

Putting people first - Part II: practical insights of how to use Human Learning Systems



Your hosts today will be:



Diana Hekerem, Head of Transformational Redesign Support – ihub



Dee Fraser, Chief Executive, Iriss

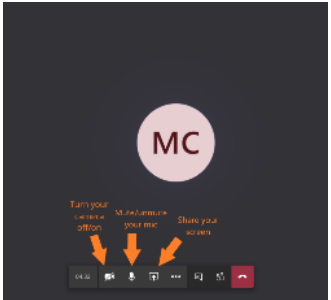
Recording



This session is being
recorded

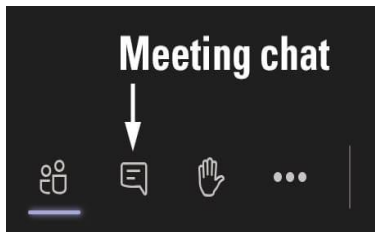
If you have any questions about the use of the
recording, please contact the
team his.collaborativecommunities@nhs.scot

Housekeeping



Mute your microphone and have your video off on entry and throughout the meeting. To give an update

- unmute your mic
 - turn your video on
- and then*
- mute your mic
 - turn your video off



Questions will be submitted from the audience via the MS Teams chat which will be monitored by ihub staff.



A more detailed electronic follow up survey will be sent via email to help us plan for future sessions.



Technical support please contact:
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Agenda

13:00 **Welcome and introductions** - Diana Hekerem, Head of Transformational Redesign Support, Healthcare Improvement Scotland

13:10 **Human Learning Systems experiments** - Dr Toby Lowe, Visiting Professor at the Centre for Public Impact

13:30 **Breakout rooms session**

Breakout room 1 - The Plymouth Alliance, Gary Wallace, Public Health Specialist, Plymouth City Council

Breakout room 2 – Gateshead, Mark Smith, Director of Public Service Reform, Gateshead Council

15:40 **Summary and reflections** - Diana Hekerem, Head of Transformational Redesign Support, Healthcare Improvement Scotland
and Dee Fraser, Chief Executive Officer, Iriss

15:50 **Next steps**

16:00 **Event close**

Human Learning Systems experiments



Dr Toby Lowe, Visiting Professor at Centre for Public Impact



Centre for
Public Impact
A BCG FOUNDATION

Exploring doing public management differently

Toby Lowe, Visiting Prof of Public Management, CPI
@tobyjlowe

Overview

- Changing the purpose of management:
Learning as management strategy
- System stewardship: managing and governing Learning Cycles
- Learning your way to learning - how you might start your exploration





Recap

Creating real outcomes requires
doing public management differently -
learning as management strategy

