Coventry Health and Wellbeing Board
19th October 2015

What role should the HWBB play in a systems approach to a healthy Coventry?

Applying Collaborate's work on systems change and collaboration in Coventry

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A bit about **Collaborate**? Building cross sector collaboration in the delivery of better services to the public

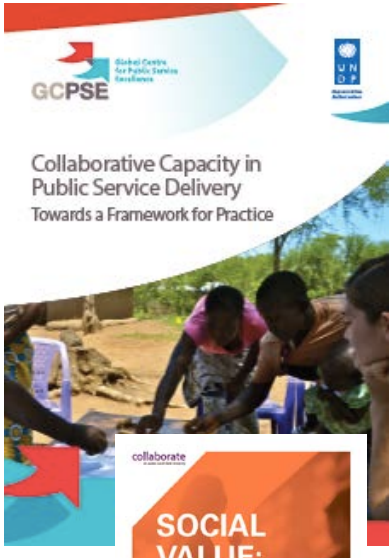
Collaborate CIC is an independent policy and practice hub based at London South Bank University. We were established in 2012 to support the development of collaborative models of public service delivery - helping leaders to work better across sectors for the benefit of citizens.

We are chaired by Lord Victor Adebowale CBE, and are governed by a board drawn from across the public, social and business sectors. Henry and Sarah are the two senior executive directors, running the business day to day.

Our work starts from the premise that today's complex problems need a more adaptive and collaborative approach - and we work with our partners to develop thinking, culture and practice to address this. We start with the needs of the citizen (or service user), involve them in coproducing and co owning the solutions in their communities.

We are currently working in a across the UK to support public service partners to deliver better services to the public in the context of austerity, devolution, changing demographics and rising expectations. We are also leading a Commission on "place-based health" to explore what an approach to health would look like that put place, people and outcomes above institutions, sectors and silos.

We have just completed a piece of work in Coventry, funded by Lankelly Chase, on systems change and collaboration for those facing multiple complex needs. We believe the nine preconditions for systems change we have developed in Coventry could be helpful in reconceptualising the role of the HWBB.



An overview of our proposed approach with HWBB

Our understanding is that Coventry HWBB is at a pivotal point in its development – a new Chair, a review of the three year strategy, a discussion on priorities based on JSNA all catalysts for this discussion. Devolution and the Marmot review providing crucial backdrops to much of your thinking.

Our work both with Coventry on systems change but also leading a Commission this Autumn on "place-based health" has shown us that taking a systemic approach to any transformation is critical and that combination of System Preconditions and then Collaborative Delivery are crucial.

Some money has been allocated (as follow on from our initial work funded by Lankelly Chase) that allows us to work with you to apply the thinking we did in develop our preconditions for systems change (see next slide) and support you to think through your role in enable a systemic approach to health which has a focus on delivery (not just nice conversations and relationships which we know are good and in place).

We suggest a 4 step process:

1). Consider the preconditions framework (slide 4) and the extent to which those preconditions are present in your system. Using this to agree the vision, principles, priority outcomes, and any supporting infrastructure (November)

2). Work together to apply the collaborative delivery framework (slide 7) to HWBB remit and consider therefore what your role should be as system conveners, enablers, incentivisors, delivery catalysts and accountants (November)

3). Use this thinking about your role and where you can add most value (combined with the JSNA) to decide the HWBB priority focus for the year(s) and how you want to spend your time together as system leaders (December)

4.) Pilot the application of this on one of those priority areas by kick starting it with a one day delivery clinic (January)

By going on this journey with us over the next three months we will also build collaborative capacity between you as a group of people – we can hold any tension while you do this.

