HS Paper 5/16

Board Meeting: 5TH JANUARY 2016

OVERVIEW OF THE BOARD SEMINAR HELD ON 4/12/15

Recommendation/action required:

The Board is asked to note the discussion and confirm the strategic direction agreed at the Board seminar held on 4/12/15.

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OVERVIEW OF THE BOARD SEMINAR HELD ON 4/12/15

Purpose of Paper

1. This paper provides an overview of the key discussion points made at a Board Seminar held on the 4th December 2015 and records Board members' decision to continue with NHS Health Scotland's mission and vision as described in the organisation's current strategy 'A Fairer Healthier Scotland' (AFHS).

Background

2. A Fairer Healthier Scotland runs from 2012-2017. The last stages of planning for the delivery year 2016/17 are underway. It is important that a new strategic plan is developed and is in place by the autumn of 2016 in time for 2017/18 delivery planning.
3. A seminar was held on the 4th December to engage Board members in discussion regarding NHS Health Scotland's future strategic direction.
4. Discussion at the seminar – co-facilitated by some non-executive Board members - was stimulated through presentations and questions in relation to what we currently know about performance and progress in two key aspects of strategy development:
    - Strategic Direction
    - Strategic Capability

5. The programme and full flip chart notes from the seminar are appended to this paper. The following sections of this paper give an analysis of the key discussion points from the seminar.

Strategic Direction: key points from the discussion

6. The vision and mission of AFHS remain fit for purpose, albeit with some tweaking to bring them up to date. However there was a perception amongst Board members that the gap between the long term vision and mission of the current strategy and what was attainable in a five year timeframe was too wide.

7. Board members felt it was important that priorities were identified, with an emphasis on where NHS Health Scotland can make the biggest difference and impact.

8. Policy rhetoric favourable to a focus on reducing health inequalities has been evident for 40 years. However, the gap between rhetoric and action remains wide. It was felt that the rhetoric of health inequalities not being inevitable was important to continue, however more work was needed in reaching common understandings of what is meant by fairness and wealth.

9. The political landscape is likely to be relatively stable for the next 5 years and is likely to further diverge from UK government policies. It was felt important that this operating environment is capitalised on and that a narrative about Scotland-specific policies is developed.

10. The realities of operating as an NHS Board were discussed. It was queried whether we had been as challenging as we could have been in relation to NHSScotland policies – person centred care being given as one example where there has been little inequalities focus impact on the work.

11. There have been substantial achievements in the policy areas of tobacco and alcohol policy. As a small organisation we have had far-reaching impact. It was felt to be important that for stronger support for action we keep the focus of our reach and influence on Ministers and Civil Servants and other key policy and decision makers.

12. We should continue with developing partnerships with a focus on impact and influence- Audit Scotland being given as one example that merits attention and development.

13. Work through alliances with other sectors rather than directly with the public was suggested as the best approach for the organisation. However there was also discussion around the role of public opinion in shaping policy and influencing politicians.

14. The rhetoric about economic growth as an integrated approach to improving people's lives gives a major hook for the organisation's work. Reducing health inequalities through a focus on economic justice should be developed in our narrative. There should be a 'stepping up' of our focus on health economics and in recommending the economic benefits of improving health equitably.

15. National versus local work: the focus must be national, however the majority view seems to be that local support work delivered alongside others will be also be important, if this work is used to inform and develop national learning and improvement action.

16. Our stakeholder feedback has given strong indicators for future direction in how we develop and market our 'products and services'; the language we use; the outcomes we set and the alignment of our work with the operating realities of local partnerships.

17. The relationship, efficacy and relative impact of 'producing resources' and/or developing Knowledge into Action (KIA) consultancy/improvement services needs to be further explored.

18. The strategy development timeline was discussed - it was agreed that a dynamic process should get underway that is timeous with and takes account of what emerges from the Public Health Review and the Scottish Parliament Election.