**Management for control undermines the
creation of real outcomes**



Change the purpose of management

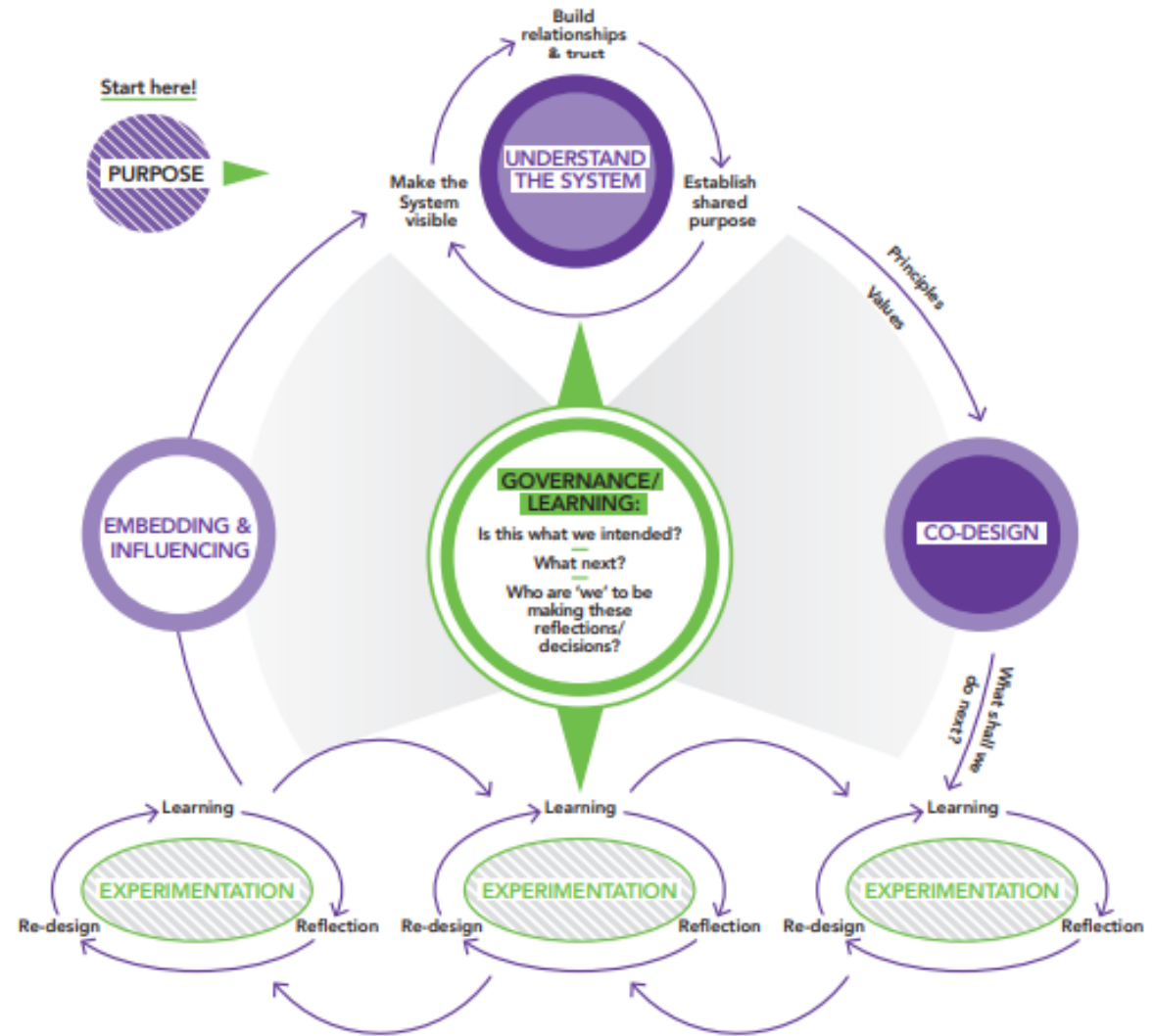
Learning as management strategy