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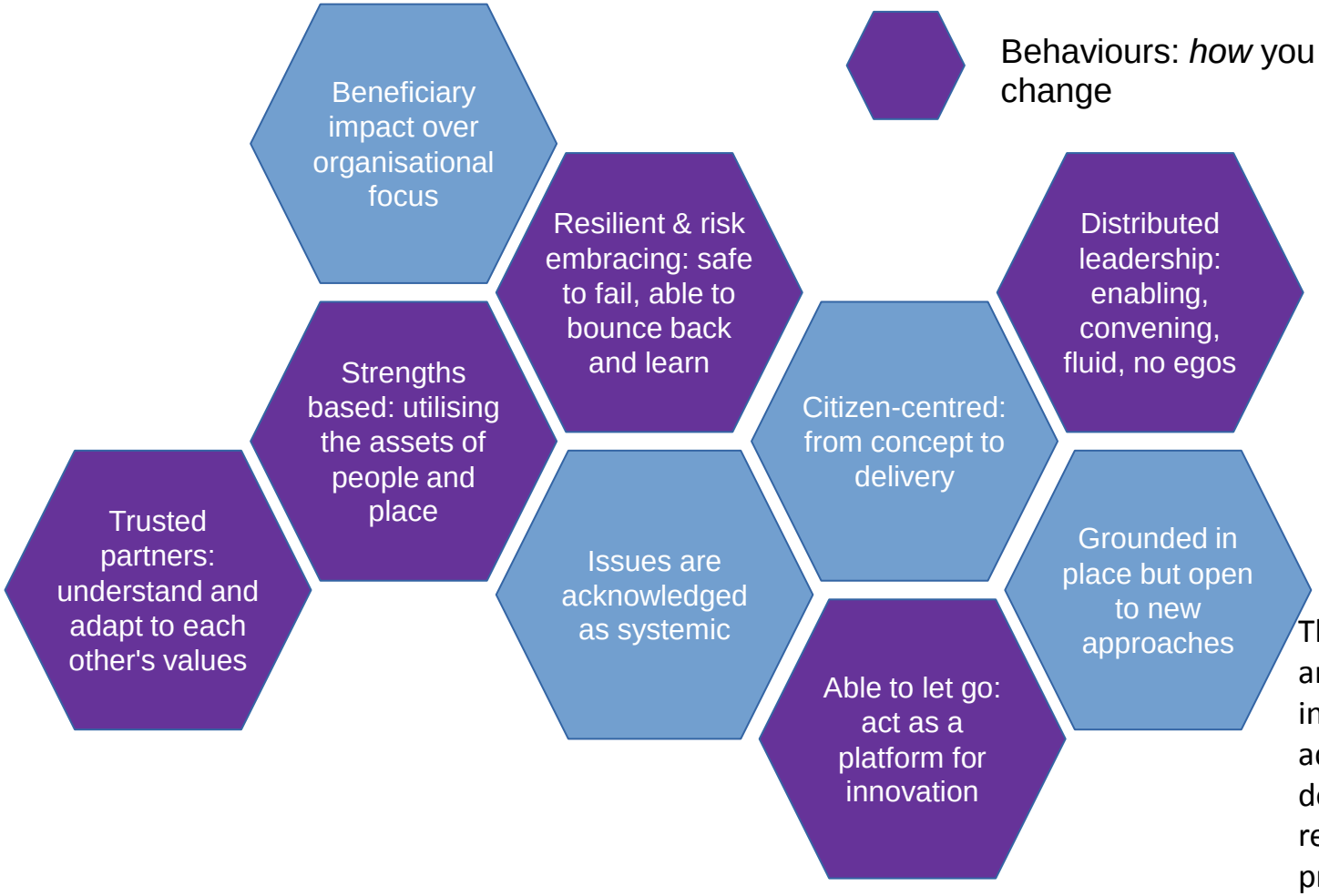
Introducing our pre-conditions for systems change (developed with Coventry): A focus on vision and behaviours…

Having spent time in Coventry understanding what makes it tick, we believe these preconditions underpin whether systems change is likely to happen. We believe, they will apply equally well to health outcomes as to our work with people facing multiple complex needs

Vision: the ambition of the system

Behaviours: *how* you go about systems change



These pre-conditions are neither linear nor independent: they are adaptive and inter-dependent as people, relationships and priorities change.

Summary of nine pre-conditions for systems change:

Beneficiary impact over organisation focus: setting aside the boundaries of organisations and focusing on the outcomes for the place and people, above and beyond what it might mean for you and your organisation.

Citizen-centred: from concept to delivery: getting under the skin of what we really mean by 'citizen-centred', where the system challenges itself to put the clients at the centre of its decisions and business approach.

Issues are acknowledged as systemic and requiring collaboration: a genuine acknowledgement early on that the change being sought is systemic and will require multiple actors to work together.

Grounded in place but open to new approaches: harnessing the assets of the place as the starting point but without being constrained by 'the way things are done around here' in order to learn, try new things and leapfrog traditional routes to change.

Trusted partners: understand and adapt to each others values: supportive partnerships, relationships and ways of working that can aid delivery – honesty and trust being key – this is not about sharing values but about understanding each other's values and adapting accordingly.

Strengths based: utilising the assets of people and place: focusing on the positive capacity of individuals and communities – rather than on their needs, deficits and problems – applying this way of thinking to the whole system and considering the place as well as the people.

Distributed leadership: enabling, convening, fluid, no egos: leading from behind and building guiding coalitions across the system – rather than being 'owned' by a single person or organisation – recognising that this will change over time as the system evolves.

