unconstitutional and unable to remove President Obama from office. So they are now engaged in a political guerilla war to defund and derail in any way possible. It is the last gasps of a wealthy and entitled opposition. Brits should take pride that your system guarantees access to medical services regardless of race, ethnicity or class. The differences could not be more profound.

Yet, both our systems face serious challenges in providing high quality and patient-centered care to all those in need of medical attention. In the U.S., we are aware of the quality challenges that have come to light because of the failures at Mid-Staffordshire Hospital in recent years.

We know that, most often, these kind of problems are systemic and not simply an aberration at one or a few institutions. The recent Francis and Berwick reports from earlier this year confirm that systemic reforms are essential to guarantee not just access but quality, patient-focused care as well.

Since the late 1990s, with the release of two landmark reports from the U.S. Institute of Medicine, *To Err Is Human* and *Crossing the Quality Chasm*, the systemic flaws and shortcomings in American medicine have become a national conversation. Prior to the release of these reports, public opinion surveys showed Americans' confidence that we had 'the best quality medical care in the world.' The work of U.S. foundations such as the Commonwealth Fund have demonstrated conclusively that the quality of U.S. medical care is mediocre at best when compared with the systems of other advanced nations, including Britain's. American medical care excels the best at spending exorbitant amounts of money for poor results. For every dollar we spend on medical care, the second most expensive nation (usually Norway, Germany or Switzerland) spends about 65 cents. Brits spend less than 50 cents for every dollar we spend in the U.S. And our quality is mediocre as compared with our peers, and we fail to provide coverage to all our citizens.

That is why the Affordable Care Act, in addition to seeking universal coverage in the U.S., also prioritises the reform and improvement of our medical care delivery system. The law does this in a variety of ways:

- By moving away from a reimbursement system that rewards medical providers for the volume of services provided and toward rewards based on quality and value
- By creating new organisational structures such as Accountable Care Organisations to promote patient-centered care and to take responsibility for patients beyond the institutional walls
- By re-designing primary care through the creation of Patient Centered Medical Homes
- By penalising hospitals with very high rates of preventable readmissions and hospital acquired infections, and much more

Dr Donald Berwick, who has advised the NHS over about ten years, is the developer of a medical reform concept known as the Triple Aim. The goal of health system reform must be to: 1. Improve the patient experience of care; 2. Improve population health; and 3. Lower the per capita cost of providing medical services. It is fair to say that these three goals are the motivators of the system reform efforts included in the ACA. Improvement is a journey, not a race. The Triple Aim is now extending over the globe, because in truth, the challenges we face in the U.S. and in Great Britain, are challenges faced by health systems around the world, everywhere. Increasingly, we understand how much we can learn from each other.

We look forward to supporting efforts to improve and sustain the National Health Service.

Professor John E McDonough, DrPH, MPA, is Director of the Center for Public Health Leadership at the Harvard School of Public Health and a new honorary Professor at HSMC.

Postgraduate programmes

HSMC welcomed a new intake of students on 30 September 2013. The department delivers a number of UK-based Masters programmes as well as contributing to a number of interdepartmental programmes.

HSMC offers an MSc in Healthcare Policy and Management with optional specialisms in Commissioning, Quality and Service Improvement and Integrated Care. The programme consists of:

- a) Four core modules:
 - Health Service Management
 - Health and Healthcare Policy
 - An Introduction to Organisational Development in Health and Social Care
 - Public and User Involvement in Health Care
- b) Two optional modules which are selected according to specialism if a specialist track has been selected (20 credits each)
- c) Dissertation/Research Project

The programme is designed for senior managers, clinicians and policy makers working in or with health care and social care organisations, or with an interest in developing their careers in this direction.

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

Postgraduate Certificate for CCG leads

After discussions with local GPs working in CCGs, HSMC has designed a new PG Certificate in Healthcare Commissioning (jointly badged with NHS Clinical Commissioners) which was launched in January 2013. It builds on previous successful programmes such as the MSc in Healthcare Commissioning delivered for NHS London and NHS West Midlands; the UK's first MSc in Public Service Commissioning (delivered jointly with the Institute of Local Government Studies); and a series of local and regional commissioning development programmes delivered throughout the country. Aimed at both clinicians and managers, previous participants have given consistently positive evaluations, and state that these programmes help those in commissioning roles to understand what commissioning is, where it has come from, where it might be taking us and how to do it differently and better.

