NHS
Leadership Academy

Supporting and developing leadership for co-production, community development and personalised care

www.leadershipacademy.nhs.uk

Contents

Executive summary

This report presents the findings of a research project that has been undertaken over the last few months to explore how the NHS Leadership Academy can maximise the potential of 'people power' through its work, ensuring that programme participants are equipped to manage the changes inherent in the NHS Long Term Plan. It describes the extent to which the Academy is developing NHS leaders who understand and promote the principles of co-production, community development and personalised care in and beyond their organisations, within a context of system transformation and local, place-based wellbeing.

The report describes what is meant by leadership in personalised care, co-production and community-building. The definition includes:

- Starting with place and community – leading for the greater good and for population health across systems and boundaries
- Creating the conditions for change and system-wide transformation, based on what matters to people and communities
- A genuine commitment to partnership working, collaboration and co-production
- Driving forward a culture of collaboration, creating and harnessing energy for change and enabling people to take control and self-organise
- Embedding the principles of co-production throughout the system so that services truly reflect what people want
- Being open-minded, curious, authentic, flexible, humble and self-aware
- Willingness to take risks and try new things
- Having technical skills in asset mapping, dealing with large groups, participatory methods of working with communities, facilitating conversations, sharing stories and experiences, techniques for leading change and inclusive practice
- Identifying and overcoming barriers to change
- Exploring ways to shift traditional power and the way money flows through the system
- Bringing lived experience to work and a commitment to seeking out and acting upon the lived experience of others.

This project has looked at the knowledge people gain whilst participating in the programmes and the degree to which the programmes equip leaders with the skills and qualities necessary to ensure that co-production, community development and personalised care are promoted and championed. The project has also looked at the commissioning and delivery of programmes - whether or not they are co-produced - and the audience for the programmes.

A case for change is made across the Academy as well as a series of recommendations which include:

1. **Building the Academy's leadership in personalised care 'offer'** at national and local level. This includes integrating core programme content around personalised care, co-production and community-building into all the national programmes and the offers of the local Academy teams.
2. Ensuring that the **practical and applied elements of the programmes e.g. projects, assessments and placements, require attention to be paid to community, co-production and personalised care**, and where possible are co-produced by the participants.
3. **Modelling co-production through delivery** – developing a highly skilled faculty of people with lived experience to co-deliver the Academy's programmes.
4. Making the argument for and **shifting towards multi-sector leadership development**, including with citizen leaders and voluntary sector, to reduce siloed working and increase potential for leadership across the public sector to be place-based.
5. **Investing in development for Academy staff and faculty** - so they have a base of knowledge and skill to be able to commission and deliver in co-production and know what good looks like; also investing in capability-building for providers
6. **Ensure Academy infrastructure supports the change** – aligning marketing, funding models, strategy, performance, evaluation and the Healthcare Leadership Model with this agenda.

Full detail is provided on pages 22-25 of this report.

These recommendations come at a moment of transition for the NHS in terms of policy and future direction and implementing them will require commitment from all Academy staff and openness to change. The benefit to the Academy will be significant and this work will ensure the Academy stays relevant and is seen as a cutting-edge force for good in driving personalised care across the NHS.

Introduction

This report presents the findings of a research project that has been undertaken during the course of 2018/19 to explore how the NHS Leadership Academy can maximise the potential of 'people power' through its work, ensuring that participants in its programmes are equipped to work in co-production, across system boundaries, with a focus on the building of healthy communities. Latterly the scope has been widened to include personalised care, given its particular emphasis in the NHS Long Term Plan.

The report draws together information and views from a range of sources: the national team and its offers, the network of local Academy teams and outside experts in the fields of co-production and personalisation. The report builds on a 'primer', published in January 2019 which set out the theory and context around community development, co-production and personalised care (see Appendix 1) and what this means for NHS leaders and leadership development.

This project has looked at the knowledge people gain whilst participating in the programmes and the degree to which the programmes equip leaders with the skills and qualities necessary to ensure that co-production, community development and personalised care are promoted and championed. The project has also looked at the commissioning and delivery of programmes - whether or not they are co-produced - and the audience for the programmes. Some recommendations for change are made in all these areas.

The work has uncovered pockets of truly excellent practice across the Academy which provide a strong foundation for change. There are green shoots of progress elsewhere, such as positive attempts to 'involve patients' or to promote citizen leadership; these areas would benefit from going further and deeper. Finally, there are some elements of provision which do not reflect co-production, community-building or personalised care at the moment and would therefore benefit from a re-design, which may include changing the language used and developing new modules, content and approaches to fill the gaps.

The report is of strategic importance for the Academy at a time of significant change and transition. It is recognised that the recommendations are wide-reaching and challenging. They will necessitate discussion and reflection about the strategic purpose of the Academy, its funding models, its willingness to take a lead on the concept of personalised care and the degree of commitment and ability within the Academy to effect change.

Strategic policy context

At a policy level, the NHS Long Term Plan[1] makes a clear commitment to prevention, and a focus on healthy populations/communities as well as a concerted effort to reduce health inequalities. It commits the NHS to place-based working, through Integrated Care Systems and Primary Care Networks. Integrated Care Systems, bringing commissioners and providers together with local government, will shift the focus of the NHS towards prevention, reduction of inequalities and building the health and wellbeing of populations from the ground up. Primary Care Networks will be the 'building blocks' of integrated care, supporting and driving proactive, personalised and coordinated services at a local level.

These ambitious aims will require NHS leaders to be able to work with people across boundaries at a neighbourhood level to recognise and develop their ability, potential and power to make change happen for the greater good. Leaders aiming to drive these changes will need a comprehensive package of organisational and leadership development that reflects the current policy context. A maturity matrix for Primary Care Network development and a framework for their support has recently been developed within NHS England and co-production, citizen leadership and community-building feature prominently within both.

Personalised care runs through the Long Term Plan, with an intention to reach two million people by 2023/24. Personalised care means people having choice and control over the way their care is planned and delivered. It is based on 'what matters' to them and their individual strengths and needs. This means a shift in power and decision-making, to enable people to have a voice, to be heard and be connected to each other and their communities.

Implementing personalised care will require the training thousands of front-line staff, ensuring that every person with a long-term condition has the opportunity to co-develop a care and support plan and to set wellbeing goals, starting with the question 'What matters to you?' Personalised Care is expected to reach 2.5 million people by 2023/24, with an ambition to double that figure within a decade. 200,000 people should have access to a personal health budget by 2023/24 and 1,000 social prescribing link workers will be recruited to help people connect with supports in their local communities.

> *'A one-size fits all approach to health and care simply cannot meet increasing demand and changing expectations. Making personalised care happen will require a new kind of leadership, the ability to work across boundaries and with people to make transformational change happen.'*
>
> James Sanderson, Director of Personalised Care, NHS England

In implementing personalised care, the NHS will be expected to adopt the operating model shown in Figure 1.

[1] NHS England (2019) Long Term Plan https://www.england.nhs.uk/long-term-plan/ (accessed 8 April 2019)

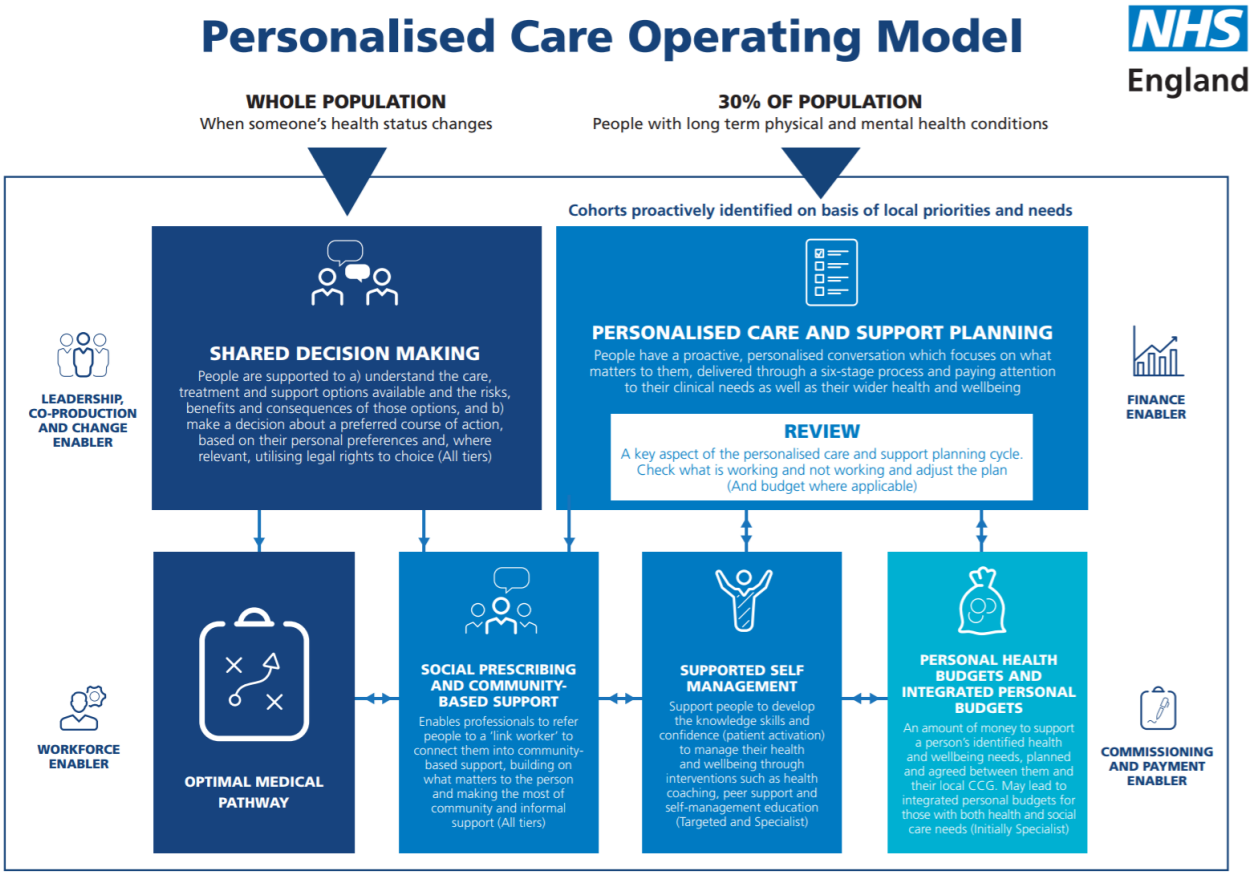


Figure 1 Comprehensive model of universal personalised care[2]

In addition to the Long-Term Plan, the coming together of NHS England, NHS Improvement and the NHS Leadership Academy brings clear joint responsibilities and accountabilities for the 'quadruple aim'[3] of improving population health, improving care and making most efficient use of resources while enhancing the working lives of staff. Implementing the changes set out in the plan will involve joint working at multiple levels and has clear implications for the NHS People Plan due for publication later in 2019.