Summary

- Vision and Mission fit for purpose for a further strategic phase with only minor tweaks needed to language
- Develop a focused 5 year strategic and tactical plan aligned to this vision and mission
- Maintain focus and Unique Selling Point (USP) on being a Knowledge into Action Organisation, but stepping up the 'into action' part.
- Step up work on economic impact of inequalities in health and align narrative with Scottish Governments focus on economic growth. Economic growth underpinned by economic justice
- Plan and allocate resources on what will have the most impact
- Plan to develop partnerships with those who have the most impact
- Use stakeholder feedback for continuous improvement
- Discuss and plan relative split between producing resources /products and consultancy/advocacy services.
- Harness and align with opportunities for leadership in the policy and public sector landscape- with a key focus on the outputs from the Public Health Review and the Scottish parliamentary elections.

Strategic Capability: key points from the discussion

19. The organisation is noted as having being in transition over a long period of time. It was accepted that this is a feature of most organisations as they continuously adapt to changes in their operating environment. However transition can get in the way of dynamism and adaptability.

20. There has been a change in the way the organisation sees itself from one that is about connecting other people and organisations to more about what its unique contribution is. This connects with the proportion of spend that has changed – less on products, commissioning others and more on Health Scotland staff offering services and expertise directly.

21. There is now strong rhetoric within the organisation on knowledge and the KIA cycle. However, more work needs to be done to have a strategic plan for how we allocate resources across human resources and products or other resources. Key areas could be shifting resources to strengthen workforce capability and capacity and where appropriate managed disinvestment from some areas of work

22. The organisation has a number of functions and services which inevitably lead to complex working arrangements. Continuous focus on internal and external collaborative working is needed to ensure the sum of the parts is always reached.

23. The organisation's role in providing and developing public health leadership capability is critical for its future.

24. Our capability to reach into and influence different sectors needs to be developed. Balance between engagement with Scottish Government and the Private Sector was given as an example to be considered. The balance between national and local work was discussed whilst important to get the balance right- it is also important to recognise primary role is at national level. Any local work should therefore be predicated on the intention to share the learning or other products from the work at national level

25. There was a perception that we don't segment who we are speaking to enough and this leads to reduced impact and wasted effort.

26. Strong, but also distributed, leadership was acknowledged to be important, this was dependant on people knowing what the organisation is trying to achieve, what their role in this is and then being enabled to get on with their job without looking for permission

27. It was agreed that workflow was helped by having clear corporate priorities and that distributed leadership would be a sign of the organisation having more appetite for risk.

Summary

Transition is a feature of most organisations, however care is needed to ensure the process of transition doesn't stifle dynamism and adaptability.

Therefore, be known as a **dynamic and adaptive** organisation rather than one in transition.

Focus on how we make collaborative working more effective, internally and externally.

Strive to get the balance and relationship 'right' between services and the products/resources we produce.

Enable staff to identify with and understand the role of the organisation and see their part in achieving the overall aims of the organisation within a framework of personal and corporate accountability linked to risk appetite.

Identifying and agreeing the **key** partners and audience segmentation.

Develop a workforce that has the capacity and skills to work with partners to translate knowledge into action.

Cleary defining the organisation's role in providing and developing public health leadership capability is critical for its future.

Finance and Resource Implications

28. The Board will continue to need to monitor, debate and think about the balance of finance that we allocate to different functions and resource and how we prioritise in different economic and operating climates

Partnership

29. Internal staff engagement sessions have taken place prior to the Board seminar. A report from these sessions will be discussed at a Partnership Forum meeting. Further engagement with staff is integral to our internal communication and engagement plan.

Communications

30. Staff are updated re Board meetings and seminars via the monthly Corporate Cascade. The communications and engagement plan includes internal and external engagement throughout the development of the strategy and leading up to its launch. Engagement with staff in the development of the next strategic plan forms part of our communication and engagement plan. A stakeholder analysis has been undertaken to inform external communication and engagement in developing out strategy.

Risk

31. There is a risk that the uncertainty regarding how the public sector landscape will look following the public health review and the next Scottish parliament election will constrain our ability and delay the development of our next strategic plan. The Board has set an open risk appetite for our public affairs work which should mitigate this risk and enable us to continue to develop our strategy in a dynamic and ambitious way.