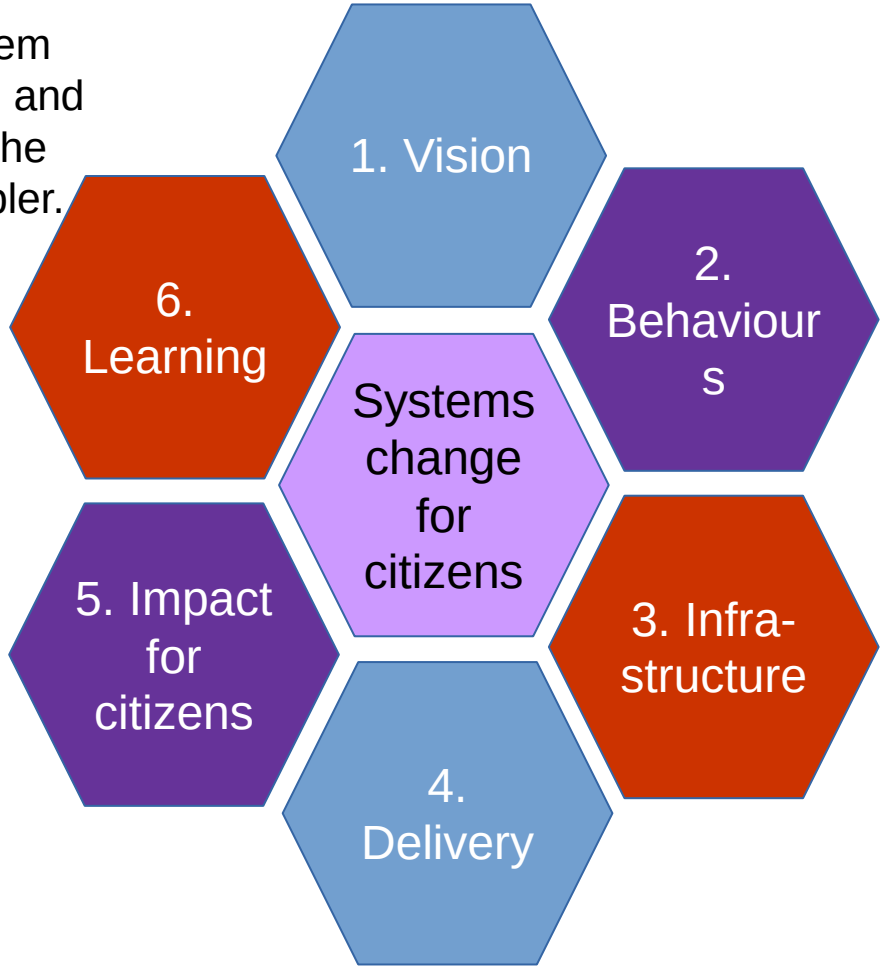
Resilient & risk embracing: safe to fail, able to bounce back and learn: acting as a multiplier for other pre-conditions, this is about the ability to take risks – to fail fast, to learn and to try again – not letting individual or collective resilience be drained.

Able to let go: act as a platform for innovation: moving from public servants as bureaucrats to public servants as entrepreneurs – receptive to disruption, able to seed and support innovation, sharing control and acting as a platform – rather than always delivering.

But system vision and system behaviours alone don't equal delivery…

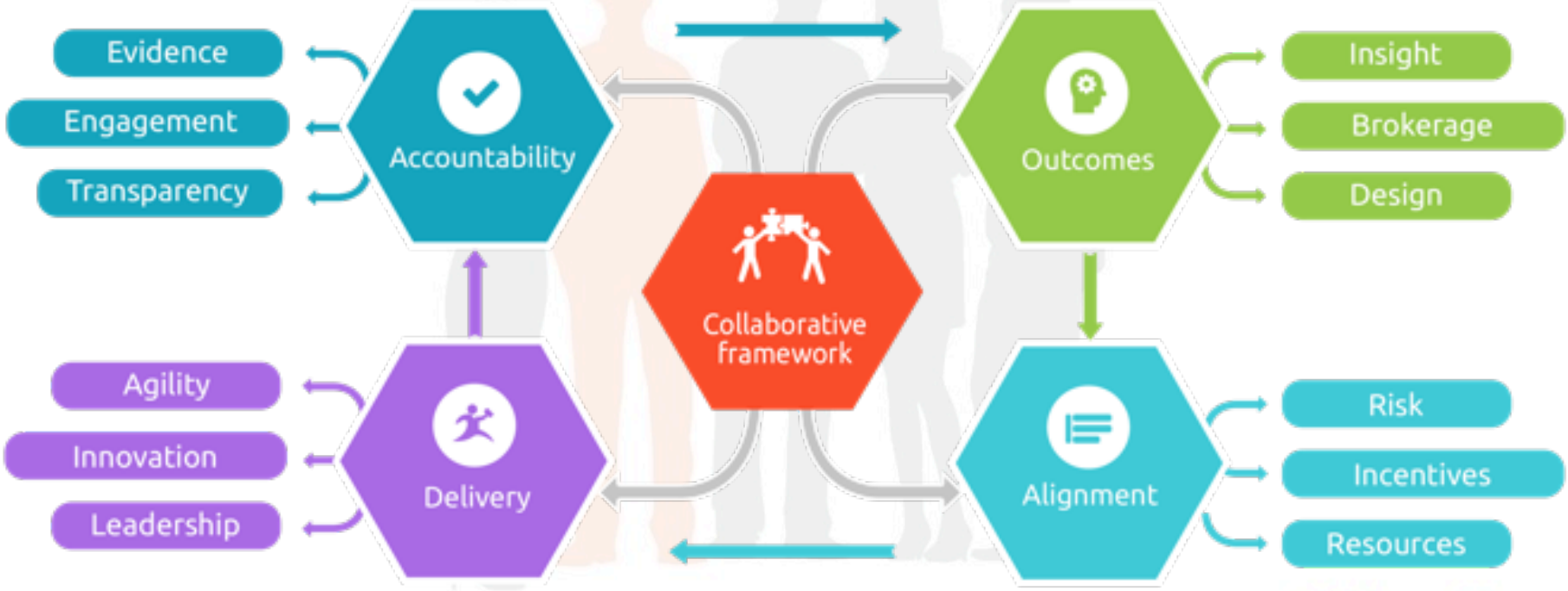
Our work with Coventry demonstrated that beyond the preconditions for system change (vision and behaviours) you also require systems or collaborative infrastructure and delivery. System Governance is a key part of that infrastructure and this is where we believe we can add value to the HWBB to consider their role as a system enabler.