[2] NHS England (2019) Universal Personalised Care. Implementing the Comprehensive Model https://www.england.nhs.uk/publication/universal-personalised-care-implementing-the-comprehensive-model/ (accessed 8 April 2019)

[3] Bodenheimer T, Sinsky C (2014) From Triple to Quadruple Aim: Care of the Patient Requires Care of the Provide *Ann Fam Med* 12(6): 573-576

The evidence base

The business case for personalised care, co-production and community-building is strong and becoming increasingly clear. When people have good social support networks, are involved and included in their communities and are valued for their contribution, they experience better health. Being lonely or lacking social contact and connection can kill you - it results in a similar risk to your health as smoking 20 cigarettes a day. If you have good social supports you have a 50% greater likelihood of survival compared to those with poor or insufficient social relationships, consistent across age, sex, cause of death. You are less likely to die after a heart attack if you have friends.

We know that informed, activated patients can get better health outcomes at lower cost. When people have the knowledge, skills and confidence to manage their health and are supported to take control and responsibility through personalised care, they are less likely to visit emergency departments, less likely to be obese, less likely to smoke, and less likely to have breast and cervical cancer. Peer support and voluntary groups working with and in communities have a better chance of promoting health-creating behaviours than professionals have by just telling people to change their habits.

Co-production and community building are not just 'nice to have' things - they are crucial and often overlooked factors that impact on health outcomes, community wellbeing and the efficiency, quality and sustainability of NHS services. Embedding the principles and components of personalised care into the way the NHS works can reduce demand, save money and enable the NHS to focus on the things that really matter to people.

For an excellent summary of the literature and evidence, see *At the Heart of Health. Realising the Value of People and Communities* (2016) published by Nesta, the Health Foundation and partners.[4]

[4] Nesta and the health Foundation (2016) At the Heart of Health. Realising the Value of People and Communities (2016) published by Nesta, the Health Foundation and partners https://media.nesta.org.uk/documents/at_the_heart_of_health_-_realising_the_value_of_people_and_communities.pdf (accessed 8 April 2019)

Project scope

Though clearly interlinked, the scope of this project deliberately touched only lightly on leadership development for people with lived experience, sometimes referred to as developing 'peer leaders', 'patient leaders' or 'lay partners.' The Academy's Patient Experience team focuses on this, as well as the involvement of people with lived experience in the work of the Academy, ensuring there is 'patient voice' in the national programme offers.

This report, by contrast, is primarily concerned with **the extent to which the Academy is developing NHS leaders who understand and promote the principles of co-production, community development and personalised care** in their organisations. To share power with people and families, to seek community wellbeing/population health above the success of a single organisation and to challenge and transform the system all require a fundamental shift in mindset.

The Academy has already started to implement this agenda. There is a funded commitment in the business plan for the following Level 2 and 3 KPIs; this report constitutes the 'national review' referred to in PC4a:

PC4 *Leadership with and by patients and citizens is promoted and supported*
a) Complete national review of current patient and citizen programmes and disseminate best practice and recommendations
b) Each regional team develops a co-designed intervention - responding to recommendations - on leadership with and by patients and citizens
c) Each regional team delivers of minimum of one cohort of above
d) National programme and practice boards produce response to recommendations.

The report does not specifically address *inclusion*, but there are obvious and important links between the two agendas. Both raise fundamental questions of equality and social justice. Personalised care was borne out of the personalisation movement, which started as a movement of people fighting for their rights around choice, control and independence. Making progress around either agenda requires significant culture change and very different ways of working and thinking about leadership and leadership development. Leadership for inclusion and personalised care both involve developing inclusive leadership practice, which the Academy's Building Leadership for Inclusion initiative has defined as a mix of conceptual knowledge, practical skills, psychological awareness and resilience as well as the skills necessary to transform cultures. To make transformational change happen, leaders need to be aware of power and be prepared to share it, to engage with a diversity of voices and be prepared to challenge the status quo.

The project also did not specifically examine *systems leadership* development as this is being led as a separate Academy workstream, but again there are important crossovers with this work. The system leadership behaviours identified by the North West (NWLA) Academy's work are very similar to the behaviours and qualities identified by Thames Valley and Wessex (TVWLA) Academy and partners, as part of the Leadership for Empowered and Healthy Communities (LEHC) programme (see Appendix 2). These include being open-

minded, curious, brave and willing to take calculated risks, engaging and building relationships at all levels and across organisations, including with citizens and communities, embracing diversity and starting with 'place' or community in mind, understanding local areas, a community focus for the greater good and enabling self and others to explore creative approaches.

The changes to programmes and ways of working for the Academy as set out in the report recommendations effectively speak to all of these interconnected and interdependent agendas.

Definitions

A primer on co-production and community development circulated across the Academy late in 2018 (see Appendix 1) explained the distinction between 'involvement' of people and true co-production' defined by Nesta, the New Economics Forum and the Innovation Unit in 2012 as: 'delivering public services in an equal and reciprocal relationship between professionals, people using services, their families and their neighbours.' Co-production does not mean collaboration between professionals and organisations or engaging with staff – it means a genuine partnership between publicly-funded services and those that use them. In practice, co-production means involving people with lived experience as equal partners in all aspects of commissioning, service design and in the way services are delivered.

The primer also defined community development as the practice of working with people at a neighbourhood level to recognise and develop their ability, potential and power to make change happen for the greater good. It requires an understanding of and commitment to nurturing the assets in a community – the skills, knowledge and passions of local people, the informal groups, clubs and networks in an area and their collective reach, local stories, history and culture, and the buildings, staff, money, connections and power of local institutions. In practice, community development means ensuring there are conversations with people at a neighbourhood level, asking questions such as, 'What makes this a good place to live?', 'What do people and the community do to help each other or improve things around here?', 'What helps us feel independent/in control/in good health?', and 'What would make a good life for you round here?' Just as co-production doesn't mean 'getting a patient to sit on a board', community development doesn't mean writing a long strategy then 'consulting' people in it. It means sharing power.

Personalised care is described earlier in the report (see pages 6-7).

Methodology

A series of semi-structured interviews were conducted with staff from national and local Academy teams between October 2018 and March 2019. A 'primer' was written to inform these conversations in December 2018 on which feedback was sought from Management Board and from a range of key external informants in January/February 2019. A blog was published in February 2019 and comments sought using Twitter. Three virtual roundtable discussions were held in March 2019 for Academy staff, members of the Personalised Care Group (NHSE) and key national stakeholders from the Coalition for Collaborative Care.

The information was pooled with previous work undertaken by the author including:

- Research conducted in 2012 on behalf of Thames Valley and Wessex NHS Leadership Academy and other partners to explore the leadership skills, qualities and behaviours needed to grow and nurture strong communities, as part of the Leadership for Empowered and Healthy Communities (LEHC) programme (semi-structured interviews with 30 stakeholders)
- Research to inform the development of a citizen leadership programme for the National Skills Academy for Social Care (now Skills for Care) in 2014 (1-2-1 interviews and a one-day focus group)
- Research undertaken in 2015-16 for The Performance Coach (TPC), for TVWLA and the Oxford Allied Health Science Network (AHSN) to inform the 'Leading Together' programme (interviews with 31 people).

All of the above engaged people across a range of organisations, sectors and groups, including staff, managers and commissioners from various services areas including learning disabilities and mental health, and people with lived experience including disabled and older people, people with long-term health conditions including dementia, people in receipt of a personal budget and unpaid family carers.

The Academy's offers and activities were viewed through a number of lenses:
Whether the **knowledge** content, information people receive, and language used, are consistent and up-to-date with the current policy landscape around personalised care, co-production and community building. This includes a well-being and population health focus and a focus on place, particularly through primary care networks.[5]

- Whether **co-production is modelled** in programme design and delivery
- Whether programmes **build the skills and mindsets** needed to lead transformational system change working across boundaries with citizens and communities
- Whether development happens in **optimum conditions** - the learning environment, audience (i.e. who is in the room) and access routes to the programmes
- Whether **action learning, projects or programme assessments** are consistent with the aims of personalised care, co-production and community development
- Whether **evaluation** of the programmes covers the extent to which leaders develop knowledge and skills to embed personalised care, co-production and community building.

[5] There are caveats to this report – it is only as good as the information received, from reading the programme handbooks and from interviewing programme leads. I cannot comment on delivery as I have not been able to observe or participate in the programmes or interview participants.

Findings and discussion

The national Academy offer

There is some great content on systems leadership across the national programmes and a fantastic reach, targeting leaders at all levels. However, the national programmes do not have up-to-date content around personalised care, co-production or community building at present. The programmes are not co-delivered with people who use services, nor is this specified when tendering the programme delivery.

Most staff I have spoken to in the Academy stated that more is needed around personalised care, co-production and community development and that they would welcome the opportunity to incorporate the ideas into the next iteration of the content and design of their programmes. They stressed the need for support in making the necessary changes, in terms of knowledge, skills and capacity. Detailed analysis can be seen below.