Shift from control-based management

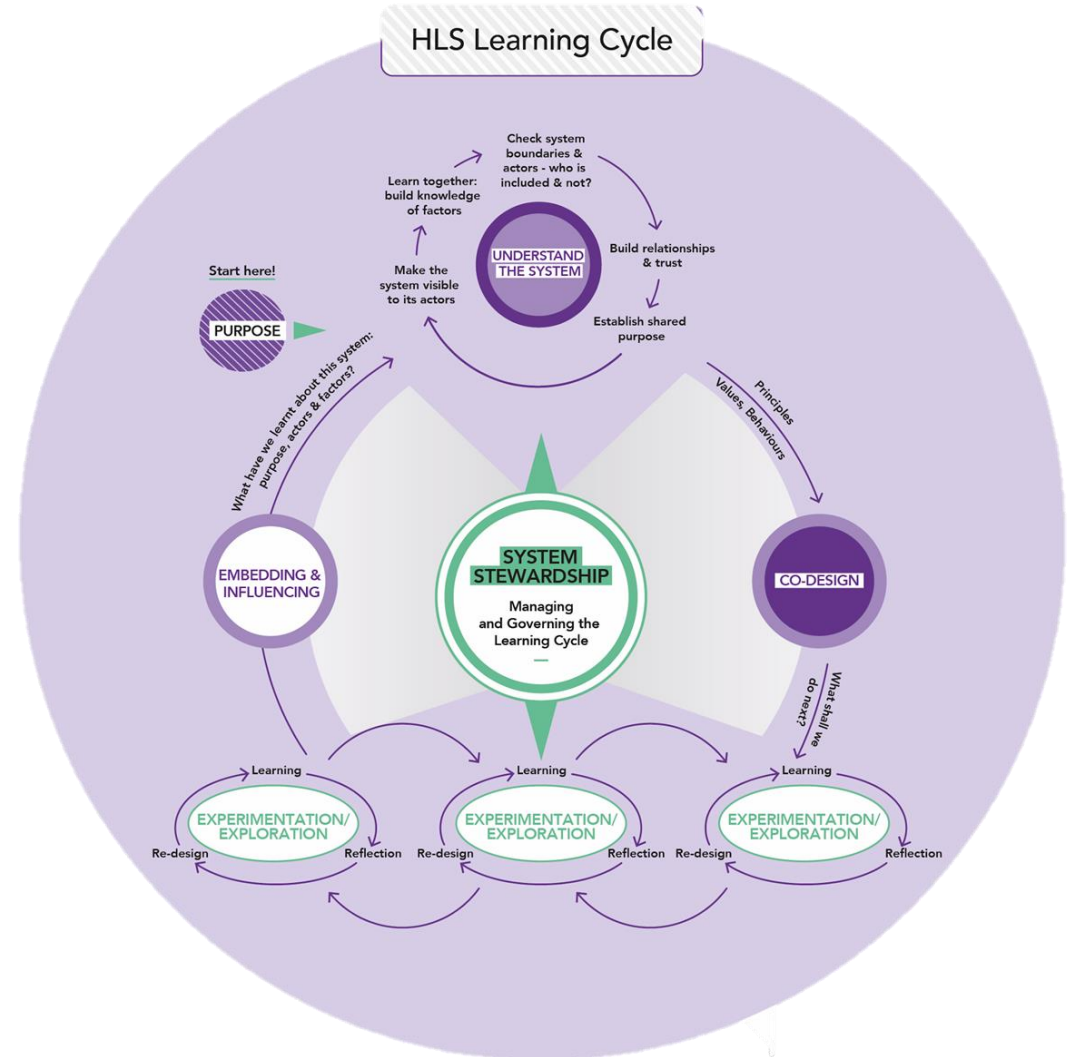
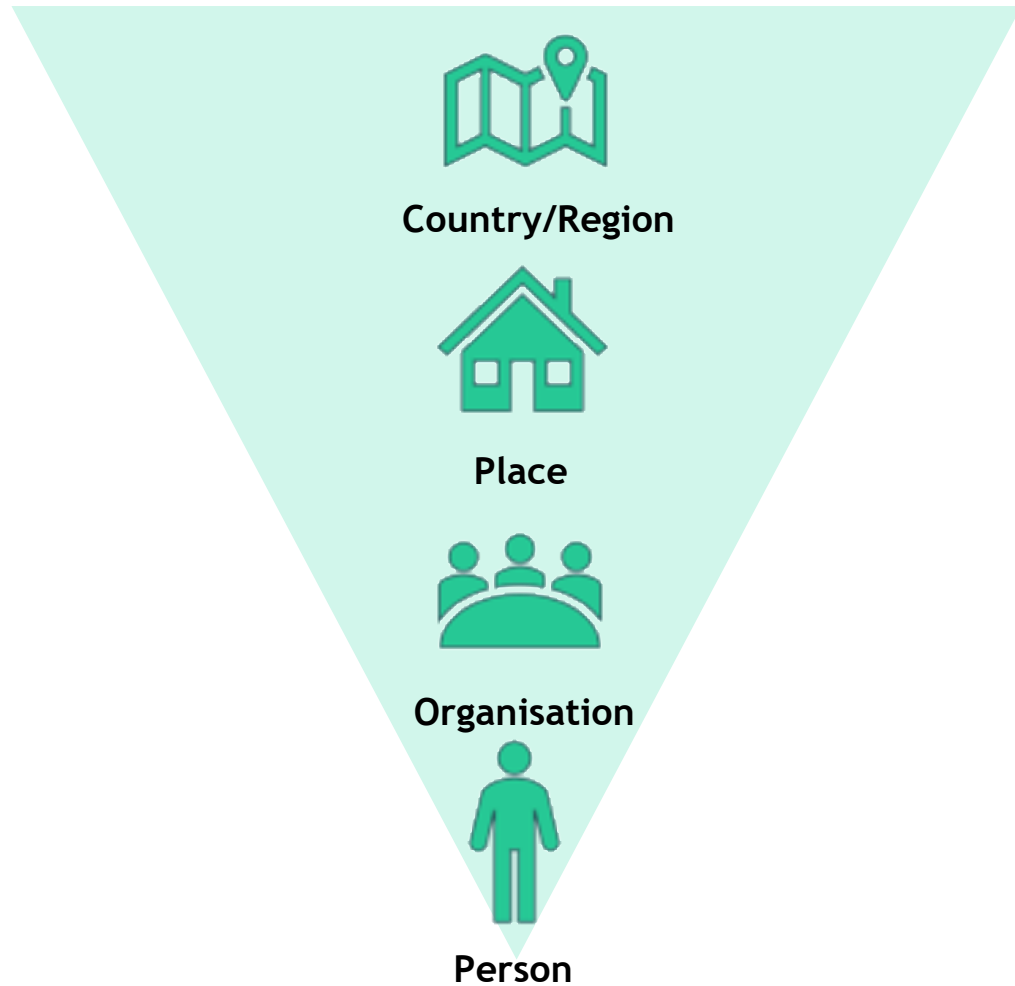
The task of managers is to **manage and govern Learning Cycles**