1. Vision – the ambition of and for the system
2. Behaviours – of all those in the system, as individuals and parts of the system
3. Infrastructure – to support systems change particularly: Resources (human and financial), Incentives (commissioning, performance management) and Accountability (governance, risk and regulation)
4. Delivery – is the system vision delivered or just talked about.
5. Impact for citizens – is the system vision delivered in a way that has a positive impact for the citizens of that place
6. Does the system learn, adapt, and continually evolve to meet the changing needs of all those within it



Creating the right climate for collaborative delivery and then doing it!

Our Collaborative Delivery Framework (developed with the UNDP) takes us through a four stage process to ensure collaborative delivery. We would apply this framework with the HWBB at a workshop in November and then consider, therefore, what role the HWBB should be playing to enable the priority outcomes to be delivered. Having done this and agreed priority areas we would pick one of those areas a do a one day delivery clinic (in January) to apply this thinking to one bit of the system



Plan on a page: Key activities and timeline

Key outputs and timeline	1. Flip the starting point: agree the opportunity to reframe the HWBB's approach. 19th Oct.	2. Full day Workshop: apply preconditions framework and delivery framework to Health outcomes – what role should HWBB be playing to achieve these outcomes Late November (w/c 23rd Nov)	3. Refine workshop outputs, apply to possible priority areas and bring paper to HWBB to agree. For 7th December HWBB	4. Collaborative delivery clinic: For one priority area do a one day delivery clinic to reconfigure approach. Pilot methodology which could then be applied more widely. Early January 2016
Description of activity	Discuss to what extent the preconditions exist in the health space and how they might be used to support the development of a new strategy.	Develop answers to the following questions: a) What are our key outcomes? b) Are they aligned (risks, incentives, resources)? c) What accountability mechanisms do we need? d) Therefore what should HWBB role be?	Bring together workshop outputs with JSNA to identify likely priority areas in paper for discussion and decision at HWBB	Summary feedback/next steps after each session plus final report with recommendations – published something as a commitment device perhaps?
Collaborate role Sarah (MD) Saira (Programme associate)	Support Robina and attend HWBB to discuss and agree approach	Design and deliver one day workshop. Brief Diagnostic phase to build on HWBB work do date and key focus e.g. inequalities, better care fund etc.	Apply workshop thinking with Robina to what HWBB priorities and roles should be for her paper.	Design and deliver one day delivery clinic (CCC will need to lead of logistics and Robina co facilitate)
HWBB role	Agree approach on 19th October	Attend workshop in November and come prepared to consider a different approach and maybe way of working…	Robina work with Collaborate to iterate thinking post workshop and produce paper for 7th Dec. Board. HWBB agree focus of first delivery clinic	Support attendance at delivery clinic by identifying right people. Identify in whom (alongside Robina) we should build capability to repeat this in other parts of the system without Collaborate.

Collaborate operating principles

1. We care about outcomes and values, not sectors
Our work actively promotes services to the public that engage government, business and civil society, blurring traditional boundaries and prioritising outcomes over sector preconceptions

2. We support collaborative citizens
Our starting point is the voice of the citizen, family and community, and our approach will always look for ways to support their capability, independence and resilience

3. We work with people who want genuine collaboration
Our clients and partners are people who want to collaborate to deliver better outcomes - we help them to make it happen through different thinking, culture and practice

4. We offer honest relationships, not pre-baked solutions
Our way of working is different - we believe that the best approaches are co-created; we work hard to convene networks, broker relationships and be 'comfortable with uncomfortable'

5. We build readiness and unlock capacity
Our approach is to enable others to find their own solutions; we use independent evidence and diagnostic insight, then build capability in others to make delivery sustainable