Edward Jenner programme – there is no specific content on personalised care, community development or co-production in this programme, but lots of opportunity to build on its strengths which are its reach and accessibility. When new content is being developed it would be worth considering co-delivery and equality and diversity of class/social background – having a segment being narrated by citizens/someone running a community group could be really inspiring.

Mary Seacole programme – the second module is about 'patients.' This could be re-designed to include the concepts of personalised care, coproduction and community-building, replacing the concept of 'patient' as passive recipient of care, to 'people' or 'citizens' playing an equal part in achieving the outcomes of care. There is an opportunity in module five of the programme (systems) to ensure that people and communities are seen and considered as part of the system, as well as the modules on performance management, and improvement (the latter including content on improvement for local wellbeing and what people and communities want, not just defined by those with positional power).

Elizabeth Garrett Anderson programme – the programme materials do mention person-centred, coordinated care and 'patient experience' up front which is great, though this language does need to be updated as the policy landscape and language has moved on from simply 'person-centred' to 'personalised' care, implying a more radical shift towards putting people in charge of their health and achieving the best outcomes and quality of life for them. The 'engaging patients and communities' section could go much deeper, including the concept of working with and building strength in communities and embracing co-production; the section on a learning culture by implication could include co-production; the critical evaluation in module six could include a requirement to co-produce the work.

Rosalind Franklin – this programme is still in the design phase and there is opportunity to influence content as it is developing. In the current policy context, and as a new initiative, the programme should be referencing personalised care, co-production and community-building at the outset and using this as the frame. Other options discussed with Academy leads have

included a detailed module on this topic, and to embed this agenda in the simulations that happen as part of the programme.

Nye Bevan programme - 'person-centred coordinated care' is mentioned on the first page of the handbook; this language could do with updating and reframing e.g. changing references from 'patients' to 'people' and from 'providing care' to 'promoting wellbeing'; there is mention of power and privilege but not explicitly about sharing power with people and communities through co-production. Learning and reflection about co-production and community building could be a requirement in the portfolio.

Aspiring Chief Executive programme – the handbook mentions gaining insight from and engaging with 'patients' but mentions communities only in terms of providing 'assurance'. The Building Leadership for Inclusion report states: *'Mainstream approaches often take a leader-centric approach that fails to address dominant power relationships and perpetuates the status quo.'* This rings true for the way this programme is currently presented. It could go much deeper in terms of the need for and 'how to' of developing and growing community assets, co-production, sharing power and the idea that the further away from the front line the person is in terms of positional power, the more important it is to 'walk the floor' of the organisation and 'hang out in the precinct' in the place where the organisation is geographically located to gain a deep understanding of the assets, needs and desires of the local place, community and workforce.

Chief Executive Development Network – I have not seen any content for the sessions run as part of this network but there is an opportunity to push the co-production and community agenda through this initiative. The network could also be opened up to voluntary sector leaders.

Stepping Up and **Ready Now programmes** – there is currently no content on personalised care, co-production and community development in these positive action programmes. There are important links between staff experience and quality of care and also between the principles of inclusion, equality, wellbeing and social justice for staff and for people who use NHS services, particularly with regard to health inequalities, which the Building Leadership for Inclusion initiative also recognises. There is mileage in thinking about how to bring the two things together.

NHS Graduate Management Training Scheme – limited information was available but there is scope to embed the concepts of personalised care, co-production and communities through this programme, in terms of learning opportunities, placements and mentoring.

Health and Care Leaders/2025 Leaders – there is some great systems leadership content in this programme but it misses citizens and communities. There is nothing specifically within the programme about personalised care, co-production or community development. The programme handbook could set the scene in terms of outcomes for people and values and principles of co-production and community building. Day 2 (visit) includes MIND but not any smaller community groups which is a missed opportunity to uncover the richness of local networks and people that can be harnessed for local wellbeing. The lack of voluntary sector

leaders on the programme is a real missing link. It may be hard to include citizen leaders in this but co-production in the delivery could redress the balance. The 'Connecting' part of the programme could include voluntary and community groups. There are a few mentions of engaging citizens in the 2025 handbook but it could include more.

Clinical Executive Fast Track Scheme – the content for this scheme is similar to Nye Bevan so there are opportunities to do similar development work as mentioned above. Quite a few people have spoken about a wish to integrate this into Nye Bevan or other programmes as we need leaders of the future who can work together.

Strategic System Leaders – great systems leadership content but nothing about personalised care, co-production or community building. This programme is not part of the national offer for 2019-20.

Healthcare Leadership Model – there is scope to look at this in the context of the planned review, with a view to incorporating elements of systems leadership qualities, skills and mindset about co-production and communities; integrate with focus on health inequalities and leaders fully engaging with the communities in which staff live and work.

Local Academy activity

Thames Valley and Wessex

TVWLA has been a partner and sponsor of the ***Leadership for Empowered and Healthy Communities programme*** since it was started in 2011. The programme explores how leaders can grow and nurture capacity in local communities to improve health and wellbeing and ensure better outcomes for people living with long-term conditions, disabled and older people.

The programme is aimed at senior leaders and clinicians across health, social care and beyond who want to be part of a movement for change. Participants are encouraged to think radically about the role of 'social capital' in health and social care and the role of public service leadership in shaping the communities that citizens need and want. It is a joint venture between TVWLA, Coalition for Collaborative Care, Skills for Care, Think Local Act Personal and ADASS and the co-produced leadership framework which underpins the programme can be seen in Appendix 2.

The programme is the Academy's gold standard in co-production and community development, but is light on personalised care at the moment. The North West Leadership Academy (NWLA) have expressed an interest in running a local version and there is scope to build in to other local offers around the country as well a drawing on its success to inform the national programmes.

TVWLA in partnership with the Oxford Academic Health Science Network commissioned the ***Leading Together Programme*** – a three-day programme for NHS leaders and citizens that aimed to, 'ensure that people are involved in creating healthcare systems that meet their needs and that professionals listen and learn from the people who use services.' It was co-designed and co-delivered with people who use services. The aims, principles and content

were good but there were issues with recruitment to the programme – the 'lay' participants as they were called were not generally representative of the local communities, people were not particularly well briefed, and some came with a very strong vested interest. For future cohorts.

It is recommended that providers be required to partner with/bid with a local voluntary sector infrastructure organisation to engage and reach into local communities beforehand. In terms of staff, recruiting people who really want to achieve transformational change with local communities – lack of commitment shoed in dropout rates as the days progressed.

TVWLA was a founding member and current partner for the ***2020 programme*** - a leadership development programme modelling collaborative leadership across the Frimley Health and care system. The programme has become a key enabler in delivering local ICS priorities. The programme has developed since its inception and now focusses on 'place' and 'communities.' Fellows on the programmes are encouraged to listen and learn from the communities that they serve, spending time within the community to find out the real lived issues and challenges. A collaborative effort of discovery, curiosity, innovation and commitment to a change challenge has reinvigorated professionals to see the opportunities to change how health and care can contribute to improving health outcomes within the local place. The programme is evolving and could be improved by co-delivery and more specific content on community development.

Kent, Surrey and Sussex

The *Effective Patient Leader Programme* is a three-day leadership development opportunity aimed at developing local 'patients' to become effective leaders. The programme aims to give citizens 'an insight into the challenges faced when planning services' and to 'learn collaborative behaviours needed for co-production.' Kent Surrey and Sussex Leadership Academy (KSSLA) also run a one-day *Amplifying the impact of patient leadership* workshop which offers practical methods to help patient leaders refine their key messages and to be more impactful in their communication, whether informally, in meetings or in public speaking situations. Both programmes could be improved by recruiting more deeply from local communities, by developing staff and local citizens together, by including content about sharing power and building change agency and ensuring the agenda is jointly owned – moving from 'how can we help you engage with our agenda?' to 'how can we all work together in this system to build supportive communities that keep people well and out of hospital?'

Yorkshire and Humber/North East

Yorkshire and Humber Leadership Academy (Y&HLA) and North East Leadership Academy (NELA) teams have run several cohorts of programmes aimed at developing 'patient leadership.' Co-design and co-production is encouraged through their Organisational Development (OD) and Inclusion activity and networks. The NELA has commissioned programmes for people with learning disabilities, commissioners and families, on behalf of the regional Learning Disability Network. The Y&HLA intends to work with the national team next year to build a consistent approach around storytelling *'Liminal' Programme*, mentoring approaches, the *Lived Experience (LEN) Network* and a 'Patient Leaders' conference in

2020. They would like to do more around co-production and involvement and are keen to develop this further and upskill their staff.

East Midlands

The East Midlands Leadership Academy (EMLA) doesn't do much in this area at present and was refreshingly honest in their assessment of their current engagement as, 'not meeting the standards of co-production.' They would like to explore their role around equipping leaders to co-produce with communities and enabling people to develop a different mindset and skill set.

West Midlands

The West Midlands Leadership Academy (WMLA) is committed to working with citizens in true co-production, moving away from tokenistic consultation. They are developing an associate faculty of people with lived experience in order to co-produce local leadership development. Until now, recruitment has been through 'traditional' channels but they are keen to explore how they can go deeper into local communities. In Dudley, they are developing a ***citizens' academy for young people with mental health needs***. The WMLA is not doing anything badged as 'personalised care' at the moment but they have developed a three-day ***Integrated Care programme*** with local authorities, voluntary sector organisations and local citizens which could form strong foundations for a local personalised care offer.

North West

The North West Leadership Academy (NWLA) has a strong track record in working in co-production and across boundaries. They have co-developed a ***framework for systems leadership skills***, which has a lot of synergies with TVWLA's LEHC framework around collaboration, openness, flexibility, working across boundaries and working in complexity. Their definition of this work, a version of which the Academy could consider adopting is, 'collaborative leadership in systems at multiple levels including citizens.' The systems leadership framework could be strengthened by more explicit mention of communities and citizens. The NWLA is keen to collaborate as this agenda emerges.

They have run seven cohorts of a ***Leadership for Integration*** programme, as part of which, participants were encouraged to bring a partner from the wider public sector and local community. This is a great foundation and could be taken even further by involving the voluntary sector explicitly and local community groups/citizens.