Based on three 5-day modules, the programme consists of:

- Strategic Commissioning
- Decision-making and Priority-setting
- Procurement and Market Management

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

New Masters specialism in integrated care

In 2013 HSMC introduced a new MSc specialism in integrated care. Alongside broader inputs around health service management, health care policy, organisational development and patient involvement, the programme will focus in particular on the skills, knowledge and concepts necessary to work successfully with people from different professional backgrounds and with partners from different parts of the health and social care system. Key topics will include current barriers to integrated care, the benefits of working together, the governance of partnerships, the outcomes of integrated care and the importance of organisational culture.

For further details, contact Kate Vos: c.j.vos@bham.ac.uk

HSMC hosts University of Melbourne teaching programme

In November 2013 HSMC hosted the University of Melbourne's International Public Management module, which is an elective module of the Masters in Public Policy and Management run by the Melbourne School of Government. The module was led by Helen Dickinson who recently left HSMC to take up a role as Associate Professor in the new Melbourne School of Government.

Staff from HSMC and Inlogov were involved in teaching on the module, which seeks to provide students with a sense of what the major challenges and dilemmas are in the design and delivery of health and local government services in a UK setting. Students also had an opportunity to meet University of Birmingham students at an evening event and had the chance to hear from Dr Mark Newbold, Chief Executive of Heart of England Foundation Trust. The final day of the week-long module was spent visiting Birmingham City Council where students met senior officers and politicians.

Discussions are currently in place about the possibility of developing an international public management module at the University of Birmingham in the near future which will involve students from Birmingham and Melbourne learning together.

For more details about the Melbourne School of Government see <http://government.unimelb.edu.au>



Where are they now?



**James Taylor, MSc
Health Care
Management (2008)**

My last update included news of a successful completion of the London Marathon in 2011, which

was then followed by completion of the Marine Corps Marathon over in Washington DC later in the same year. I then took up a new professional challenge in late 2011, moving back to the East of England, where I undertook the NHS Graduate Scheme (General Management) between 2001 and 2003, as Programme Manager at Cambridge University Hospitals NHS Foundation Trust - to manage the set up of the Major Trauma Centre at Addenbrooke's Hospital, as part of the East of England Major Trauma Network. When the initial programme of work around the Major Trauma Centre completed in April this year, I took the opportunity to head out to Botswana to undertake a one week

project scoping visit as a volunteer with 'Addenbrooke's Abroad' - looking specifically at opportunities to develop a collaborative link project with the Botswana Ministry of Health, supporting the development of Emergency Medical Services (EMS) in the country.

'Addenbrooke's Abroad', is a charitable organisation which was established in 2006 in recognition of the benefits for patients and health care professionals, both overseas and in the UK of engaging in global health. Following the initial visit, plans are now taking shape to formally develop the EMS link project, with a specific focus upon enhancing the clinical skills of multi-professional teams from both the hospital and pre-hospital setting in caring for major trauma patients. Major trauma, which is largely attributable to motor vehicle collisions, is the second leading cause of death in Botswana behind HIV/AIDS.

I continue to work at Cambridge University Hospitals NHS Foundation Trust, maintaining my clinical practice as a Paramedic. Following research I undertook as part of my MSc in Health Care Management at HSMC, I have published work in the Journal of Paramedic Practice relating to leadership and organisational change, and I'm a peer reviewer for the journal.

For more information on Addenbrooke's Abroad, please follow the link below:
www.act4addenbrookes.org.uk/Aboutus/Addenbrooke%E2%80%99sAbroad
James.taylor@addenbrookes.nhs.uk

James Taylor

Programme Manager, Cambridge University Hospitals NHS Foundation Trust, Addenbrooke's



**Tom Duncan, MSc
Health Care
Management (2013)**

After finishing my MSc last December I went to work for Careflight in the Northern territory of

Australia, which was an amazing experience. I am not sure I used many of my HSMC skills out there but it was definitely noted that I was 'medical director' type material.