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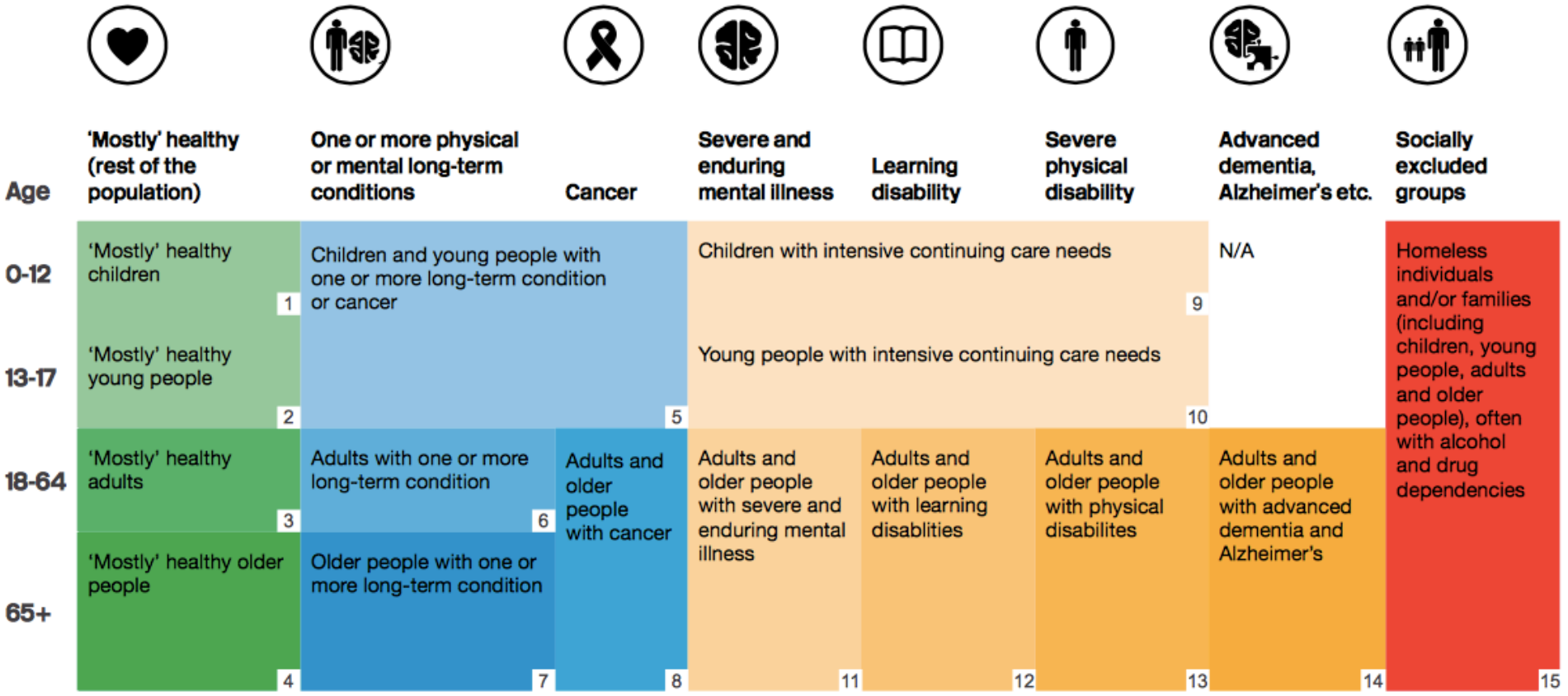
Food for thought: how are others approaching this

We wouldn't suggest a lift and shift of any of the next four slides, but it is interesting to see what others are doing as a catalyst for our conversations and work together in November. We would seek to develop, with you, your system vision and priorities to underpin your next HWBB strategy.

Below is how Lord Darzi categorises different aspects but this doesn't include the wider determinants of health so feels quite healthcare rather than health focussed.



Food for thought: how are others approaching this (2)

This approach from Devon is quite similar to where your JSNA work would naturally lead you…

However how would this fit with the wider system integration role for the HWBB – what should the Board be doing to enable integration, provider side innovation, creative commissioning, community resilience or whatever is important to you?