Equality and Diversity

32. The development of our next strategy will continue to be based on the principles of equality, diversity and the human right to health. The development of our Board has included recruiting a more diverse membership.

Sustainability and Environmental Management

33. Our digital first approach will continue as will our commitment to our social responsibilities for sustainability and efficient use of resources.

Action/ Recommendations

The Board is asked to note the discussion and confirm the strategic direction agreed at the Board seminar held on 4/12/15. This includes the decision by the Board that the next strategy is likely to stem from a revamped and updated AFHS Vision and Mission, rather than an entirely new direction.

Christine Duncan
Head of Strategy and Communication
29th December 2015

APPENDIX A

SEMINAR PROGRAMME

Looking Back across AFHS: Looking Forward to 'AFHS 2'
Board Seminar 4 December 2016 10:30-16:00
Please note: Tea/Coffee will be available at 10:15
Room 1/2 Gyle Square

As a Board this seminar will aim to help us:

- Determine whether the next strategy should be a refinement of AFHS, or a new direction
- Identify key learning from AFHS that should shape the drivers for the next strategy
- Outline and agree the role the Board will play in defining the new strategy over the next 18 months

Programme

10:15	**Tea/Coffee available**	
10:30	Welcome and Introductions	David Crichton
10:45	Aims and Format of the Day	Cath Denholm
11:00	**The changing strategic & policy context** Analysis, questions arising and discussion	Elspeth Molony/Ali Jarvis
12:00	**Tea/Coffee comfort break**	
12:10	**How we see ourselves and are seen by others** Analysis, questions arising and discussion	Mark McAllister/Anne Maree Wallace
13.10	**Lunch**	
13:40	**How we work** Analysis, questions arising and discussion	Tim Andrew/Paul Stollard
14:40	**Discussion:** So, is it to be 'AFHS 2' or something else entirely? Arising from today's discussions, what are the key themes that we want to explore with stakeholders as the new strategy is developed?	Gerry McLaughlin/Christine Duncan/Cath Denholm (tbc)
15:20	Timescales and role of the Board in developing the next Strategy	Christine Duncan/Mark McAllister
15:50	Closing Remarks	Gerry McLaughlin/David Crichton
16:00	**Finish**	

Note of those present, those in attendance and apologies:
Present:
David Crichton
Russell Pettigrew (until 14.40)
Ali Jarvis
Anne Maree Wallace
Paul Stollard
Maggie Mellon
Joan Fraser
Betty Fullerton
Michael Craig
Gerry McLaughlin
Cath Denholm
In attendance:
Andrew Fraser
George Dodds (until 14.30)
Della Thomas (until 14.40)
Jenny Kindness
Christine Duncan
Elspeth Moloney
Mark McAllister
Tim Andrews (from 12.00)
Apologies:
Steve Bell
Andrew Patience

APPENDIX B: FLIP CHART NOTES

Strategic Direction

Q1: Huge gap between Strategy and reality. Is it strategy we want?

Strategy needs to be about "getting places".
Focus on identifying the priorities where we can make a difference.
Different interpretations of fairness and wealth – don't have common understanding of these terms.
?need to reinforce that health inequalities are not inevitable.
HS strategy needs to influence wider strategies. We should be looking for action where there will be the biggest impact and maximum return.

Q2: Person-centredness should have provided hooks - have we really been critical enough?
Issue of being an NHS Board.
Political stability over next 5-10 years.
Likely to diverge further from UK.
Have a good rhetoric about 'Scotland' specific policy.

Additional Q: What have we achieved so far?
Smoking legislation.
Alcohol
Remember we are small organisation – we have far reach. Key relationship is/should be with ministers / civil servants.

Q3: National/Local – use our alliances with other sectors to influence policies.
Rhetoric about economic growth – integrated with improving people's lives – good hook for us.

