HEALTH AND WELLBEING BOARD WORKSHOP
BALLROOM, LINDEN HOUSE, W6
20 MAY 2016, 11.00am–14.30pm
SESSION REPORT

Attendees:
Councillor Vivienne Lukey (Cabinet Member for Health and Adult Social Care); Councillor Sharon Holder (Lead Member for Hospitals & Health Care); Liz Bruce (Executive Director of Adult Social Services); Chris Neill (Director Whole Systems, Adult Social Services); Rachel Wright-Turner (Director of Children's Commissioning); Stuart Lines (Deputy Director Public Health); Janet Cree (Managing Director, CCG); Vanessa Andreae (Practice nurse, CCG); Dr Tim Spicer (Chair, CCG); Keith Mallinson (Chair, Healthwatch)

Apologies:
Councillor Sue Macmillan (Cabinet Member for Children and Education), Councillor Rory Vaughan (Health, Adult Social Care and Social Inclusion Policy and Accountability Committee Chair), Dr Mike Robinson (Director of Public Health), Ian Lawry (Co-optee, Sobus)

Introductions

Chris Neill welcomed Board members. He reminded people that at the Health and Wellbeing Board meeting in March facilitated by Chris Ham that members agreed to hold an informal half-day session to develop the joint health and wellbeing strategy and that today's session was the result.

Mr Neill began the session by asking board members to share perspectives on health and wellbeing, the content of any conversations members had had with one another since March and on their role on the Board. The following points were made:

- That the role of Healthwatch was ensuring the patient voice was listened to and included in the decision making process.
- That too often changes in health and care feel done to others without people having much of a say.
- That mental health provision had been a Cinderella service for too long and needed to be brought into more of our thinking
- That organisations were often more powerful that patients and that this needs to change.
- That tackling health inequalities and ensuring social mobility were a key driver and personal motivation
- That there was a strong community in Hammersmith & Fulham and the Board needed to build on existing community ties to improve health and wellbeing
- That the role of the Board was about the art of the possible

After perspectives had been shared, Chris outlined the session plan and gave a synopsis of the paperwork in front of members. He particularly highlighted the draft strategy discussion document which set out a potential framework for the Board's next joint health and wellbeing strategy. Chris explained the document would be updated with the feedback gathered at today's session. Chris also drew attention to

an A3 pyramid diagram in front of members explaining that any thoughts and reflections captured here by members throughout the session would also be used to update the draft strategy. Chris highlighted that the next formal Board meeting was 20 June and that officers would bring a near-final draft strategy document to that meeting along with the North West London Sustainability & Transformation Plan (STP).

Case studies: International integrated care systems

Mr Neill gave a presentation that drew out the features of a number of international integrated care systems. He made the following points:

- Kaiser Permanente in California has a strong prevention ethos which stemmed from its origins as a health care system for workers building dams in the Californian desert in the 1930s. Organisational features also included the use of capitated budgets, risk stratification, use of technology and viewing hospital admissions as 'system failure'. Heavy use of data to understand population needs.
- The Nuka System of Care in Alaska as well as integrated health and care services has programmes which tackled wider community issues such as domestic violence, abuse and neglect through education, training and community engagement. The system also displayed strong community ownership with local people in system governance structures.
- Gesundes Kinzigtal, in Germany had a strong workforce element and development with professionals making joint decisions. As well as having traditional contracts with health providers contracted with local gyms, sports clubs, education centres, self-help groups and local government and offered a range of activities and health promotion programmes in schools and workplaces.
- The Jonkoping County Council, Sweden model had a strong data-based model that used a dashboards and a range of indicators to understand population health including non-typical indicators such as rates of obesity, physical activity, diet, deprivation, crime, truancy and educational outcomes. Model built around primary care.
- Canterbury, NZ transformation started with an analysis showing it was unsustainable on its present path. It developed a strong, clear and sustained vision of where the health and social care system had to go ("one budget, one system"), made continued investment in leadership and innovation skills for all levels of staff, empowering staff to innovate providing the freedom and tools to do it (Lean, Six Sigma). It built on existing strengths (strong primary care) and adopted and adapted ideas from elsewhere.