APPENDIX 2

Health and Wellbeing Board Outcomes Report

June 2015

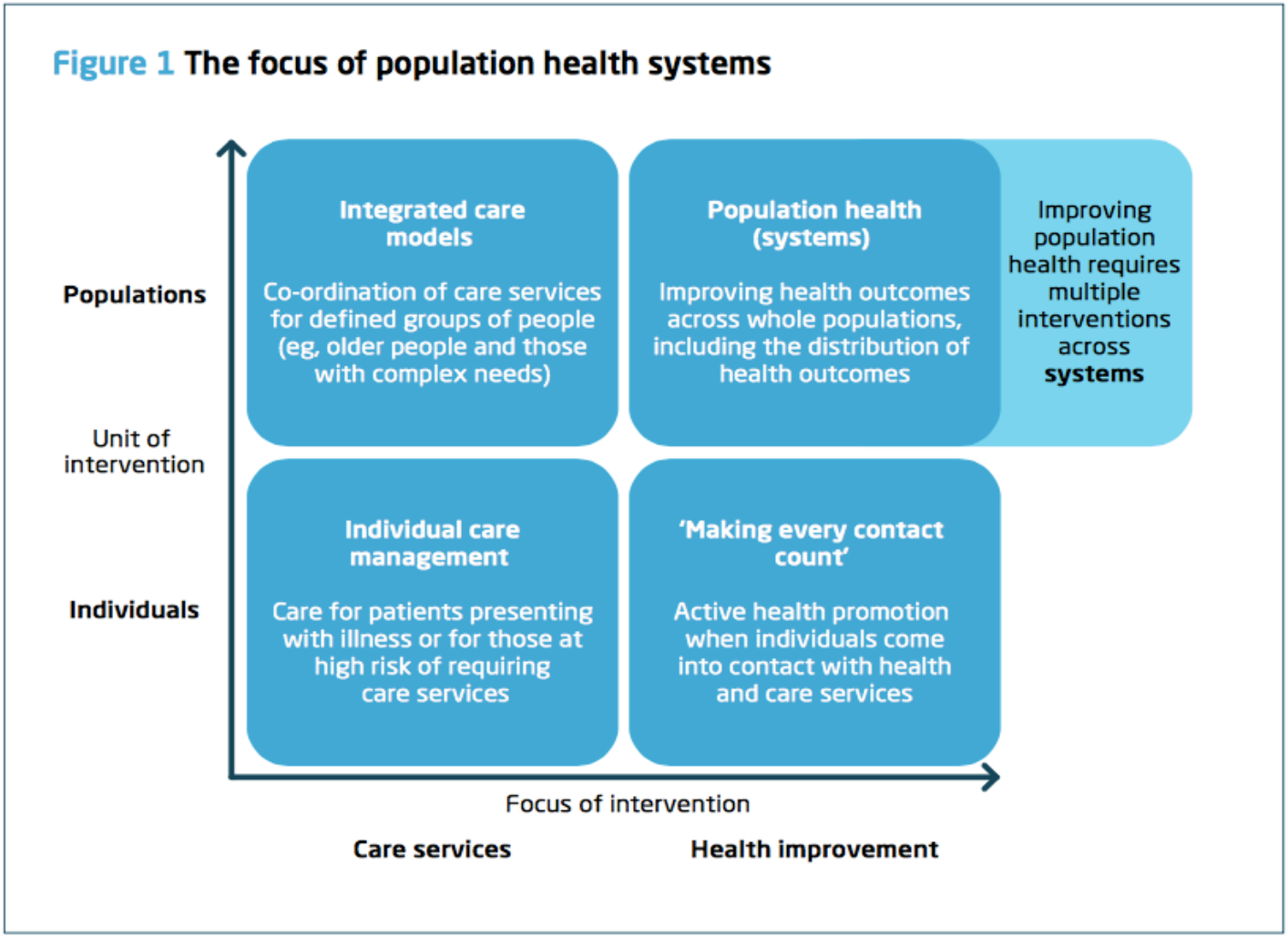
Priority	RAG	Indicator	Type	Trend	Dev/SW/Eng
1. A Focus on Children and Families	A	Children in Poverty	Chall		
	G	Early Years Foundation Score	Chall		
	G	Smoking at Time of Delivery	Watch		
	A	Teenage Conception Rate	Watch		
	-	Child/Adolescent Mental Health Access Measure	Improve	-	-
	R	Hospital Admissions for Self-Harm, Aged 10-24	Improve		
2. Healthy Lifestyle Choices	G	Proportion of Physically Active Adults	Chall		
	A	Excess Weight in Four / Five Year Olds	Chall		
	A	Excess Weight in 10 / 11 Year Olds	Chall		
	A	Alcohol-Related Admissions	Watch		
	G	Adult Smoking Prevalence	Watch		
	G	Under 75 Mortality Rate - All Cancers	Improve		
	G	Under 75 Mortality Rate - Circulatory Diseases	Improve		
3. Good Health and Wellbeing in Older Age	A	Incidence of Clostridium Difficile	Chall		
	G	Injuries Due to Falls	Chall		
	A	Dementia Diagnosis Rate *	Chall		
	G	Feel Supported to Manage Own Condition	Watch		
	G	Re-ablement Services (Effectiveness)	Watch		
	A	Re-ablement Services (Coverage)	Watch		
	A	Readmissions to Hospital Within 30 Days	Improve		
4. Strong and Supportive Communities	A	Suicide Rate	Chall		
	G	Male Life Expectancy Gap	Chall		
	G	Female Life Expectancy Gap	Chall		
	G	Self-Reported Wellbeing (low happiness score)	Watch		
	G	Social Contentedness	Watch		
	G	Carer Reported Quality of Life	Watch	-	
	A	Stable/Appropriate Accommodation (Learn. Dis.)	Improve		
	G	Stable/Appropriate Accommodation (Mental Hlth)	Improve		

RAG Ratings

Red	R	Major cause for concern in Devon, benchmarking poor / off-target
Amber	A	Possible cause for concern in Devon, benchmarking average / target at risk
Green	G	No major cause for concern in Devon, benchmarking good / on-target

Food for thought: how are others approaching this (3)

This model from the Kinds Fund provides a useful system framework for conceptualising an approach to population health but again it is quite healthcare rather than health focussed and maybe doesn't support the shift to either prevention or the wider determinants of health (housing, transport, parks) or health inequalities that you may wish to encompass as a result of Marmot