The ***Millom system leadership development project*** was a ground-breaking piece of work that resulted from a community's campaign to save their local hospital. The NWLA worked with the South Cumbria leadership who successfully bid for a systems leadership grant which enabled them to develop and deliver a highly complex and successful leadership development project. The result was a programme which supported the system leadership capability of a range of formal and informal leaders within the community and a progressive ongoing collaboration between local stakeholders. Other outputs included three leadership coaches trained and a knowledge hub to support people's development. This work was

presented at the International Foundation for Integrated Care annual conference in May 2017 and was awarded runner up for best paper and presentation out of 700 submissions.

The Academy has run four cohorts of a ***citizen leadership programme***. It is targeted women from Black, Asian and Minority Ethnic (BAME) and disadvantaged groups and aimed to activate communities and citizens, to mobilise their assets, give them a voice and sense of agency that they could make a difference in their local communities. It is easy for such programmes to allow people who already have a voice to self-select themselves to participate, but this programme clearly drew people from real communities and made a huge difference to their lives and, significantly, the assets available to the local health economy, by unleashing previously hidden talents and passions. Spreading this kind of approach is exactly what the NHS needs.

South West

Some leadership development work is being planned by the Personalised Care Group in the area with LGA, ADASS, Skills for Care, NHS Confederation and HEE. They are keen to collaborate with the SWLA.

London

The London Leadership Academy (LLA) recently ran some workshops aimed at developing a strategy for 'Patient Involvement and Engagement'. They are not doing anything specific about developing leaders around co-production, community development and personalised care at present. There is opportunity to go further and really consider how the Academy can support true co-production and sharing of power between organisations and local people and communities. There are a few sustainability and transformation partnership (STP) areas that are going elsewhere for leadership for personalised care development at the moment, so this is potentially an area of growth.

East of England

The East of England region have held events for the NHS graduates programme which have focused on population health and local needs but there is an opportunity to go further in term of community assets and co-production. They have run two patient leadership programmes with three more planned.

Other relevant programmes

In Control's ***Partners in Policymaking*** and associated courses have been running in the UK since 1996. They are locally commissioned and bring together family carers, people who work in social care, health services, education, leisure and other providers to build new alliances and make real differences to the future of vulnerable people.

Partners and its spin-offs ***All Together Better*** and ***Partners in Leadership*** enable participants to gain knowledge and confidence to campaign and advocate for a better future for vulnerable people. A strong valued base of inclusion and equality underpins the

programme. The programmes cover the history of personalisation and the independent living movement, changing perceptions of disability and health, what's working and what's not, asset-based community development, ways to involve more people in decision-making and to find out what is important to people and communities; using people's experience to drive up quality standards; the implications of personal budgets for people, services and commissioners, change management and personal impact, culture change and how to make positive change happen together, individually, locally, nationally and beyond.

NHS Horizons's ***School for Change Agents*** is an online and global community across health and care. It is free and highly interactive providing an opportunity for change agents and leaders in health and care to build their skills, confidence and networks for leading change. It is open to everyone and provides virtual learning sessions over six weeks and in 2019 will include a module on personalised care for the first time. The curriculum has been externally evaluated by the Chartered Institute for Personnel and Development, and shown to deliver significant impact for both individuals and their organisations in terms of knowledge and skills in leading change, building a sense of purpose and motivation to improve practice, ability to challenge the status quo and connecting participants with others.

Horizons also run the leadership components of the ***Think Ahead*** programme, which is a new route into social work, offering a fast-track graduate entry into the profession for those seeking to specialise in mental health social work. The programme includes key concepts and applied activities, designed to build participants' skills and confidence to lead change with others. Themes include change through activism, power, mobilising, organising and public narrative and being a change agent in a complex world- including applied complexity approaches. Participant feedback data showed a significant shift (from previous cohorts) in satisfaction with the training and confidence to apply the approaches.

The Kings Fund run a '***collaborative pairs'*** leadership programme designed for pairs - a manager or clinician and a 'patient' or service user - from the same local health and care system to work together on a shared challenge. The programme provides support and challenge at a number of different levels including access to a peer network to stimulate thinking and enable participants to develop practical solutions.

Altogether Better's ***Collaborative Practice Leadership Development Programme*** is designed for GPs, practice managers and other practice staff and aims to give them an in-depth understanding of collaborative practice – a way of enabling health services and local people to find new ways of working together to improve lives, release resources and improve services. The programme aims to develop the leadership and coaching skills needed to change attitudes and mindsets across the whole team and bring about culture change. The programme is delivered through a mix of action learning, individual and group coaching, and bespoke consultancy. Participating practices get access to a strong peer support network with other members of the cohort, who will all be delivering collaborative practice in their own settings.

Southbank University run a ***Postgraduate Certificate in Systems Change*** which aims to equip people involved in health and social care, including citizens, professionals, community leaders from across the community and health and social care sectors, with the knowledge and skills to lead complex collaborative change.

What Academy staff think

Staff in the national team and local Academy teams have been extremely supportive of this work and have stated they are keen to do more around co-production, community-building and personalised care. It is keen there is an appetite to change and to learn and develop together. Staff being so open to change gives the Academy a fantastic opportunity to harness their energy and commitment. Comments include:

"We could do more work to challenge systems leadership thinking – it still doesn't go beyond the big organisations – health, social care, police – not as much about community being an integral part of the system, but it needs to be central to what we do, like inclusion."

"We have been talking about this for ages, and it backs up everything I've been trying to do."

"What you are doing sounds fantastic. All progress happens from communities at a grassroots level upwards… I hope senior leaders take your work seriously, so it has an impact on everyday culture."

"We readily accept the importance of systems and place-based leadership and we are needing to make sure we are convergent with the Long-Term Plan."

"We could do a cultural shift in co-production. Local authorities understand the community focus."

"This is timely, but we need support and knowledge to do it."

"(We are asking) is there more that could be threaded in as an integral part? We could gain some real learning if we went and visited others, organised exchanges and got people in. We need public health in the room."

"The ideas sound interesting but how would it be put into practice? We would rather do targeted development e.g. with STPs, start small, let it grow, like Myron's Maxims – we need to go with the initiative and energy."

"We want to open it up more to organisations outside the NHS but we are told we can't."

"We do need challenge around diversity, and support to engage with the communities that the Academies serve. We need to learn more."

"It would be good to get the golden thread of co-production and community in all the programmes."

"We are thrilled the Academy is taking this forward."

Views on leadership behaviours needed

The framework for the Leadership for Empowered and Healthy Communities described in 2013 the leadership skills and behaviours which are needed to build strong, healthier communities in which everyone is valued and can contribute as an equal citizen. It was developed following a period of research and was synthesised and co-produced with a group of people with lived experience. It states, "(Leaders need) the ability to see the big picture around communities and health and wellbeing…to promote community connections, social capital and to work with people and communities in developing the vision. It is about starting from a grassroots level and creating the conditions to allow ideas and mutually agreed priorities to develop.

"Collaborative leadership is emerging as a key theme. The ability to work in partnership with others will be vital in ensuring joined up health and wellbeing strategies and in driving efficiencies through the system. But it is more than just working with organisations – it is about embedding the principles of co-production throughout the system so that services truly reflect what people want, need…and so that staff and local people feel valued partners in the process of improving health and wellbeing for all.

"Dealing with communities means you sometimes have to change course and to be humble enough to say, 'I was wrong!' It is about removing barriers and creating the conditions within an organisation and local communities for new ideas to flourish."

These ideas are echoed in the system leadership behaviours research more recently undertaken by the NWLA. The attributes identified include:

- An open-minded mindset
- Authenticty
- Reflective and having courage to take risks
- Builds trust and relatoinship at all levels and collaborates with others including people and communities
- Starts with place and community in mind, develops common goals
- Breaks down divides to enable change beyond their own service
- Being supportive and agile and leading others to be the same
- Does things differently, delivers, and is accountable.

Research the author has undertaken for other programmes along these lines has elicited similar views including:

- Relationships, empathy, self-reflection and humility
- Open to learning and curiosity, flexible and willing to try new things/experiment
- Courage
- Understanding the big picture
- Valuing other perspectives, plurality
- Going beyond personal to the system
- A commitment to collaboration
- Skills in asset mapping and techniques for leading change
- Some technical skills including how to set up projects in co-production
- Leading change and quality improvement with communities; creating and harnessing energy for change

- Barriers to change and strategies for overcoming them.

Lastly, from the wider engagement as part of this research, the following were identified as important qualities that NHS leaders need and areas that leadership development should focus on:

- Exploring new ways to reach out and bring people, staff and communities together – and when thinking about the conversations that happen, move away from conceptualising ‘our’ space or ‘your’ space, but occupying a middle space, where we develop common understanding, purpose and goals
- Harnessing knowledge, skills and assets of people and communities in the pursuit of improvements to services and ultimately better lives for people who use them
- Promoting social change; a sense that we need to be more radical and involve communities more in transforming ‘our NHS’
- Driving forward a culture of collaboration, joining up the system, seeing each other as equals, building bridges, facilitating conversations, sharing stories and experiences
- Opening up programmes to a far wider range of participants than currently access the development offers
- Exploring ways to shift traditional power and the way money flows through the system; enable people to take control and self-organise
- Embrace risk, be bold and resilient, develop trust, have an open mind, humility and give it time
- Bringing lived experience to work and maintaining a personal connection to it; experience how others live, really understand the people who use services and what matters to them.

In summary, we need to ensure our programmes enable people to challenge the status quo, shift power and change the culture of organisations. Leadership should be systems-wide and place- and community- focused. We can include modules on personalised care and co-production but it will take more for our programmes to do what is really needed to transform the NHS along the lines of the shift talked about in the Long-Term Plan and Universal Personalised Care.

Recommendations

What does this mean for the Leadership Academy?

This report builds a case for change across the Academy and the following recommendations include a mixture of:

- Practical steps – developing materials and modules
- Developmental steps – capacity and capability building
- Mindset shifts - for the Academy and how it conducts business as usual.