Whilst I was out there I got a job on the National NHS Medical Director's Clinical Fellow Scheme through the Faculty of Medical Leadership and Management. This scheme, sponsored by Sir Bruce Keogh, enables 23 doctors to take time out of clinical work and be immersed in the world of medical leadership. I have been seconded to the National Institute for Health and Care

Excellence where I am working with various teams across the organisation. The study I did at HSMC has been invaluable in terms of providing a framework for understudying how organisations work in general but also the challenges in developing guidance for healthcare systems, how to get the guidance implemented and barriers to implementation.

I know that lots of people on the scheme are keen to try and get some formal qualifications so I have been promoting Birmingham as a good course, whether for the PG Cert or the full MSc.

Dr Thomas Duncan FRCA

Clinical Fellow, National Medical Director's Clinical Fellow Scheme
National Institute for Health and Care Excellence



Postgraduate programmes *continued*

NHS Leadership Academy programmes launched

In September we saw the launch of the Nye Bevan (senior) and Elizabeth Garrett Anderson (mid-tier) Leadership Development Programmes. Delivered via a consortium that includes KPMG, Manchester Business School, National Voices and Line Communications, both programmes comprise blended learning with a dedicated Virtual Campus (VC), face to face workshops and action learning sets. Although details of both programmes are available online, the brief summary below focuses on the Anderson programme (and Bevan will be profiled in future editions of the newsletter).

The Anderson programme consists of a 24 month learning journey comprising eight study modules, and exploring the knowledge, skills and behaviours that are important for leading others when building a culture of patient-centred care within the healthcare system.

Eighty-five per cent of this programme is accessible on-line at any time of the day (or night!) It takes as its focus the work participants are already doing and uses this as the basis for their learning. The curriculum focuses participants' attention on what is practical and works, and helps to lighten the study workload, as some of the learning is within their day-to-day job.

There are many novel features to the *Virtual Campus* and these have been noticed immediately by participants, some of whom thought they would just get presentations and reading on-line, only to find poems, patient stories, vox pops, videos (immersive scenarios, talking heads, animations), work-based activities with their team and line manager, as well as some traditional theoretical primers, and much more.

Some participants' feedback on the virtual campus:

"The resources on the Getting Started section of the Virtual Campus are thought provoking and they are just the start!"
"I am finding the VC really well presented and well resourced. There is a vast amount of information to plough through. I really like the way I can look back over things I have done - much better than a lecture which is for the most part gone except for a few handouts."



"The videos have already started me to think about my behaviours and the effect I have on others, so I am encouraged this programme will enable us to be more self-reflective and conscious of our impact on our direct teams, wider organisations and, ultimately, the experience felt by patients. Feel assured this will be a very positive journey."

"All the videos were thought provoking in some way, but the most provocative thought for today is 'what's it like to be on the receiving end of me?'"

The other fifteen per cent of time is face-to-face learning in residential workshops and regional action learning sets. At the first residential workshop, we heard that participants expected to just sit in lectures, so were rather taken by surprise that most of their learning was experiential, interactive and required them to engage in reflexive activities that focussed on intra-personal and inter-personal behaviours, as well as opportunities to experiment with doing things

differently, taking up different roles and learning from others.

For HSMC, we continue to break new ground through this work, both by accrediting a leadership development programme of this kind and through extending our use of blended and work based learning approaches.

For those interested, the NHS Leadership Academy are about to reopen their site for applications in the near future. If you are interested, have a look at their web site which tells you more about the programme and how to apply:

www.leadershipacademy.nhs.uk/grow/professional-leadership-programmes/elizabeth-garrett-anderson-programme/joining-instructions-for-the-elizabeth-garrett-anderson-programme/

Deborah Davidson
Senior Fellow

Projects update

U21 Health Organisation and Management network

Professor Russell Mannion is co-director with Dr Helen Dickinson (Melbourne University) of the Universitat 21 (U21) Health Organisation and Management network. This network has active members from elite U21 universities based in North America, Europe, Australasia and Asia and serves as an international forum for debating, developing and undertaking innovative research into all aspects of health organisation and management, including comparative research across countries and health systems. Key themes include topics such as health care quality; professional identities; organisational incentives, rewards and cultures; patient choice and public involvement; evaluation of commissioning practice and priority setting; and health system organisation and integration. r.mannion@bham.ac.uk