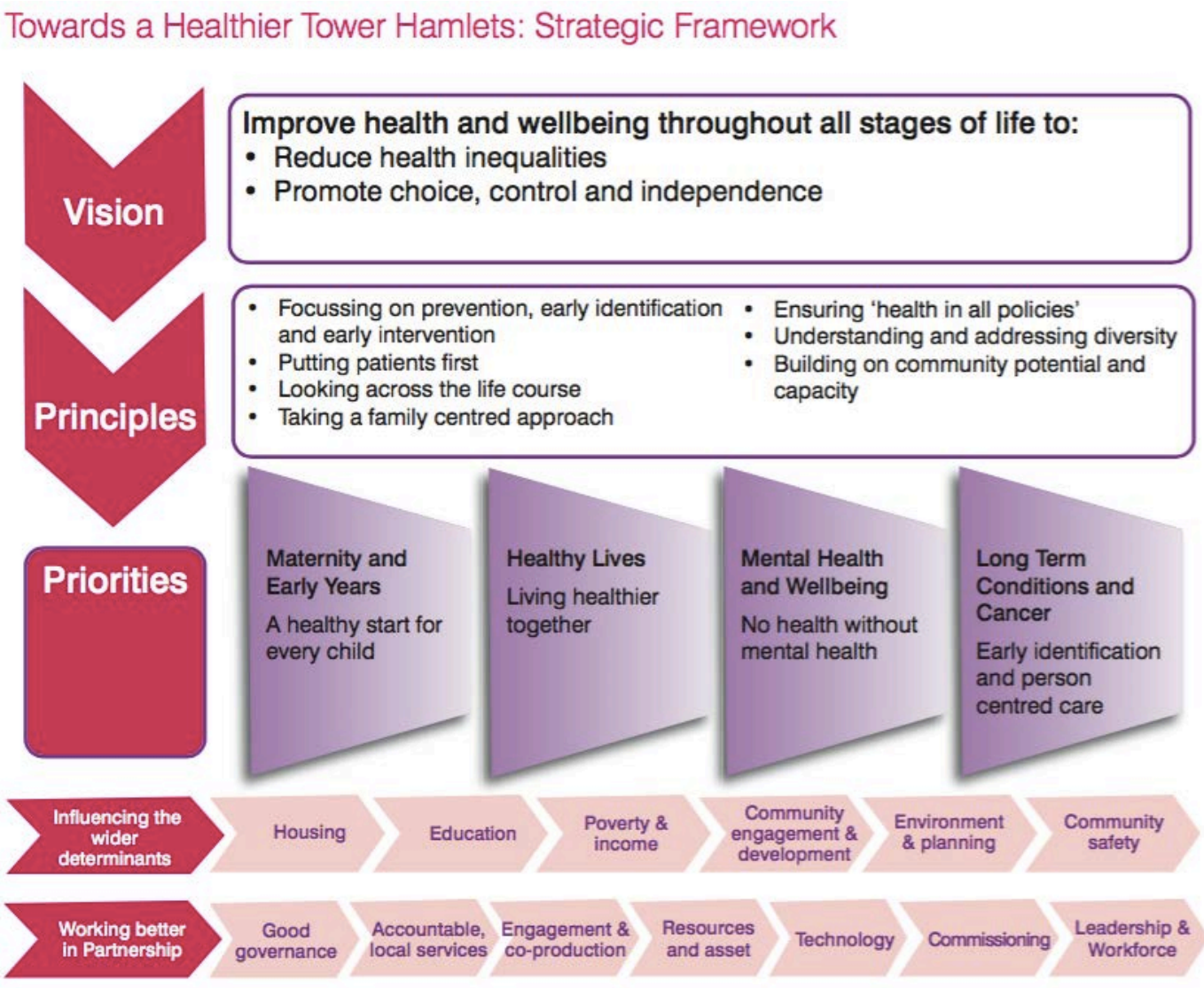


Food for thought: how are others approaching this (4)

We quite like this from Tower Hamlets, which combines priorities that emerge from the JSNA work but sits these beneath a vision and set of principles to give strategic systems focus, underpinned by some thinking on wider determinants and some of the infrastructure to support delivery.

This obviously is a top level framework and requires detail beneath it.

What isn't clear from others approach is an articulation of the HWBB role in achieving place-based health – this would be something for discussion in November.



Food for thought: how are others approaching this (5)

In Suffolk their three step approach: Strategic outcomes, priority areas and key measures encompasses several of the things that are important in a systems shift. They have supported this with thinking about leadership, commissioning and integrated care organisations.