1. Build the Academy's leadership for personalised care offer

a) Core programme content to be developed and integrated into all the national programmes around personalised care, co-production and community-building. This should include basic knowledge transfer and awareness raising but it is mostly about mindset, skills and new ways of working including how to spread change through networks, the concept of 'new power', understanding local democracy, concepts such as host leadership and systems leadership (defined as how to be an agent of change within systems rather than being a 'system' leader by dint of positional power).

b) It could also include skills development in working with large groups and communities, asset mapping, appreciative and participatory approaches, generative listening, and coaching-style approaches (and how this links in with what personalised care aims to achieve for people who use services, through health coaching, social prescribing, shared decision-making and care and support planning).

c) Ensure core content is part of the offer at a local academy level too, whether as part of organisational development and support work or when delivering bespoke programmes to meet local demand. Ensure this approach is embedded into primary care networks development offers.

d) Develop a local 'leadership for personalised care' offer – the Personalised Care Group (PCG) of NHS England will provide matched funding to support this work; local Academy teams could combine this with the Academy's funding for local sites around 'leadership for and with citizens' and fulfil both commitments through the same means.

e) Develop the leadership for Empowered and Healthy Communities programme into a stand-alone multi-sector national 'leadership for personalised care' offer to sit alongside the 'family' of offers. There are various possibilities for delivery of this programme and it will be funded by the PCG. This will act as a test bed for developing the other local and national offers and help to drive implementation of the other recommendations

f) Ensure the core content is included as part of the Graduate Management Training Scheme and provide opportunities to make links with and undertake leadership work in relation to the national roll-out of personalised care.

2. Include practical and applied elements around community, co-production and personalised care

a) As part of all programmes where there is a requirement for a project, ensure that there are requirements to co-produce the work, and to include elements of co-production, community building and personalised care within the work. Requiring application of equality and diversity principles and system leadership behaviours and principles would be even better.
b) Ensure assessment criteria for the above include co-production, community building and personalised care (potentially alongside equality, systems leadership)
c) Ensure a wide range of practical and applied elements to every programme that incorporate co-production, community building and personalised care (and inclusion and systems leadership) and enable participants to gain insight that is much wider than their own role or service area. This could include secondments and shadowing, partnerships with voluntary sector and a range of rolling webinars and learning opportunities that could be organised centrally and in partnership e.g. with the Coalition for Collaborative Care. Above all, leaders on the programmes need to experience and experiment with ways to involve people with lived experience, to grow and develop communities as a mean to improving quality and outcomes and promote personalised care and to build their own and others' confidence and change 'agency'.

3. Shift towards multi-sector development, including with citizen leaders and voluntary sector

a) The environment we create around us affects learning and the level of insight we can gain. Therefore, developing leaders in mixed, multi-sector groups needs to be the way forward for public sector leadership development. It is recommended that the Academy adopts the strategic principle of mixed cohorts for its national offers and does what it can to make the case for relaxing restrictions imposed on it, for the greater good.
b) Invest in research to develop the business case for delivering leadership development to multi-sector cohorts, to support the above.
c) Prioritise partnership working at a local and national level, to enable cross-funding and the building of joint offers with social care, education, local government, housing, police and the voluntary and community sector and open access to the voluntary and community sector through bursaries.
d) Ensure the work of local Academy teams is open to and actively includes local people drawn from the heart of communities and not just through traditional routes such as PALS or Patient Participation Groups, to ensure that local work reflects the diversity of local communities and promotes inclusion. This includes inclusion of people from different social classes as well as those with protected characteristics. Local partnerships with voluntary sector infrastructure organisations, councils and housing authorities who may have better links to people and communities than NHS organisations could underpin this.
e) Provide support, guidance and development opportunities to local Academy teams re: the above.
f) Align marketing, funding and strategy with the above.

4. Model co-production through co-delivery

a) Ensure that providers of the Academy's programmes are required to deliver their programme in co-production with people who use services and have facilitators who understand and are skilled in the co-production and community development agenda
b) Make changes to commissioning to enable the above to happen – open up and develop the market to include smaller providers and specify that all providers engage a community sector partner to ensure development work is rooted in the local community
c) Prioritise the development of a faculty and network of experienced and skilled facilitators with lived experience, including those with lived experience of personalised care, the latter working with the PCG's peer leadership academy. This includes a national faculty and local networks linked to the local Academy teams. Note: there is an NHS England policy on paying expenses and fees which the Academy will need to apply consistently.

5. Invest in development for Academy staff and faculty

a) Train and skill up all Academy staff in the principles of personalised care, co-production and community-building so they have a base of knowledge and skill to be able to commission in co-production, know what good looks like and seek to challenge and improve quality
b) Invest in capability-building and skills development for faculty, associates and providers in delivering leadership for personalised care, co-production and community building.

6. Ensure Academy infrastructure supports the change

a) Ensure the programmes are evaluated in terms of how they increase practices which support and champion co-production, community-building and personalised care. Seek and share practical examples of successful change. Programme evaluations in general could be wider in terms of impact on place and community, the 'health' of the local systems/networks (i.e. the capability and capacity of a system to promote wellbeing), and the impact on local social capital and wellbeing.
b) As part of the planned review, revise the Healthcare Leadership Model, so that it includes essential qualities for personalised care, co-production and community development, as well as systems leadership and inclusion. In this and the recommendation above we need to recognise that both those things drive change in the NHS and even if content of programmes is changed, leaders and organisations won't prioritise these things if they are not judged or evaluated on them. The 360 process as part of the LEHC programme attracts comments like, 'my manager didn't know what I was talking about initially but doing the 360 enabled me to have a formal conversation about learning and objectives that considered these behaviours and that has filtered into different conversations in the organisation.'
c) Ensure recommendations to be accepted are reflected in to KPIs for the Academy and objectives for staff.
d) Provide adequate support and investment for the changed identified. (Note: the report author will be seconded to the Academy from NHS England for four days a

week from April 2019 to support the implementation of agreed recommendations. As mentioned earlier. funding will be provided from the Personalised Care Group in NHSE to match the sums identified for local Academy teams. A separate sum which will fund/part fund the national stand-alone offer.

e) Promote these concepts and the Academy's offer as part of the leadership workstream of the workforce implementation plan and ensure they are included in the support framework for primary care network development.

Conclusion

Personalised care, co-production and community development are essential building blocks to wellbeing and the NHS of the future. The NHS Leadership Academy is uniquely placed to contribute to the agenda by ensuring that the next generation of NHS leaders is community-literate and see the growing of social capital and wellbeing as part of their core mission.

If we want to achieve transformation we must not just 'tinker round the edges' - this needs to become an essential part of the Academy's leadership offer - just as we want personalised care and place-based approaches to become routine ways of working within the NHS. With personalised care about to take off across the country a huge amount being invested in it and receiving significant ministerial attention, the Academy needs to be seen as opinion formers and the 'go-to' body for change leadership. If we fail to do so, then we risk being 'left behind' and the system will simply go elsewhere.

Appendix 1

Personalised care, co-production and strong communities– a primer

Background and context

The Leadership Academy has commissioned a project to explore how it can maximise the potential of 'people power' through its work, ensuring that participants in its programmes are equipped to work in co-production, across boundaries, and focus on health creation and community capacity, not just how to lead services or organisations.

This short primer sets out the theory and context around community development and co-production and what this means for NHS leaders and leadership development. Recommendations from the project will build on what's already working well across the country and highlight opportunities for change, in order to build an even stronger Academy offer into the future.

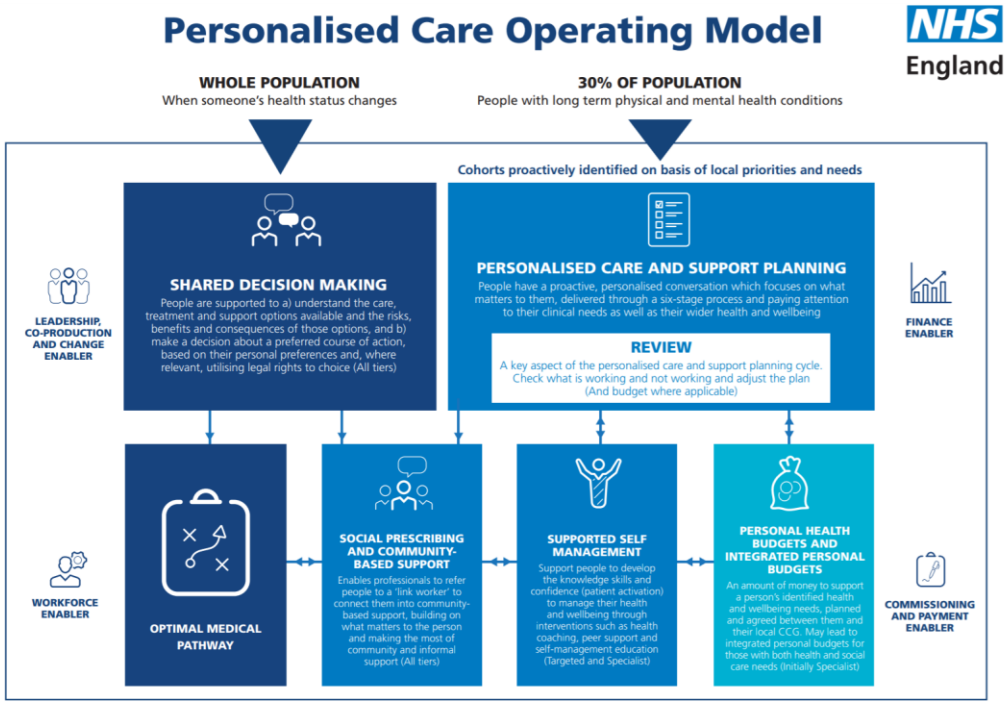
What is personalised care?

Personalised care is one of the five major, practical changes to the NHS that will take place over the next five years, as set out the recently published Long Term Plan. The plan signifies an intention to 'roll out' personalised care to reach two million people by 2023/24 and to double that again within a decade.