“System Stewards”

Framing the work of “public service” in terms of Learning Cycles



Commissioners operate at different system scales





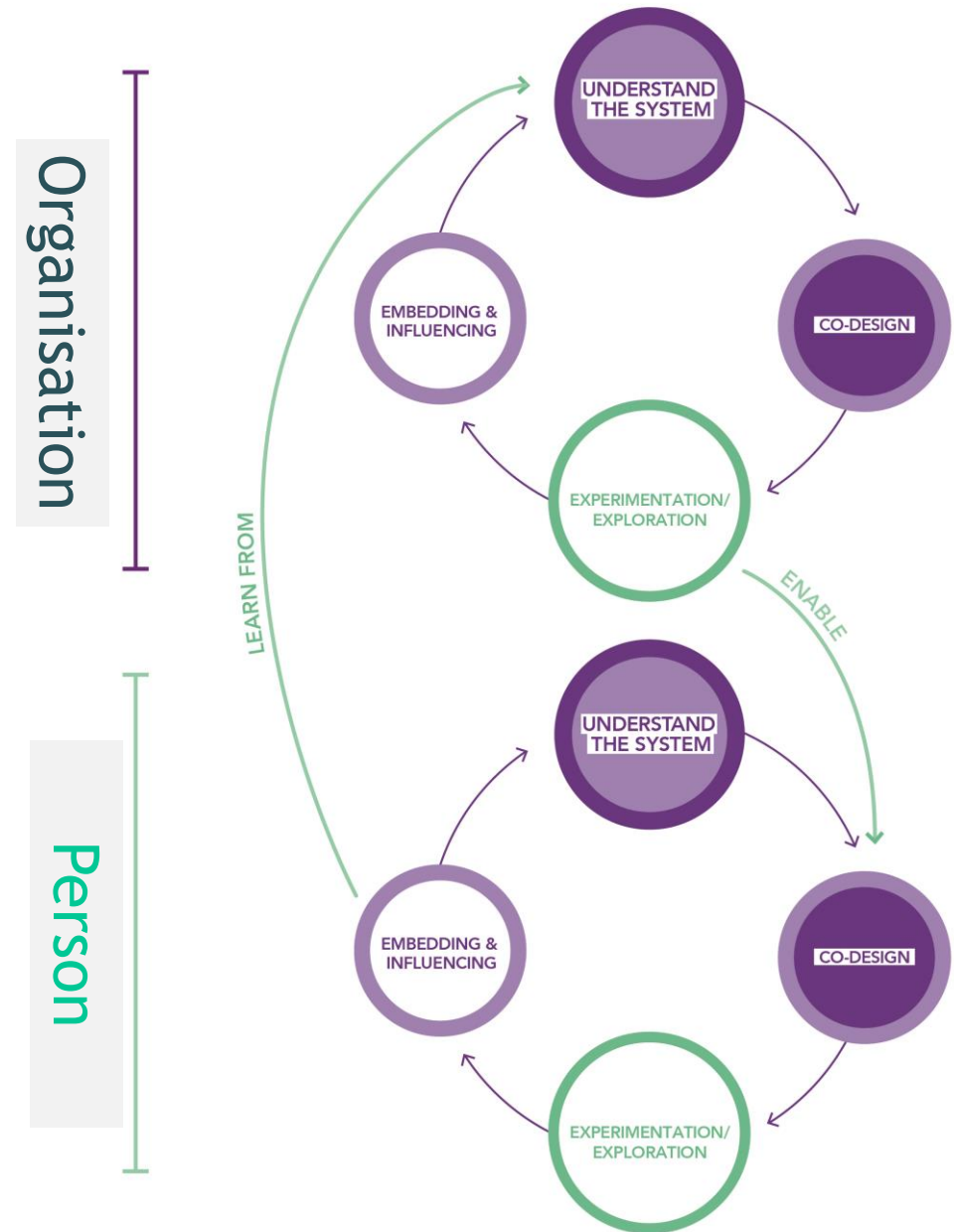
Questions for “organisation” system scale:

“Learning from” questions:

- What patterns do we see from across all the “person’s life as systems”?
- What policies do we need to change to enable change for people?
- e.g. do we need to change how equipment is allocated?

“Enabling” questions:

- What are maximum case loads for workers?
- What information systems do we need?
- What shared reflective practice spaces?
- What staff capabilities?



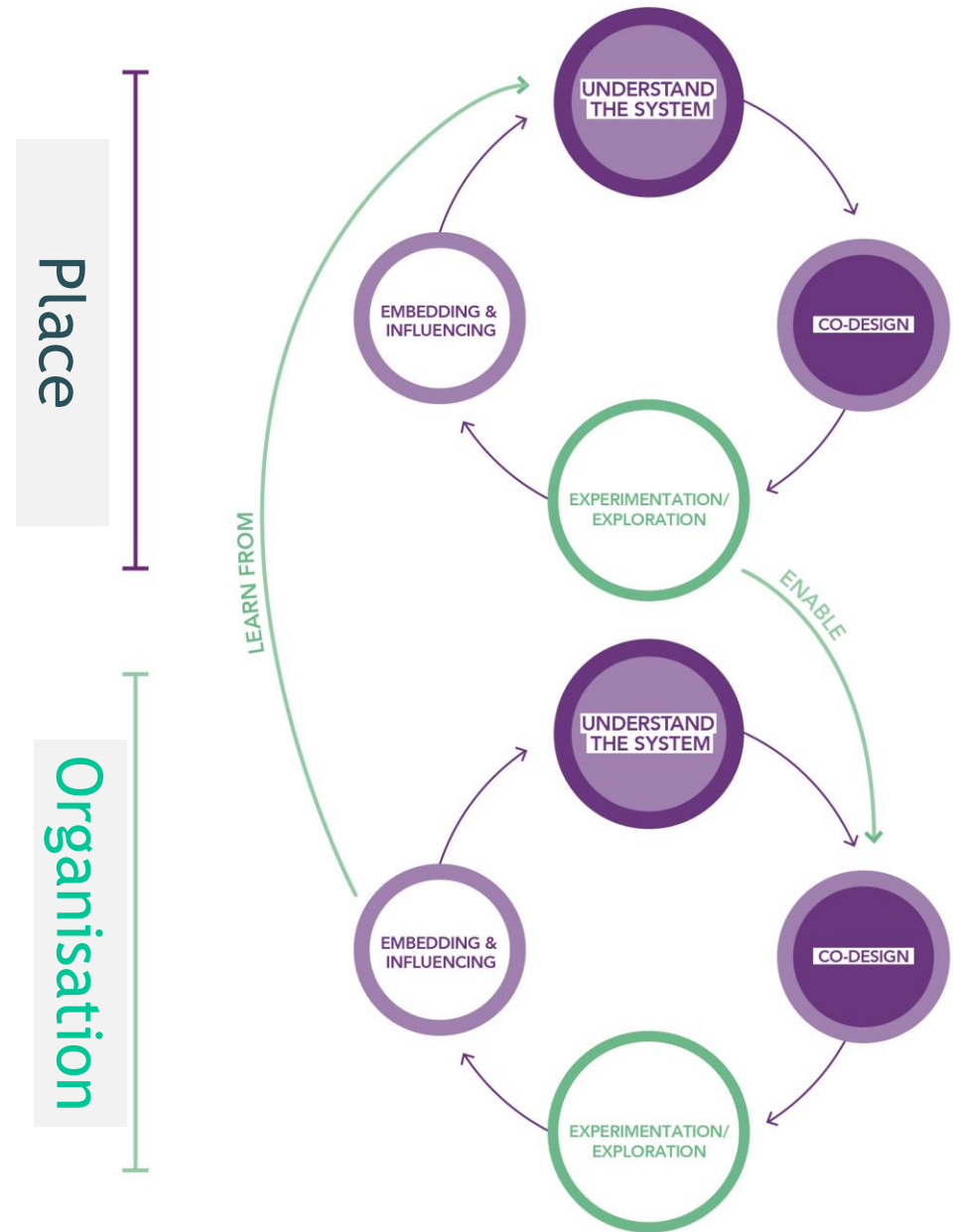
Questions for place system scale:

“Learning from” questions:

- What patterns do we see from across all the organisations as systems”?
- What policies do we need to change to enable change for people?
- e.g. do we need to change how houses are allocated?

“Enabling” questions:

- How do we fund organisations to learn together?
- How do we enable learning between organisations? - e.g. what shared reflective practice spaces are needed?
- What staff capabilities?





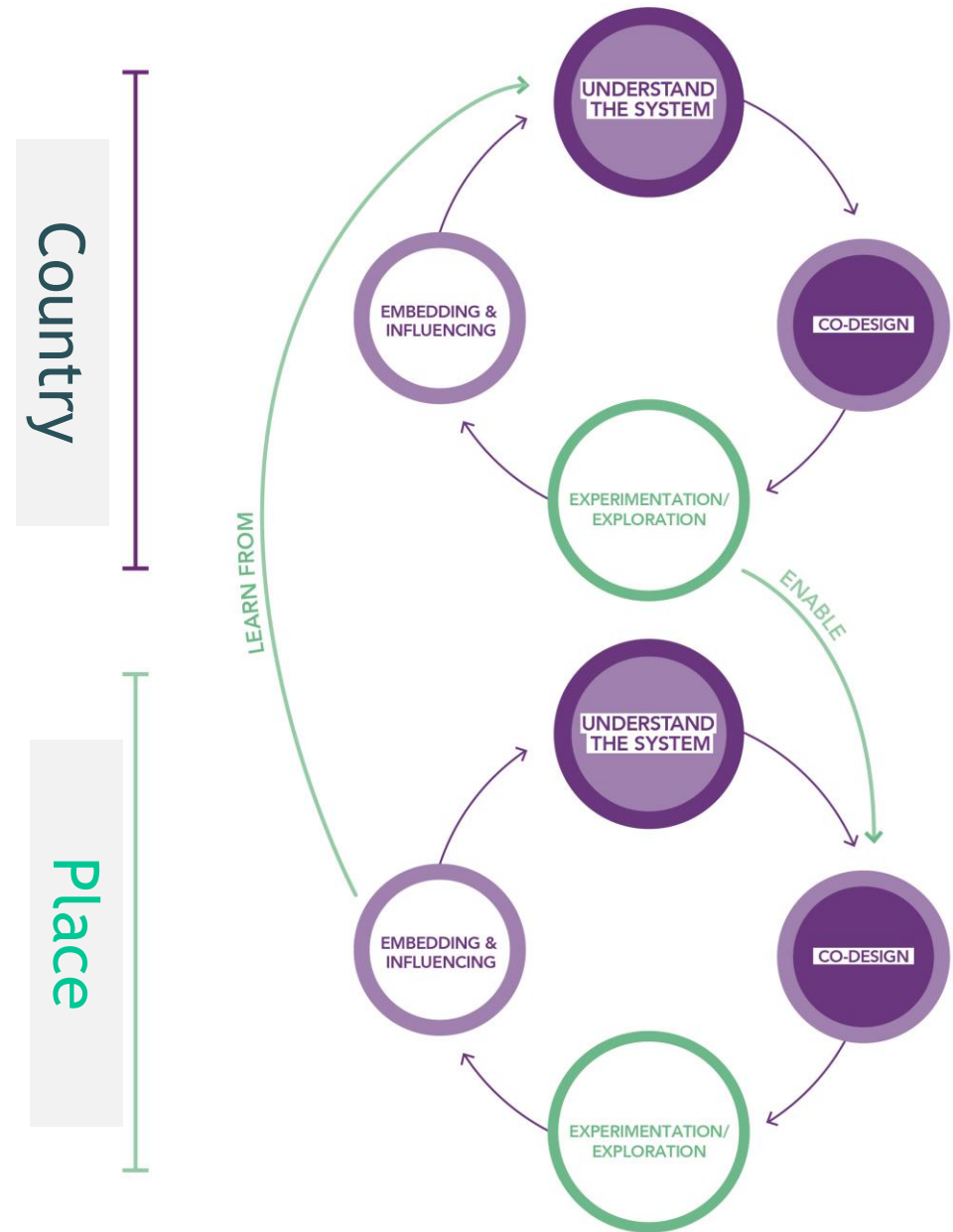
Questions for country system scale:

“Learning from” questions:

- What patterns do we see from across all the places as systems”?
- What policies do we need to change to enable change for people?
- e.g. do we need to change how the benefits system operates?