Social welfare and disability rights in Korea



HSMC's Jon Glasby has recently seen his book, which he co-authored with Rosemary Littlechild in IASS, on *Direct payments and personal budgets: putting personalisation into practice* (The Policy Press, 2009) translated into Korean. He has since been invited to present to the 2013 International Conference of the Korean Academy of Social Welfare (KASW), the largest social welfare conference in Korea. His visit builds on strong links with Korea across the broader School of Social Policy, with a long-running Policy into Practice MA for Korean civil servants. While in Korea, Jon spoke about challenges and opportunities in English social care, with scope to compare and contrast experiences with speakers from the OECD, the US, Japan, China and Germany. He also met with the Chief Executives of disability organisations such as the Korean Disabled People's International, the Korean Disabled People's Development Institute and the Korean Foundation for People with Disabilities. j.glasby@bham.ac.uk

Deepening our understanding of quality improvement in Europe (DUQuE)

Russell Mannion is part of a research team financed by the EU 7th Research Framework Programme which is exploring the effectiveness of quality improvement systems in European hospitals. The study is being led by the Autonomous University of Barcelona and also involves colleagues from UCLA, and the Universities of Cologne and Utrecht. This study is using large scale quantitative data sets to assess the impact of organizational culture, professional involvement and patient empowerment on quality improvement, patient safety and clinical outcomes. Data has been collected from hospitals in the Czech Republic, France, Germany, Poland, Portugal, Spain, Turkey and the United Kingdom. r.mannion@bham.ac.uk

Developing new approaches to adult social care

Turning the welfare state upside down? is a new policy paper from HSMC on the need to develop new approaches to social care that build more effectively on social capital and community resources. Commissioned by Birmingham City Council, the report is based on a review of Council websites across all local authorities in England and interviews with key national stakeholders, social care leaders, user-led organisations and good practice examples. With the Care Bill being debated in Parliament, this generated significant media and policy interest, appearing in a number of national newspapers, on the BBC and on ITV. For the full policy paper, see:

www.birmingham.ac.uk/hsmc-policy-paper-fifteen

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Reaching economic alternatives that contribute to health

REACH (Reaching Economic Alternatives that Contribute to Health) is a deliberative group exercise based on a board game, where citizens are asked to debate and prioritise a range of interventions that address the social determinants of health. The REACH game was devised and developed by academics and policymakers in the United States. Dr Marion Danis from the National Institute of Health at the US government presented the work here at HSMC in June. Following on from this visit,

Iestyn Williams and Kate Warren are leading a project to adapt the REACH game for the English context.

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Time to care: evaluating a model of emotional support for nurses working on acute wards in hospital

This research project is examining the feasibility of implementing a support system, based on the Samaritans' model for their volunteers, into a busy ward environment for nurses. It is now nearing the end of the 12 months funding and is at the stage of collecting data through interviews and surveys, and compiling a report of findings. The three sites are all working to different timescales and so the final report will be published in early spring 2014. y.sawbridge@bham.ac.uk

Evaluation of the impact of high-intensity specialist-led acute care (HiSLAC) on emergency medical admissions to NHS hospitals at weekends

Professor Russell Mannion is co-applicant with colleagues from Birmingham Medical School on a newly funded NIHR HS&DR project which is evaluating an intervention to improve the care of acutely ill medical patients admitted as emergencies to NHS hospitals at weekends. This three year study, led by Professor Julian Bion aims to evaluate the effect of specialist intensity on differences in quality of care between patients admitted at weekends vs weekdays, and any effect of HiSLAC in reducing these differences.