Personalised care means people have choice and control over the way their care is planned and delivered. It is based on 'what matters' to them and their individual strengths and needs. Personalised care means a new relationship between people, professionals and the health and care system. It provides a shift in power and decision-making that enables people to have a voice, to be heard and be connected to each other and their communities.

Personalised care takes a whole-system approach, integrating services around the person including health, social care, public health and wider services. It provides an all-age approach from maternity and childhood right through to end of life, encompassing both mental and physical health and recognises the role and voice of carers and the voluntary sector. For many people, their needs arise from circumstances beyond the purely medical, and personalised care is a means to support them by connecting them to supports in their communities.

The NHS will be expected to adopt the operating model as follows:



The Long Term Plan sets targets for personalised care including:

- 200,000 people will benefit from a personal health budget by 2023/24
- 1,000 social prescribing linkworkers will be in place by the end of 2020/21, rising further by 2023/24, ensuring 900,000 people are connected to their community to improve their health and well-being
- A roll out of training for front-line staff in shared decision-making and care and support planning.

What is co-production?

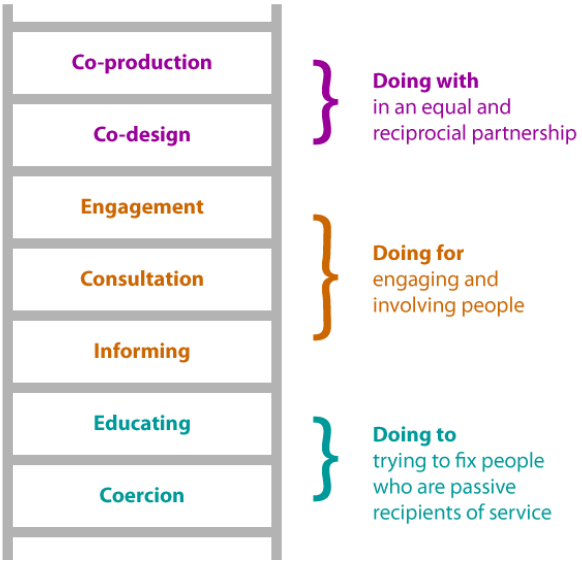
The word 'co-production' was first used in the 1970s by Elinor Ostrom, an Economist at Indiana University to explain why crime rates rose when police stopped walking the beat and started patrolling in cars instead. The relationships that police developed with people and the informal knowledge that they exchanged with the community when they walked the beat were critical in preventing and solving crimes. She argued that the police need communities as much as communities need the police in order to increase community safety, and used the term 'co-production' to describe this relationship.

Co-production was defined more recently by Nesta, the New Economics Forum and the Innovation Unit in 2012 as: 'delivering public services in an equal and reciprocal relationship between professionals, people using services, their families and their neighbours.' The report stressed that public services and neighbourhoods become far more effective 'agents of change' when they work together.

Co-production in the true sense is more than just consultation or involving people as consumers of services. It is not another word for 'patient and public involvement' or

volunteering. It is not about professionals or organisations working together (though the term is often misused in this way to describe partnership working). It is not about inviting people into professional meetings as a 'representative' or just to tell their story. It means a genuine partnership between publicly-funded services and those that use them.

The ladder of participation (this version taken from the Think Local Act Personal (TLAP) website) shows the difference between 'patient involvement' and genuine co-production. As you move up the scale there is potential to move from surface level, one-way engagement to having a more profound and radical impact on systems and places and ultimately people's health and wellbeing.



See here for examples

In practice, co-production means involving people with lived experience as equal partners in all aspects of commissioning, service design and in the way services are delivered.

At a 1-2-1 level that means ensuring that person-centred conversations happen, and that people with long-term conditions have the opportunity to co-create a care and support plan with someone from their GP practice – often a nurse or in the future, asocial prescribing linkworker. These conversations start with the question, 'What matters to you?' not, 'What's the matter with you?' This happens in some places but not everywhere. The number of people satisfied with their involvement in decisions about their care has remained static for many years – about a third of people want to be more involved.

At a strategic level, co-production means having people with lived experience on decision-making groups and sharing power with them. Done properly this means building capacity and support for a wide range of people to participate and ensuring that they are representative of the local community.

Co-production also means working at a community level and engaging with what matters to local people, through community development.

What is community development?

Community development is the practice of working with people at a neighbourhood level to recognise and develop their ability, potential and power to make change happen for the greater good. Done well, it strengthens the capacity of local people and groups and that of local agencies - private, public and voluntary - to deliver things that matter to people and build local resilience and wellbeing, growing trust and relationships at a local level from the ground up.

Asset-based community development (ABCD) further defines the practice as 'building on the strong and not the wrong,' by facilitating conversation and effort framed around the strengths and assets in a neighbourhood or place, rather than bringing people together to solve a problem.

Community 'assets' that exist in an area, adapted from the ABCD Institute definition include:

- The skills, knowledge and interests/passions of local people
- The range of local informal groups, clubs and networks and their collective reach
- The resources – staff, money, connections and power - of public, private and non-profit institutions
- Public space and buildings, housing and economic productivity
- The shared stories, culture, history and heritage of local places.

In practice, community development means ensuring there are conversations with people at a neighbourhood level, asking questions such as, 'What makes this a good place to live?', 'What do people and the community do to help each other or improve things around here?', 'What helps us feel independent/in control/in good health?', and 'What would make a good life for you round here?', 'What skills and talents do you have that (could) contribute to making this an even better place to live?', 'Who else do you know who would be useful to talk to round here,' and 'Could you help us by asking a few people these questions too?'

The questions aren't part of a 'consultation' that is communicated out. ABCD starts with a skilled community development worker identifying the 'connectors' in an area. Connectors are found by door knocking, asking people in the street and being in the neighbourhood. The paid worker plays a role of convenor/host/facilitator/navigator and works with the connectors to shape a project and conduct the asset-mapping. Once this is done and a convening group is formed and functioning, themes can be identified for collective action and the magic starts to happen.

Using this approach, neighbourhoods can be turned around, relationships between statutory services and local people improved, health improved, health-creating behaviours and the social determinants of health improved – better diabetes control, more physical activity, increased educational attainment, crime rates reduced, pride, social connectedness, feeling you have a voice – it's about growing and nurturing local social capital for local communities.

Fig 1 – A community 'asset' map - building on the strong and not the wrong. See also https://www.cvalive.org.uk/abcd/our-abcd-projects/new-addington-fieldway-asset#

ABCD in action in Croydon

Local agencies have invested money into community development in Croydon over the past seven years. It is one of the exemplar sites for ABCD practice across Britain. Taking the ABCD approach, Croydon Voluntary Action have been identifying connectors in the community and conducting comprehensive asset-mapping across the borough.

Since the work began in 2011, more than 1750 people have been recruited to speak with others in their community, to find out what interests them, and to make connections and help them set up new activities. More than 208 new community-led projects have been run, some of which have secured funding and some which have been able to operate completely with the time and resources donated by local people and organisations.

37 GP practices now signpost people to community supports and activities that grew out of the ABCD work. The NHS calls this social prescribing, but that's just the bit you can see on the surface – the conditions were created way before then through community development. GPs now report that community development is lifting a load from doctors. According to the Guardian, in the year to July 2018, there was a 20% reduction in hospital outpatient referrals and a 4% drop in emergency hospital admissions from the Parchmore medical centre, in Thornton Heath, which pioneered the scheme and 30,000 social 'prescriptions' have been made at a cost of £50,000.

See more at https://www.cvalive.org.uk/abcd/abcd-projects-2015-16

Why is this important for the NHS?

At a policy level, the arguments for personalised care, co-production and community-centred approaches have been won. There are not many |NHS staff who would argue against people being involved in decisions about their care. Indeed, many clinicians know that they need to get people to take responsibility and control for their own health. We know that informed, activated patients can get better health outcomes at lower cost (Wagner, 2001). More activated patients are less likely to visit emergency departments, less likely to be obese, less likely to smoke, and less likely to have breast and cervical cancer (Greene and Hibbard 2012). There is also general agreement that peer support and voluntary groups working with and in communities have a better chance of promoting health-creating behaviours than professionals have by just telling people to change their habits.

At a policy level, the NHS Long Term Plan makes a commitment to prevention, and a focus on healthy populations/communities as well as a concerted effort to reduce health inequalities. Personalisation runs through the plan, with a commitment to roll out a comprehensive personalised care model, as detailed earlier. The plan commits the NHS to place-based working, through Integrated Care Systems and Primary Care Networks.

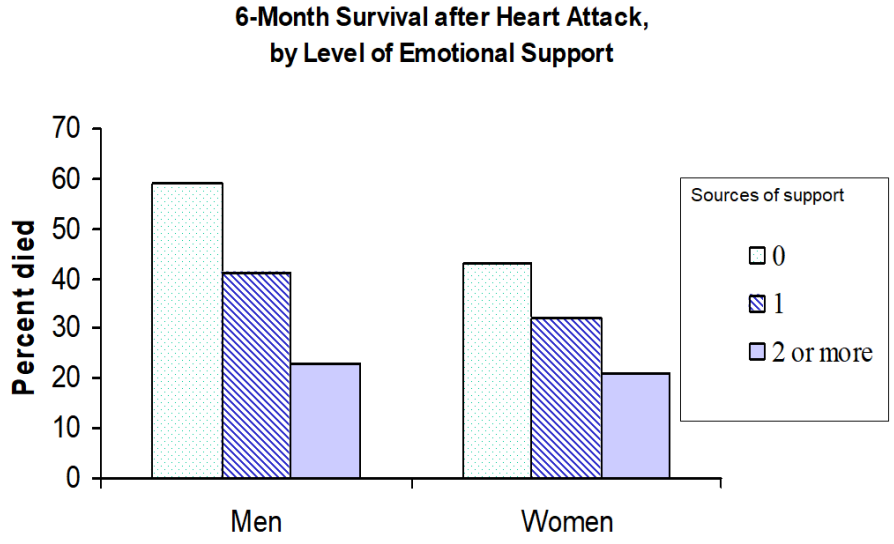
Chapter 2 of the Five Year Forward View stated, 'we have not fully harnessed the renewable energy represented by patients and communities,' and stated that the NHS needs to do more to support people to manage their own health, to engage with communities and citizens in new ways and to build stronger partnerships with the voluntary and community sector. It recognised the 'powerful consensus and shared desire' of people across health, social care and the public sector who want to see organisations and services run differently and better for and with the people who use them, and for organisations to work together better, with long-term wellbeing goals for places, rather than short-term financial ones for organisations. These include #socialcare future, the network of Leadership for Empowered and Healthy Communities alumni, NHS Alliance, Think Local Act Personal's Building Community Capacity network and the 3000+ people who have engaged with the Coalition for Collaborative Care (C4CC).