“Enabling” questions:

- How do we fund places, so that practitioners & organisations can learn together?
- How do we enable learning between places? E.g. what shared reflective practice spaces?
- What are the national workforce needs?





Learning your way to learning

Where can you explore this approach to managing differently?
Where can you create space for a new set of rules/practices?

Start from the ground up: where are the workers who do/want to view their work in terms of learning relationships with the public?

Explicitly frame their work in terms of Learning Cycles:

- what are you learning from those?
- What does the team/organisation/place need to do to enable those Learning Cycles?

How will their Learning Cycles be managed?

- What work has been done to “understand the system”?
 - How do you know?
 - Who needs to reflect on/give feedback for that?
- How were experiments/explorations co-designed?
 - Who needs to be involved?
 - What actions will you try out?
 - What data will you gather?
 - How will you make sense of that data, and with whom?
- How will you share learning from these experiments?
- What needs to happen to enable this Learning Cycle?



Creating permission-space for your experiment

- Do you really need permission?
- Highlight the evidence around the failings of the current paradigm - **it is impossible (and wasteful) to contract and performance manage for real outcomes**
- Find others who are dissatisfied with the status quo
- Don't try to convince skeptics: you cannot 'prove' that a new paradigm is better
- Build a new reality and invite them in.



If you need help

Human Learning Systems Collaborative:

<https://www.humanlearning.systems/partners/>

People and organisations who have done this

People and organisations who can help you to do it.



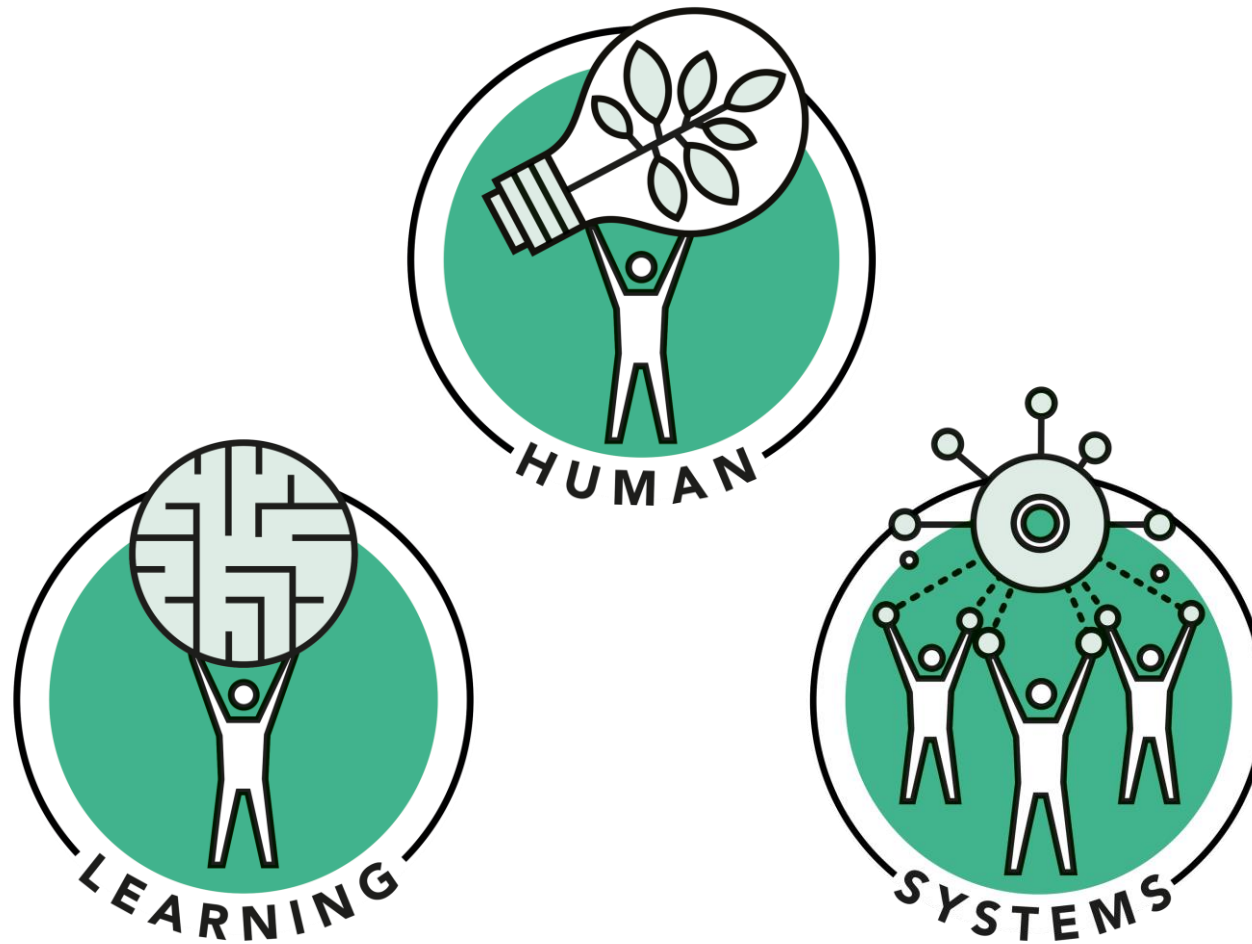
Up next

People and organisations who have done this!