Common features of the systems included:

- Population-level data to understand need across populations and track health outcomes
- Population-based budgets (either real or virtual) to align financial incentives with improving population health
- Community involvement in managing their health and designing local services

- Involvement of a range of partners and services to deliver improvements in population health.
- Population segmentation and risk stratification to identify the needs of different groups within the population
- Targeted strategies for improving the health of different population segments
- Developing 'systems within systems' with relevant organisations, services and stakeholders to focus on different aspects of population health.
- Integrated health records to co-ordinate people's care services
- Scaled-up primary care systems that provide access to a wide range of services and co-ordinate effectively with other services
- Close working across organisations and systems to offer a wide range of interventions to improve people's health
- Close working with individuals to understand the outcomes and services that matter to them, as well as supporting and empowering individuals to manage their own health

Discussion

Following the presentation, members had the following reflections and thoughts on what could be learned from the models:

- That the presentation had offered helpful lessons for the Board but that international models could not always be fruitfully compared with the UK because of differing national taxation regimes. It was highlighted that, for example, in Sweden, citizens pay 40% tax for an excellent healthcare system but that this wasn't the case in the UK.
- That in an ideal world, the NHS and social care would be taken out of national politics altogether to encourage more long-term thinking.
- That the STP had been rushed and was a missed opportunity to have a debate with the public about a broader vision for health and social care in North West London. It was hoped today's session could be used to agree that vision locally and start to communicate it widely.
- That the STP had been done to both patients and professionals and the model of care that it sets out is not one where people own their own health. That digital and app-based technologies that, for instance, allowed you to monitor diet, exercise and other lifestyle factors, promised significant opportunities for catalysing a shift toward self-care.
- That the NHS had been overly patriarchal in the past and that now what was needed was a supportive stance that enabled people to take greater responsibility for their own health and the health and wellbeing of their families.
- That 'coaching for health' training which worked with people to plan and make manageable changes to their lives was a good example of the sort of approach needed.
- That there was considerable waste in the public sector and that we need to consider how to get more out of what we have so that more resources could be used on the frontline.

The group broke up into small groups to consider the presentation. Reflections included:

- That developing a shared vision across HWB organisations was of critical importance. Priorities and outcomes, by comparison, were likely to be relatively uncontroversial given the clear evidence and what we know about health and need locally.
- That early intervention, reducing wasted patient time and giving more responsibility and control to the patient were all crucial features of the model needed locally
- That the importance of prevention and early intervention is known but the question was how to do this i.e. how far upstream do we go? It was suggested that we need to employ behaviour change methods and nudge techniques, looking to the plastic bag ban for instance as an instructive policy example.
- That we need clear messaging such as the five ways to wellbeing
- That we need to bring together and treat physical and mental health equally
- That a key feature of our local model should be an emphasis on empathy and listening to people.

<u>Breakout session one – What is our vision for Hammersmith & Fulham by 2021?</u>

Chris introduced the first breakout session highlighting the draft vision in the discussion document. He asked people to mix up into groups, and drawing on the previous discussion and case studies, discuss a vision for the borough for the next five years and how we will deliver it. Groups had the following feedback:

- That there was consensus by the group that supporting independence and self-care and prevention and early intervention were an important part of the vision and that one of the Board's aims is to enable resident's to be responsible for their own wellbeing and wellbeing of those around them.
- That the best start in life and the children and families agenda needed to feature more prominently in the vision. Using the stream metaphor, going upstream means targeting children to be healthy.
- That the enthusiasm and responsiveness to health messages in schools meant the Board could use children and young people to improve health in families.
- That good mental health had to be a stronger feature of the vision and treated equally with physical health. That the Board should move away from thinking and talking in terms of "mental health" towards something like "social health" – emphasising the important role of community networks and social connections.
- That the pictogram from the Canterbury, NZ model of care described the model needed locally (see Appendix A). I.e. with people, families and communities at the centre with services and community resources wrapping around the outside.
- That joined up thinking was needed so that no matter where people in the system present they are signposted and referred correctly. This meant equipping all public sector staff with a base level of knowledge and skills beyond their core business.
- That it was important to educate people about how the health and social care system works and how and when to access it and that we should use existing

resources such as health champions and carers champions to communicate these messages.
- That the NHS has traditionally done digital very poorly and that we need to exploit the potential of digital technologies to facilitate control and choice and enable patients to manage their health in the way that best suits them (including digital and apps). That digital will increasingly become the way people want to engage but that we still need to offer other channels to interact in the way that best suits people