When people have good social support networks, are involved and included in their communities are valued for their contribution they experience better health. Being lonely or lacking social contact and connection can kill you – as much of a risk to your health as smoking 20 cigarettes a day. Co-production and community building are not just 'nice to have' things - they are crucial and often overlooked factors that impact on health outcomes, community wellbeing and the efficiency, quality and sustainability of NHS services. Embedding the principles and practice of co-production and community development into the way the NHS works can reduce demand, save money and enable the NHS to focus on the things that really matter to people.

Why we all need community connections

- Social networks are consistently and positively associated with reduced illness and death rates (Fabrigoule et al 1995, Bassuk et al 1999 and Berkman and Kawachi 2000)
- An international meta-analysis of data across 308,849 individuals followed-up for an average of 7.5 years, indicates that individuals with adequate social relationships have a 50 per cent greater likelihood of survival compared to those with poor or insufficient social relationships, consistent across age, sex, cause of death (Holt-Lunstadt et al (2010).
- People with stronger networks are healthier and happier (Bennet 2002)

- Social relationships can reduce the risk of depression and dementia (Morgan & Swann 2004 and Fratiglioni 2000).



Berkman et al, Emotional Support and Survival Following Myocardial Infarction. Ann Intern Med, 1992. Slide courtesy of Dr Brian Fisher, New NHS Alliance

What does this mean for NHS leaders and the Academy?

If we want healthier, happier citizens who are supported to stay well in their communities and to manage their conditions well, we need NHS leaders to develop a 'literacy' of community (RSA, 2015). We need NHS leaders now and in the future who can see the big picture and develop common purpose with others around wellbeing, think much wider than the service or organisation in front of them, who are skilled and willing to work with people at a grassroots level, who are prepared to share power, drive transformation, develop others and ensure that co-production and community building become part of the DNA of the NHS.

This involves setting up and leading partnerships for wellbeing, working across boundaries, harnessing social movements and activism, seeking out and nurturing community connectors, building a vision and narrative for change with local people, delivering services collaboratively and in co-production, commissioning with communities, ensuring that resources are spent on prevention and not just on services to treat ill health. Leaders need to prioritise co-production and community development and make it everybody's business.

For more information on the leadership qualities that are needed, see the Leadership Framework for Empowered and Healthy Communities, developed with TVWLA.

There are implications in this for the Leadership Academy. Its aims, actions and the purpose and content of its programmes will need to reflect a 'big picture' focus on wellbeing. This might include:

1. Core programme content at all levels around co-production and community, networks, the concept of 'new power', local democracy, host leadership and system leadership
2. Leadership skills development in working with large groups and communities, asset mapping, appreciative and participatory approaches, generative listening, better conversations
3. Opportunities to build confidence and change agency through place-based projects, secondments and shadowing, partnerships with voluntary sector in delivery and commissioning of programmes
4. Ensuring the learning environment reflects and facilitates leaders' development – developing leaders in mixed, multi-sector groups, cross funding and building joint offers with social care, education, local government, housing, police and the voluntary and community sector (making the case that such an approach will improve health outcomes), and opening access to leadership development to citizen leaders
5. Co-delivery – ensuring providers of the Academy's programmes delivering the programme in co-production with people who use services, and have facilitators who understand and are skilled in the co-production and community development agenda
6. Commissioning differently – opening up the market to include smaller providers and specifying that all providers engage a community sector partner
7. Evaluating the impact of programme on local social capital and wellbeing.

Conclusion

Co-production and community development are essential building blocks to community wellbeing and the NHS of the future. The Leadership Academy is uniquely placed to contribute to the agenda by ensuring that the next generation of NHS leaders are community-literate and see the growing of social capital and wellbeing as part of their core mission.

A full report and recommendations will be available at the end of 2018/19. To contribute views and ideas please contact Catherine.wilton@nhs.net.

Appendix 2

Leadership for empowered and healthy communities: A framework

April 2013

directors of adass adult social services

The National Skills Academy SOCIAL CARE

think local act personal

skillsforcare

Local Government Association

NHS Thames Valley and Wessex Leadership Academy

Forward

I am very pleased to see this leadership framework produced. It could not come at a more opportune or critical moment for public health and the wider health community. There is good evidence that social networks have a preventative effect on both physical and mental health and that spending time and resources on growing and nurturing strong communities can be a costeffective way to improve the health of the whole population. This approach must become one of the cornerstones of public health in the years ahead.

Leadership will be central to the success or failure of our ambitions to transform the way we work and the communities we serve. That is why this leadership framework is so timely and such an important piece of work. It should serve as an important resource to support the development of the strong and effective leadership that will pave the way to healthier and happier communities in the 21st Century.

Dr Ruth Hussey OBE CMO for Wales

I am delighted to welcome the Strong Communities Leadership Framework. Good leadership is fundamental not only in the commissioning and delivery of consistently excellent care and support but also in creating the conditions for resilient and mutually supportive communities to grow and flourish.

We all know the challenges we face with reduced public expenditure, whether as individuals, communities, commissioners or providers. At the same time, we know of many great examples, where people and communities are working together with professionals to transform services and where older and disabled people and those with long-term conditions are supported to be active, valued and contributing members of their community. These initiatives not only benefit people with care and support needs, they benefit everyone.

The Strong Communities Leadership Framework has been written in partnership, not only with social care providers, but also with people who use services, their carers and families, the voluntary sector and health providers. I believe it will be a key tool for everyone who wants to ensure that building strong communities and co-production become part of the mainstream of care and health services in the future.

Jo Cleary, Executive Director, Adults and Community Services, Lambeth Council, co-Chair of the ADASS Workforce Development Network and Chair of the National Skills Academy for Social Care

Leadership for empowered and healthy communities: A framework

Health and social care leaders are facing an unprecedented challenge. Reduced public resources and rising demand are coinciding with major structural reforms and clinicians assuming new commissioning responsibilities. However, this is also a period of great opportunity to positively transform health and social care. In times of crisis it is possible to challenge ourselves to do things differently and better, to move away from a process and service-driven system to one in which people can live as independently as possible for as long as possible within strong, healthy and supportive communities.

There is strong and growing evidence that community-based approaches to improving health and providing care and support can be cost-effective, deliver better outcomes and help to prevent health and social care needs arising. Focussing on so called 'social capital' opens up opportunities for stretched public resources to be used more effectively and efficiently by tapping into and releasing the skills, talents and energy of local people and groups.

A cross-sector approach to building strong communities

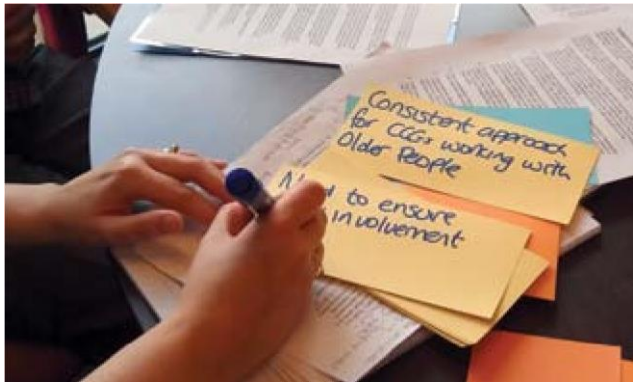
This leadership framework was developed as part of the Leadership for Empowered and Healthy Communities project which is a joint venture between the Association of Directors of Adult Social Services (ADASS), the Local Government's Ageing Well Programme, Think Local Act Personal, the National Skills Academy for Social Care, Skills for Care and NHS South Central Strategic Health Authority.

The framework

Leadership based on collaboration

The framework describes the leadership skills and behaviours which are needed to build stronger, healthier communities, in which everyone is valued and can contribute as a full and equal citizen. It highlights a new style of leadership based on collaboration and co-production – the ability to work across boundaries and organisations and work together with local people in a spirit of genuine and equal partnership. It is grouped into four themes: • Strategic Intent

- Facilitative and Collaborative Style
- Driving transformation and change
- Flexibility



1 For references and more information see the Building Community Capacity website www.thinklocalactpersonal.org.uk/BCC/EvidenceAndEvaluation/whatworks/EconomicCase

Strong business case for developing social capital

The framework focuses on the skills and behaviours needed to nurture and develop people's personal and social support networks and to enable groups and communities to come together in a spirit of mutual support and reciprocity.

There is a strong business case for such an approach – strong social networks are associated with reduced illness and death rates and can protect against dementia and depression. 'Giving' in itself, for example through community participation and volunteering, is associated with positive health and wellbeing, reduced mortality rates and provides a huge amount of social value (one study showing a social return of between
£2 and £8 for every pound spent on volunteers.) Participating in groups has been shown to cut mortality risk, whilst several studies into of the value of peer support in mental health have demonstrated savings in bed days and a 50% reduction in hospital re-admissions compared with traditional care. Moreover, a 'whole community' focus can improve things for all, not just those with high support needs, through reduced crime, cleaner streets, increased educational attainment and makes the most of local facilities, contributing to their economic viability. [1]

A framework based on consensus

'This framework was co-produced with people with experience of using services, drawn from the National Co-production Advisory Group, part of Think Local Act Personal. It is based on the views of thought leaders and experts from the field of health and social care and beyond, including voluntary and community sector leaders, representatives from User-Led Organisations, social innovators and provider organisations who gave their time generously to share their knowledge and insights around leadership during a series of interviews in late 2011 and early 2012. For useful cross-reference it is mapped against other current leadership frameworks – the NHS Leadership Framework and the 360 degree leadership feedback model for CCGs developed by the Hay Group. We intend to map against the Social Care Leadership Qualities Framework when it is published.