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Projects update *continued*

Transatlantic collaboration fund



Yvonne Sawbridge successfully secured a grant from this fund to visit Chicago to spend time with Associate Professor Sharon Mastracci at the University of Illinois. Her work centres on emotional labour in public servants in the USA, and has uncovered the notion of emotional labour as a core competency that can be learned and refined, with appropriate support. During this trip Yvonne met with the Chief and Associate Nurse Executives at Northwestern Memorial Hospital (see photo) to discuss their approach to supporting staff as part of their Magnet Hospital Accreditation. This trip has helped cement relationships with a view to developing collaborative research projects and published articles to support and strengthen each other's work. Birmingham and Chicago are also 'sister cities' with a range of links between local government, local third sector organisations and local Universities.
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Learning for the NHS on procurement and supply chain management (SCM)

Russell Mannion is currently undertaking with colleagues from Birmingham Business School a literature synthesis funded by NIHR HS&DR which aims to understand the strengths, weaknesses and gaps in existing theories about procurement and supply management in terms of its application to health care. The study brings together the combined expertise of HSMC and the Business School, and will provide a practical guide for NHS managers and clinicians with responsibility for the commissioning and procurement of health care services.
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Dudley CCG evaluation

HSMC are working closely with Dudley CCG to help them develop and evaluate their commissioning approach - in particular their model of integration. They are also

employing a research assistant as part of their intention to build upon the evidence base for effective commissioning, and to help them overcome the theory-practice gap in their everyday business for the benefit of their population. Yvonne Sawbridge is their initial link, and the expertise of the HSMC team will be utilised as appropriate. This is an exciting venture for both parties, with scope to translate new research rapidly into practice.

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ESRC-funded projects

Catherine Needham is leading on two new ESRC-funded projects, one on evaluating micro-enterprises in social care and one on skills for the twenty-first century public servant. The latter project is a Knowledge Exchange project with Birmingham City Council.

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Patients' Council evaluation

Robin Miller and Hilary Brown are undertaking an evaluation of a Patients' Council within a low-secure unit for people with a learning disability. This will explore how patient-led initiatives can work within a setting in which people's autonomy is restricted.

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Evaluation of the joint commissioning unit in Walsall

Having previously been involved in debates about the relationship between health and social care in Walsall in the mid-2000s, HSMC have been asked to carry out a new piece of work exploring the impact and future development of Walsall's Joint Commissioning Unit (JCU) in an era of clinical commissioning. With public health transferring to local government, new CCGs replacing former PCTs and the advent of Health and Well-being Boards, many JCUs around the country are having to re-think their previous role and remit. This project builds on HSMC's recent national evaluation of joint commissioning

(www.birmingham.ac.uk/sdo-joint-commissioning)

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Compendium of change management approaches

Robin Miller and Deborah Davidson are working with Dr Tim Freeman from Middlesex University on developing a

compendium of change management approaches for social care managers. Funded by the NIHR School for Social Care Research, this research seeks to produce an informative and practical resource for managers seeking to improve front-line services.

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Integrated care 'pioneers'

HSMC's track record of research, teaching and consultancy around inter-agency working was recognised when Jon Glasby was selected as a member of the panel identifying the government's new integrated care 'pioneers.'

International keynotes for HSMC Professor

Russell Mannion gave the keynote address to the annual conference of the Polish Society for Quality and Safety in Health Care held in Krakow, focusing on: *Hospital board governance of quality and patient safety: recent evidence from the UK and USA*. The presentation drew on Russell's work on organisational culture and health care quality as well as the findings of an NIHR study he is currently leading which is exploring the linkages between board governance and patient safety outcomes across all hospitals in England. He was also the keynote speaker at an international seminar on health care performance organised by the Norwegian National Knowledge Centre, Oslo, entitled: *The governance of quality and safety: lessons from the English NHS*. He also replied to the speech at the seminar by the National Chief Medical Officer for Norway, Professor Bjørn Guldvog. Russell holds a five year appointment as Visiting Professor in the Faculty of Medicine, University of Oslo and is involved in a research project assessing the development of integrated care services in Norway as well as undertaking research assessing health care quality in Norwegian hospitals.
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Events

The European Health Management (EHMA) Annual Conference comes to Birmingham in 2014

HSMC will be hosting the EHMA Annual Conference in June 2014. The conference - "Leadership in healthcare: from bedside to board" - will bring together researchers, policy makers and practitioners to discuss some of the key issues related to healthcare leadership as well as examine the approaches, roles and relationships that are associated with breaking new ground in leading service improvement.

The conference aims to provide interactive sessions and networking opportunities to discuss and engage with representatives from a variety of different health sectors from Europe and beyond.