The Board also commented on the tone of the vision:

- That the tone of the vision needs to be public facing.
- That the tone needs to be less about what the health and care service will do or deliver to people and more about how it will work with people. That there needs to be a shift in perspective emphasised in the language from service provider to catalyst or enabler of change
- That the vision needed to move away from a deficit or disability formulation to an asset and ability based one, emphasising the talents, resources and abilities of people and communities, especially celebrating the ageing population
- That there needed to be a responsibility deal or contract between the public and the health and care system setting out what both can expect from one another. This would include things like being a good neighbour and community member.

<u>Breakout session two</u>

Stuart and Janet introduced the second breakout session with a brief overview of health needs in the borough. Members were given a pack of information on the health needs in the borough and asked to choose their top population health priorities. Group feedback on priorities included:

Areas of commonality across the Board:
- Strong local connection / community focus
- Vision driven by values
- Strong outcomes focus

Priorities:
- Tackling health inequalities
- Social inclusion and isolation
- Best start in life and family support including an emphasis on parenting support, early help, child poverty and obesity and immunisations
- Mental health
- Obesity
- Communication, co-production and co-commissioning with residents
- Resilience, independence and self-care
- Prevention and early intervention
- Integrated services – no wrong door
- Wider determinants of health (air quality, poverty and worklessness)
- Digital: facilitate control, choice and effectiveness

Delivery:

- That once priorities are agreed the Board should dashboard progress measures and ask every item that comes to the board to say how it contributes to our priorities
- That the Board needed to select a small, manageable number of priorities and do them well
- That board members could pair up and take responsibility for the delivery of priorities
- That the priorities should be articulated in terms of the language of outcomes e.g., “our children will be immunised” etc
- That HWB meetings should rotate around areas or themes that play to priority areas and could link with PAC for accountability

Breakout session three

Mr Neill introduced the final breakout session. He explained that a strategy that set out a vision and priorities would also need to say something about how that change will be delivered. These are the enablers of change and included things like technology, workforce and governance. For the last time, people were asked to divide into groups and discuss the enablers of change that would be needed to deliver the vision and priorities discussed already. Group reflections included:

- That communication and representative engagement were important and that the Board could go out to public and make meetings public events
- That there should be a more direct link with the work of CCG governing bodies with a more overt link with GB papers
- That membership was a crucial enabler and should be reviewed to consider how best to engage with NHS providers and others such as housing and the criminal justice system.
- That governance was a key enabler and that the Board should aim to position itself at the top of tree with Governing Bodies and Cabinet delegating responsibility for health and social care decision to the Board
- That a means of tracking progress was crucial including the use of a performance management system or dashboard
- That digital and IT were crucial enablers of further integration, information sharing, analysis and the self-care agenda
- That it was important to seek to embed health in all policies – and work with planning, transport, education and the criminal justice system to do this and hold to account for doing this.

Before concluding, Chris asked Board members if they had any other reflections which they had been unable to share so far. The following reflections were made:

- That information and education were integral to everything and it was vital that people were aware of how the health and social care system worked, and what to access, how and when. From the perspective of the health and care system, a no wrong door approach was needed
- That we should consider other measures of success for the board beyond health outcomes and measures

- That addressing health inequalities and deprivation should be a strong priority that should run throughout the strategy
- That social isolation or social inclusion should be a prioritiy across the whole life course, not just for older people

Next Steps

Councillor Lukey thanked officers for organising the session. She stated that it had been very helpful and that the Board should reflect on how it uses its time during formal sessions. She endorsed the view that in future, the Board could focus on one theme at each meeting and also the idea of Board members pairing up to take joint responsibility for the delivery of the Board's priority areas. Cllr Lukey closed the session by stating her hopes that the Board would continue the discussions started today at its formal meetings.

APPENDIX A – Model of Care pictogram. Canterbury, New Zealand