Strategic Outcomes, Priority Areas and Key Indicators

Strategic outcome	Priority areas	Key measures (Indicators)
Outcome 1 **Every child in Suffolk has the best start in life**	**1.1** Early intervention and prevention	**1.1.1** Decreased prevalence of smoking at delivery **1.1.2** Decreased under 18 conception **1.1.3** Increased breast feeding rates **1.1.4** Increased uptake of free early learning for disadvantaged 2yr olds and universal offer for 3 and 4 yr olds **1.1.5** Increased "good level of attainment " at age 5 **1.1.6** Increased level of attainment at Key stage 3&4 **1.1.7** Decreased prevalence of overweight and obesity in 4-5 yr olds **1.1.8** Decreased prevalence of overweight and obesity in 10-11 yr olds **1.1.9** Decreased tooth decay in children aged five
	1.2 Promoting family focus across the work of agencies including the "Suffolk family focus" initiative	**1.2.1** Improved school attendance **1.2.2** Reduced crime and antisocial behaviour **1.2.3** Reduced NEET in 16-18 yr olds **1.2.4** Reduction in reoffending
	1.3 Supporting parents to improve their own circumstances	**1.3.1** Increased uptake of evidence based parenting programmes

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Food for thought: how are others approaching this (5)

Outcome 2 **Suffolk residents have access to a healthy environment and take responsibility for their health and wellbeing**	**2.1** Creating an environment where it is easy to make healthy choices and take responsibility for own health	**2.1.1** Decreased smoking prevalence in adults > 18 yrs **2.1.2** Increased uptake of NHS health checks in those eligible **2.1.3** Increased detection and treatment of Chlamydia infection (15-24 yr olds) **2.1.4** Increased uptake in cancer screening **2.1.5** Decreased killed or seriously injured casualties on Suffolk roads
	2.2 Increasing the levels of physical activity and encouraging greater use of our natural environment This will also contribute to achieving 1.1.7, 1.1.8, 1.2.2, 3.2.1 and 3.2.3	**2.2.1** Reduction in prevalence of obese adults **2.2.2** Increase in the proportion of physically active adults **2.2.3** Increased utilization of green space for exercise/health reasons
	2.3 Decreasing the harm caused by alcohol to individuals and communities	**2.3.1** Decreasing the rate of alcohol related hospital admissions **2.3.2** Reduced crime and antisocial behavior **2.3.3** Reduction in reoffending
	2.4 Improving access to suitable housing	**2.4.1** Decreased No. of households in fuel poverty **2.4.2** Increased proportion of affordable homes available **2.4.3** Less Statutory homelessness **2.4.4** Decreased proportion of households in temporary accommodation **2.4.5** Decreasing excess winter deaths

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Food for thought: how are others approaching this (5)

Strategic Outcomes, Priority Areas and Key Indicators		
Strategic outcome	**Priority areas**	**Key measures (Indicators)**
Outcome 3 **Older people in Suffolk have a good quality of life**	**3.1** Ensuring that health and social care services are integrated at the point of delivery	**3.1.1** Decreasing emergency admissions within 30 days of discharge from hospital **3.1.2** Proportion of people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services. **3.1.3** Proportion of people who use services and their carers who reported that they had as much social contact as they would like. **3.1.4** Increased proportion of people with long term conditions supported to manage their condition. **3.1.5** Increased proportion of people who are able to die at home.
	3.2 A focus on prevention including the promotion of healthy lifestyles and self care	**3.2.1** Decreasing falls and injuries in the over 65s **3.2.2** Decreasing hip fractures in over 65s **3.2.3** Increased proportion of over 65s receiving self directed support **3.2.4** Increased proportion of vulnerable people achieving independent living **3.2.5** Increased community-based opportunities to promote personal wellbeing indicative measures **3.2.6** Decreasing permanent admissions to residential and nursing care homes
	3.3 A focus on reducing loneliness and social isolation for older people	**3.3.1** Increased self reported wellbeing

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Food for thought: how are others approaching this (5)

Outcome 4 **People in Suffolk have the opportunity to improve their mental health and wellbeing**	**4.1**	Ensure that mental health is everyone's business not just health, social care and the voluntary sector but employers, education, and the criminal justice system	**4.1.1** Increased rates of employment for those with a long-term health condition including those with a learning difficulty/disability or mental illness **4.1.2** An increase in the proportion of people with mental illness or disability in appropriate settled accommodation **4.1.3** An increase in the proportion of people assessed for substance dependency issues when entering Suffolk prisons **4.1.4** Decreasing people in prison who have a mental illness or significant mental illness **4.1.5** Increased rates of adults in contact with mental health service in employment
	4.2	Increase access to support for improving the emotional health and wellbeing of children including access to child and adolescent mental health services.	**4.2.1** Improved emotional wellbeing of looked after children **4.2.2** Decreased hospital admissions caused by unintentional and deliberate injuries in under 18s
	4.3	Ensure that there is seamless mental health provision across agencies but also for those with multiple problems (drugs & alcohol misuse and mental ill health)	**4.3.1** Increasing successful completion of drug treatment **4.3.2** Increased young people in drug or alcohol treatment referred from child and families service **4.3.3** Increasing adults in alcohol treatment referred from criminal justice
	4.4	Bringing together all elements of physical and mental wellbeing in recognition that physical and mental health are inter-dependent	**4.4.1** The above indicators and **4.4.2** Decreased under 75 mortality in adults with serious mental illness **4.4.3** Decreased rates of suicide

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