If you are interested in attending EHMA 2014 please contact Ross Millar (r.millar@bham.ac.uk) or Tracey Gray (t.gray@bham.ac.uk)

Developing a compassionate organisation: an action learning set approach

Recent events such as the failures at Mid-Staffs and Winterbourne View have raised serious concerns about the delivery of compassionate care in the NHS. In the past, recommendations and action plans have not been the solution - as similar failings recur. As all organisations reappraise their track record to date, there is significant scope to learn from existing practice, including:

- HSMC's action research to develop an approach to systematically supporting nurses, using a model based on the Samaritans' organisational programme for supporting its volunteers
- The Kings Fund is implementing Schwartz Rounds as part of its Point of Care Programme
- A system of support known as 'restorative supervision' has been introduced to health visiting services in the West Midlands with impressive results

To build on such developments, a new action learning set aims to enable participants to learn from each other in a supportive yet challenging environment. This involves four one-day events (the 1st event took place on 5th December 2013), and each day will begin with a review of the evidence base and an update on progress with implementation of a particular model. If places are available after 5th December, new members will be welcome, at a reduced fee. For further details, please contact Yvonne Sawbridge (y.sawbridge@bham.ac.uk) or email Evelina Balandyte (e.balandyte@bham.ac.uk) to reserve a place.

UNIVERSITY OF BIRMINGHAM

Health Services Management Centre

Developing a compassionate organisation: An Action learning Set Approach
Day 1: 5 December 2013 (future dates to be negotiated)

Venue: Health Services Management Centre, Park House, University of Birmingham

The Cost: £2000 per head for 4 events - this includes venue, lunch, refreshments, seminar and facilitated Action Learning sets



Do you want to be part of a community of practice, developing an understanding of the complexities of delivering compassionate care, and implementing new approaches? The Action Learning Seminars will provide a forum to enable good practice to be shared and support those seeking to introduce a staff support system.

The Action Learning Set will involve four - one day events, held at Park House, University of Birmingham. Each day will begin with a review of the evidence base, and an update on progress with implementation of a particular model.

www.birmingham.ac.uk/hsmc

West Midlands Chairs and Non-Executive Directors' Forum – free launch event:

Thursday 27 February 2014

Following the reforms brought about by the Health and Social Care Act 2012, NHS Chairs and Non-Executive Directors (NEDs) have often found themselves having to respond to a series of deep-seated challenges in difficult policy and financial circumstances. Against this background, HSMC is proposing a new forum for Chairs and Non-Executive Directors across the West Midlands starting with an initial free evening event to bring interested colleagues together to debate some of the key issues and explore further the potential for such a network. Thereafter, HSMC will put together a formal proposal for those Trusts that wish to subscribe to such a forum, with a series of regular evening events to be designed and delivered (perhaps 8 such events a year, as an example).

If you are interested in attending the free launch event, please contact Evelina Balandyte email: e.balandyte@bham.ac.uk

People at HSMC

We recently welcomed Helen Smart, Mauva Hanson, Susan Davies, Lesley Richards and Kieron Stanley to the newly formed NHS Leadership Academy administration team being led by Tracey Gray.



Dr Laura Griffith was until recently a Senior Qualitative Researcher in the Health Experiences Research Group at Oxford and has just joined HSMC as a lecturer. Laura is an anthropologist whose research

interests include qualitative research into personal experiences of health and illness (especially in the field of mental health) and the provision of health services to address class, ethnic and gender inequalities.



Dr Karen Newbigging joins HSMC as a Senior Lecturer in Health Care Policy and Management. Originally qualifying as a clinical psychologist, Karen has over 30 years' experience in mental health. She has been

involved in commissioning, research, consultancy, postgraduate teaching and organisational development and worked with a broad range of organisations on system development. Karen's specialisms include implementation, equalities and epistemic justice, commissioning, personal agency and service transformation in mental health and social care. She is the co-author of the recent Sage publication *Commissioning Health and Wellbeing*.

New Honorary Senior Research Fellow

Dr Sandra Buttigieg, Head of the Department of Health Services Management, Faculty of Health Sciences at the University of Malta has been appointed as an Honorary Senior Research Fellow at HSMC. Sandra is a medical doctor by background and has a PhD in management from Aston University. She visited HSMC as a visiting Erasmus scholar in June 2013 and gave a very well received seminar. Sandra will be developing collaborative work with HSMC colleagues around hospital quality performance.