Q4: Persistent HI have % effect on economic growth.
Is it about economic justice – frame the argument in this way would be powerful.
Focus on 'people creating wealth' rather than a 'few'.
Should we influence the wider public – might not be directly but through others.
*Health economics – role of HS in recommending the economic benefits of improving health equitably.
Lots of hooks for this – inclusive economics/international.

Q4: Direct relationship between efficacy and difficult policy areas.

Q3: ?Stop influencing local CPPs and NHS Boards instead focus on national role.
Agreement
Local areas want help to implement action.
(Political administration may be more confident to listen to more difficult policy recommendations – other view is admin increasingly risk adverse – consider also no challenge to administration.)

Q4: the role of public opinion and conditions will be critical to policy movement.
How do we engage locally with the public?

STRATEGIC CAPABILITY

- Transition? (sign of a good organisation)
  Consolidate or keep that transition? (Staff ability to be agile towards demand or change)
- Expectations of ourselves.
- Changes in the ways we provide information and get KIA.
- Proportion of spend on human resource and the production of info/services. (People vs Product/Services) so more people offering services – "Purpose & Agency".
- Difference in way we see ourselves not so much about "connecting other people/organisations" more about what our unique role is.
- The way we work is very important "so don't split product and process".
- Public health leadership capability.

- What would give us maximum return for our input?
- Strategy is for NHSHS, not for Scotland but has implications for Scotland.
- Restrictions as a result of being a health board. But would any other organisation have better/different options?
- Small/medium sized organisation.
- National/Local focus? Balance. ("our jewel in our crown?")
- Public influence (capability x expertise)

How we work
Question (1) from Paul
Do we need to think more about those we work with and question this? Divide it up? Is there clear line of sight for staff?
"How the work works" is effected by the processes we've engineered and some of this is a bit dysfunctional… "Why does it feel so hard to do my job?"

How do we categorise our partners? Do we need to change the groupings? The Organisations and who in the organisation and what we are aiming to do with them.
Inevitable that it is messy! So more about ensuring the collaboration in the organisation works better.

Too many lines into SG and not enough into Private Sector for example…
Some may be partners, customers, opponents – don't segment enough – talking to too many people. Only when we define what we are doing – then can allocate our partners with our resource.

Community Planning Partners, IJB's include Las and Health Boards etc. Should it be this?

Question (2) from Paul
People work in complex processes internally. Is this an opportunity or a problem? Can it be smoother?
Can run a risk of blocking/bottle neck if an individual off.

Do our external partners expect us to be a communications and engagement organisation? Are they expecting to work with marketing/communications?

Role of re-alignment exercise in HS.
Leadership internally and workflow and take leadership at all levels. Have the authority to get on with the job. "Distributed leadership."

Looking at the workflow – is there a problem? Is the workflow between teams inefficient?
Corporate priorities can help with focus.

Corporate Priorities can help with focus.
Trust and letting go – "How perfect does it need to be?" We have an open risk appetite.

Is the complex flow more of a problem for those 'lower down' the organisation?

Is it the system or is it attitudes and behaviours that is getting in the way?

Is the complex flow a consequence of breaking silos?

Question (3) from Paul
Are we recognising the impact during the process rather than the end produce?
Trying to involve people along the way. Advocacy and influencing skills required with external partners throughout.
So who are partners and who are collaborators? ("Not what you know but who you know")
Distributed approach to leadership and collaboration "accountability" of leadership recently introduced to our thinking. Personal accountability and permissions….

Clarity round who we are, where we are and have started on some of how we work enquiry – "how our work works".
By moving the leadership "down" shows more appetite for risk, staff need to feel comfortable with this approach.
Culture and getting this shift to achieve a change.
How do we measure success and the quality of this may value certain types of behaviours over than others.

Summing Up
Need to have something about how we work not just about becoming a high performing organisation but need to think seriously about how we make collaborative working internally and externally more effective. An organisation that values the process as well as the product.
For this staff need to be confident to explain the role of HS or signpost to other ???
Let's be a **dynamic** organisation rather than one in transition.