Detailed explorations of how learning as management strategy has been enacted.

Gary Wallace - Plymouth Alliance

Mark Smith - Gateshead Council



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Breakout rooms

Breakout room No	Title	Speaker	Host	Facilitators
Breakout room 1	The Plymouth Alliance	Gary Wallace, Public Health Specialist, Plymouth City Council	Diana Hekerem, Head of Transformational Redesign Support – ihub	Des McCart, Senior Programme Manager, Healthcare Improvement Scotland Michelle Drumm Communications and Content Manager, Iriss
Breakout room 2	Gateshead	Mark Smith, Director of Public Service Reform, Gateshead Council	Dee Fraser Chief Executive Officer, Iriss	Karen McNeil, Improvement Advisor, Healthcare Improvement Scotland Dr Toby Lowe, Visiting Professor at Centre for Public Impact

Learning through Listening

Gary Wallace Plymouth City Council/Plymouth Alliance

Alcohol Assertive Outreach Traditional Experiment

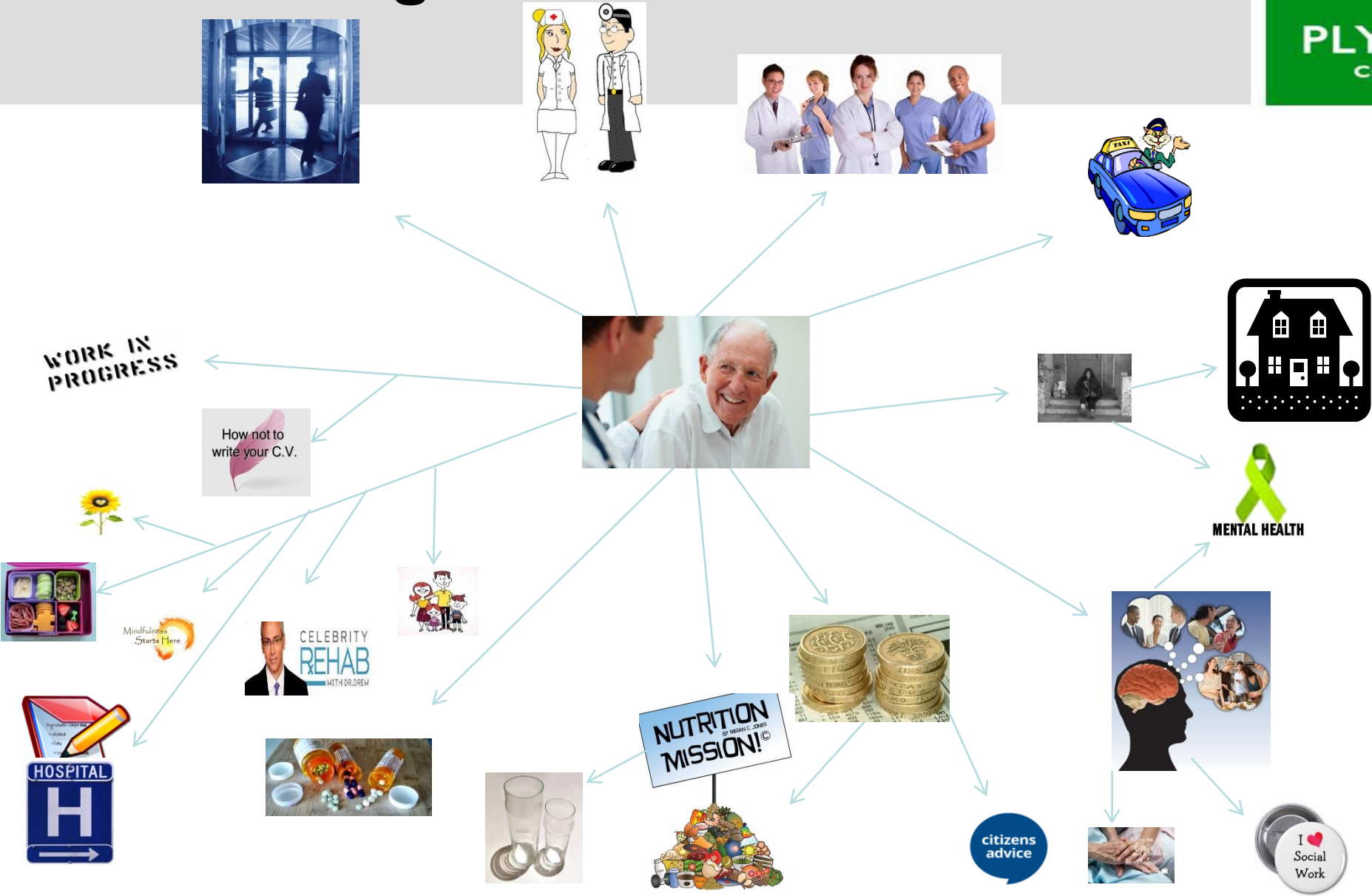
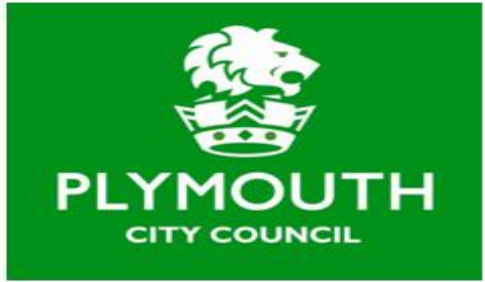
First 6 months of prototype