The next generation of public service leadership

The ability to lead this change will become increasingly more important to senior leaders and clinicians in the coming years. It is hoped that health and social care organisations will begin to use this framework when designing or commissioning training but also in recruitment

and performance management of staff. Our highly acclaimed Leadership for Empowered and Healthy Communities Programme, which will begin again in July 2013, is breaking new ground in addressing these areas in one programme. Its first cohort are senior leaders from across the country who have committed to joining this movement for change and contributing to the debate about the next generation of public sector leadership.

Developed by Catherine Wilton on behalf of ADASS, Think Local Act Personal, Skills for Care, National Skills Academy for Social Care, the LGA's Ageing Well Programme, and NHS South of England (Central).

Acknowledgements: Many thanks to everyone who agreed to be interviewed as part of this project. Thanks also to the project steering group for their continued support and time, including Jo Cleary, Maggie Woods, Martin Routledge, Jim Thomas, Guy Robertson, Chris Hume and members of the National Co-Production Advisory Group.

July 2012

Strategic intent
'Seeing the whole picture'

This theme is about the ability to see the big picture around communities and health and wellbeing. Other leadership frameworks include this theme but within the context of healthy and empowered communities there is a specific need to understand and promote community connections, social capital and to work with people and communities in developing the vision. It is far more than just consulting with people on a strategy that has been devised by an organisation in isolation – it is about starting from a grassroots level and creating the conditions to allow ideas and mutually agreed priorities to develop.

Important elements and key behaviours

Sees the big picture around communities and can connect things together. Knows the value of community connections and social capital and puts it at the heart of strategy.

Sees role as far wider than health and social care – involves universal services, local people and all other local resources in considering how own service/organisation can meet its outcomes for local people. Able to convince others of the critical role of social care in tackling the wider determinants of health and wellbeing for all, through building support networks, encouraging membership of groups, co-production and participation.

Engages the whole workforce, people who use services and the wider community in developing a vision for a better future.

Ensures that the vision is linked to corporate aims, service plans, staff development and activity on the ground.

Is adept at future scanning and invests for the long-term. Takes a whole population approach to prevention and starts from where people and communities are, not from the perspective of services.

Links with leadership feedback model for CCGs

Telling the story

'Actively engages stakeholders across the whole system' **Creating the Story**

'Leaders need to be able to grasp and make sense of the context to create a compelling vision'

Links with NHS Leadership Framework

Creating the vision

'Actively engages a diverse range of key stakeholders in creating a bold, innovative, shared vision which reflects the future needs and aspirations of the population.'

Links with the LQF for social care

Creating the vision

'Creating a bold, innovative, shared vision which reflects the future needs and aspirations of the population.'

Driving transformation
'Changing the system'

The ability to drive change and transformation is a key leadership quality in any context but here it is about recognising the imperative to reform the system in order to achieve the health and wellbeing outcomes that people and organisations want and need.

Important elements and key behaviours

Is changing organisational culture, systems and attitudes to put people who use services at the centre.

Involves people in decisions about care and support at all levels (this means a genuine commitment to co-production).

Is moving away from 'pilots' to changing the way the system works – letting go of process-driven activity. Enables co-ordination at a local level, allocating resources where necessary.

Ensures the organisation is asking the right questions – 'what would make a good life for you?' not 'what do you want me to fix?'

Able to paint a picture of the future and a compelling narrative for change for staff, stakeholders and the wider community.

Able to inspire and energise others, especially when morale is low.
Ensures the workforce and the local community feel part of the change.

Links with leadership feedback model for CCGs

Creating the story

'Has a reputation as someone who has the ability to develop and implement radical or new thinking'

Understanding patients

'Continually asks the question 'how will this benefit the patient?'

'Uses patient stories to build joint initiatives.'

Personal qualities

'Challenges powerful people and groups in the interests of patients'

Links with NHS Leadership Framework

Creating the vision

'Clearly communicates the vision in a way that engages and empowers others.' 'Uses enthusiasm and energy to inspire others and encourage joint ownership of the vision.'

Improving services

'Inspires others to take bold action and make important advances in how services are delivered. Removes organisational obstacles to change and creates new structures and processes to facilitate transformation.'

continued…

Allows time for staff to reflect on their own motivations and where they fit in to the vision. Allocates time to support people to change. In commissioning organisations: actively working to change the commissioning culture – seeing beyond traditional procurement based on needs and performance data solely – and focussing on quality, people's experience and impact on their lives. In provider organisations: actively transforming the 'offer' to commissioners and personal budget holders, trying out new models of delivery that promote and nurture social capital. Is radical – willing to challenge others or traditional practice – but also sensitive and politically aware – working with councillors and supporting them to take risks. Belief in own strengths to change and transform. Has confidence to steer things through in tough times.	**Politically astute** 'Understands how local and national politics will impact on the current and future work of the CCG'	**Managing teams: managing people** **Creating the vision** 'Is prepared to actively lead the cultural change needed to support co-production with people who use services, carers, families and the wider public.' **Improving services: critically evaluating** **Creating the vision** 'Putting people's lives at the centre of strategic planning and development.'

Facilitative and collaborative style
'Working with others and co-producing'

Collaborative leadership is emerging as a key theme for health and social care leaders. The ability to work in partnership with others will be vital in ensuring coherent and joined-up local health and wellbeing strategies and in driving efficiencies through the system. However, in this context collaboration is more than just about working with other organisations – it is about embedding the principles of co-production throughout the system – so that services truly reflect what people want, need and can contribute, and so that staff and local people feel valued partners in the process of improving health and wellbeing for all.

Important elements and key behaviours

Builds networks and personal links across a multitude of settings and engages genuinely with a wide range of people. Maintains a link to the front line – staff, people who use services and local communities.

Knows the community and places value on staff knowing it too.

Reconnects/connects mainstream services and organisations with community development – making it central not peripheral to core business.

Involves the community and local politicians, is prepared to listen and act on what people say. Enables people to speak out and participate.

Has a truly collaborative leadership style – the opposite of 'command and control'. This includes the ability to accept that senior leaders are not the only experts, an understanding of power relationships and a willingness to let boundaries blur. Supports people to find solutions themselves. Is not afraid to say 'I don't know the answer.'

Links with leadership feedback model for CCGs

Politically astute

'Builds alliances with influential people or groups'

Influencing for results

'Creates engagement by spending time meeting, getting to know and involving stakeholders'

'Builds and establishes a wide range of partnership relationships'

Links with NHS Leadership Framework

Working with others

'Works across boundaries creating networks which facilitate high levels of collaboration within and across organisations and sectors'

'Integrates the contributions of a diverse range of stakeholders.'

Improving services

'Uses feedback from patients, carers and service users to contribute to healthcare improvements.'

continued…

Sees people as assets and equals not just people with needs. Values 'connectors' in the workforce and models 'asset-based' working.

Is comfortable dealing with large groups and is willing to facilitate rather than control a debate. Values differences of opinion and diversity and encourages inclusion.

Is comfortable with and encourages use of Appreciative Inquiry as a method of building a vision with others rather than 'consulting' on problems or solutions.

Comfortable using a 'hosting' approach to leadership – inviting people in, welcoming them, responding to their needs whilst taking overall responsibility.

Is genuinely committed to working in partnership with others and ensures that partnerships are people-centred not service-driven.

Ability to deal with conflict and navigate different points of view – more than just influencing/negotiation. Willing to spend time in understanding others' agendas and language.

Accepts that solutions might be different in different places or for different people – does not seek to control everything.

Understanding patients

'CCG leaders need to listen to patients, carers and their families…this means that CCGs will have the needs of patients, carers and their families at the centre of their decision-making processes.'

Personal qualities

'Is prepared to give up power and/or resources for the benefit of the wider healthcare system'

Leading individuals and teams

Coaches and develops individuals.

Setting direction

'Involves key people and groups in making decisions.'

Managing services

'Promotes an inclusive culture.'

Working with others: encouraging contribution

Creating the vision

'Actively creates a culture of co-production, joint responsibility, joint decision-making, support and community participation.'

Flexibility and openness
'Open to new ideas'

A key attribute that emerged during the research was the importance of being flexible and willing to change and take on new ideas. Dealing with communities and people means you sometimes have to change course and need to be humble enough to say, 'I was wrong!' It also involves creating the conditions within an organisation and local communities for new ideas and entrepreneurialism to flourish.

Important elements and key behaviours

Is flexible – willing to challenge oneself, actively seeks feedback on own performance and acts on that feedback.

Is transparent about decision-making and willing to provide information openly.

Removes organisational barriers to change.

Looks for opportunities everywhere to build better outcomes using resources across a locality – understands and demonstrates that small amounts of money, small changes or different ways of working can have a huge impact.

Creates fertile ground for people to innovate – gives permission, support and allows enough time. Promotes innovation and a learning culture among staff. Prepared to take calculated risks.

Ensures that the organisation nurtures local entrepreneurialism, lean thinking and innovation – within workforce and communities.

Where possible, moves away from always using traditional procurement practice that favours large organisations – enables market shaping and ensures that small, community-based organisations can enter the market.

Links with leadership feedback model for CCGs

Leading individuals and teams

'Creates an environment where people remain focussed on delivering outcomes'

'Creates the conditions to support innovation.'

Leading a commissioning organisation

'Is aware of market trends and gaps in provision'

'Is entrepreneurial and opportunistic'

Links with NHS Leadership Framework

Improving Services

'Drives a culture of innovation and improvement. Integrates radical and innovative approaches into strategic plans'

Personal qualities: managing yourself

Creating the vision

'Prepared to challenge themselves to try new things… Creates a supportive culture which enables others to innovate.'

Further Information

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