HSMC forms new link with Harvard

HSMC is pleased to announce the appointment of **Professor John E. McDonough** as an HSMC Honorary Professor. Since 2011 John McDonough

has been Professor of Public Health Practice at Harvard School of Public Health and Director of the new Center for Public Health Leadership in charge of the School's executive and continuing professional education programmes. Between 2008 and 2010, he served as a Senior Advisor on National Health Reform to the U.S. Senate Committee on Health, Education, Labor and Pensions. His specialty is U.S. health policy and politics, federal and state, and he teaches political strategy for public health professionals.

Professor McDonough's background reflects a diverse set of professional engagements in government and public service, academia, advocacy and non-profit leadership with two significant stretches of service in government at state and federal levels. Between 1985 and 1997 he served as a state representative in the Massachusetts House of Representatives, and held a variety of health policy responsibilities, including terms as chairman of the Joint Committees on Health Care and Insurance and, whilst in that role, was deeply engaged in many community activities and organisations. Between 2008 and 2010, he served as a senior advisor on national health reform to the U.S. Senate Committee on Health, Education, Labor and Pensions (HELP).

Professor McDonough's other experience includes working as Executive Director of Health Care for All (between 2003 and 2008), a Massachusetts' leading consumer health advocacy organisation which has a broad community-based membership and stakeholder constituency where he played a central part in the introduction of the Massachusetts health reform law in 2006. He has also held positions as an Associate Professor and Senior Research Associate in the Schneider Institute for Health Policy at Brandeis University and as the first Joan Tisch Distinguished Fellow in Public Health at Hunter College, Roosevelt Public Policy Institute in New York City.

In late 2012 Professor McDonough was part of the team that bid for and won the contract to deliver a series of national leadership development programmes for middle-level and senior NHS leaders, in which he will be centrally involved in provision. In particular, he will work alongside HSMC's Jon Glasby to co-ordinate all international input and to help deliver the 'broadening horizons' module of the senior leaders' programme.

Partnerships for public health and well-being

A new book on Partnerships for Public Health and Well-being has been published as part of HSMC's Interagency working in health and social care series. Edited by HSMC Director Prof. Jon Glasby, the series contains books on children's services, disability and learning disability – with a third edition of Jon's 'Mental health policy and practice' due to form the mental health contribution to the series in 2014.

Written by De Montfort's Professor Rob Baggott, the new book explores the collaboration that is needed between a range of agencies and sectors if health and well-being is to be improved. In contrast to more traditional and more medically-focused accounts of public health, this textbook explores the contribution that partnership working can make to achieving a broader notion of health and well-being.

Very selected recent publications include:

- Davies, H.T.O. and Mannion, R. (2013) Will prescriptions for cultural change improve the NHS?, *British Medical Journal*, 346, f1305
- Glasby, J. and Dickinson, H. (2013) *A-Z of inter-agency working*. Basingstoke, Palgrave-Macmillan
- Jacobs, R., Mannion, R. *et al* (2013) The relationship between organisational culture and performance in acute hospitals, *Social Science and Medicine*, 76, 115-125
- Lunt, N., Mannion, R. and Exworthy, M. (2013) A framework for exploring the policy implications of UK medical tourism and international patient flows, *Social Policy and Administration*, 47(1), 1-25
- Needham, C. (2013) *The boundaries of budgets: why should individuals make spending choices about their health and social care?* London, Centre for Health and the Public Interest
- Needham, C. (2013) Personalized commissioning, public spaces: the limits of the market in English Social Care Services, *BioMedical Central: Health Services Research*, 13, Suppl 1
- Needham, C. (2013) 'Personalisation: from day centres to community hubs?', *Critical Social Policy* (early view)
- Powell, M. *et al* (2013): Has the British National Health Service (NHS) got talent? A process evaluation of the NHS talent management strategy?, *Policy Studies* (DOI:10.1080/01442872.2013.798533)



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HSMC's Viewpoint page is now live - see HSMC's occasional blog at the following link: www.birmingham.ac.uk/hsmc-viewpoint



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