Pre-prototype



- Looked at evidence, notably Drummond et al Assertive Community Treatment
- Visited places that were running AAOT – Salford, Maudsley
- Undertook qualitative research with frequent attenders
- Did thematic analysis
- Noticed the frequency of ‘loneliness’ ‘no connections’ anxiety, depression, social isolation in people’s stories
- Saw that most had little ‘productive’ activity in their lives
- Re-designed the team to increase support and decrease clinical time

Service diagram



Cost Savings



Using data from the existing Alcohol Liaison Service at Derriford Hospital a cohort of frequent attenders was identified (56 individuals). Analysis of data shows that in the 3 months prior to establishing the AAOT this cohort were responsible for

- 89 hospital admissions
- 369 unplanned bed days
- Costing approximately £147,600 (bed days alone)

3 month results



- During the first 3 months of the AAOT operating data shows
- Admissions for this identified cohort had fallen by 39 (44%)
- Number of day bed days had decreased by 120 (33%).
- Identified savings of £48,000 (bed days)

6 month results



- During the first 6 months of AAOT operating data shows
- 56 patients with complexities had been supported
- 194 bed days saved
- Identified savings of £77,600 (bed days)
- The savings shown do not reflect those achieved in the wider system such as the Emergency Department, Ambulance Service, General Practice, Mental Health Services and community services.

Challenges



- Staff working in a very different way

First 6 months

- X2 hospital nurses
- X1 community nurse
- X2 support worker full time
- X1 support worker part time

Very little of the work was clinical, focus was support, build relationship, connect with community resources and get services to flex around delivery

Life after project.



- Team provides step down clinic after 6/12 for ongoing health checks.
- Telephone access / consultations by Hospital Nurses
- Telephone access / consultation by Community Nurses.
- People linked to other community services

Feedback



Hi Jayne

I just wanted to drop you a few lines to tell you how much your service has been of help to me. Previously to being discharged from hospital at the end of January I was offered no on going further support. Which inevitably led to me to relapse back to alcohol. After being involved with your service since my discharge from hospital in January, I have not relapsed. Your service has also introduced me to other organisations that have helped with my self confidence & recovery. I have had the self confidence to enrol on two short courses and have also been asked by the Sunflower Centre to enrol on a peer mentor course. The one to one sessions that we have have boosted my self confidence and it's nice to know that there is someone apart from family that understands what I'm going through and is always there to talk

Feedback



Alcohol Assertive Outreach Service



Dear MAISON

The alcohol assertive outreach team (AAOT) would really value your opinion and be grateful if you could take the time to complete this questionnaire to allow us to help improve this service.

What did you like best about this service?

DIANE KELLY
A PERSON I COULD TALK TO,
SOMETHING I FIND NOT VERY EASY TO DO.

What did you like least about this service?

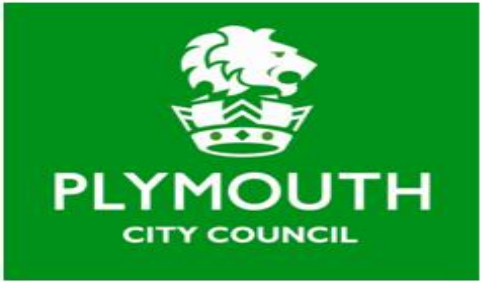
NOTHING I CAN THINK OF.

How do you think the service could be improved?

MORE MONEY FOR MORE OUTREACH
WORKERS

Any other comments?

ON A PERSONAL LEVEL I HOPE NEVER TO NEED
THIS QUALITY SERVICE AGAIN, BUT IT'S A
COMFORT TO KNOW IT'S THERE.



On a scale of 1-5 (1 being the lowest and 5 the highest). How would you rate the following?

Understanding of how the AAOT works?

1 2 3 4 5

Frequency of communication between you and your support worker?

1 2 3 4 5

Frequency of visits between you and your support worker?

1 2 3 4 5

Your outlook on the future before AAOT?

1 2 3 4 5

Your outlook on the future now completing AAOT?

1 2 3 4 5

Once completed, could you please could you place it in the envelope provided, and post.

The alcohol assertive outreach team thank you, for taking the time to provide feedback.

Vaping Experiment



- Smoking cessation services largely ineffective amongst the poorest and most needy
- Disproportionate take-up increases inequality
- Vaping popular and effective
- Gave 3 months free vapes to 20 rough sleepers/people in hostels (100% take up) and followed-up with AE (cost £600)
- In lockdown gave 300 free vapes to vulnerable poor smokers, 100% took offer up 20% stopped, all reduced smoking
- Now giving vapes to chest ward and Hepatology unit and 1500 to vulnerable poor
- Use a shopkeeper to prep the participants

I think it (vaping) works. Everyone who smokes knows smoking's bad for you – you don't need to tell a smoker about the harm that smoking causes, but you do need to tell people that they have choices like this. Everyone needs choices.



And well, I can just walk in to the shop now and they know me in there, I walk in and they say, '2 Blueberry and a Strawberry?' cause they know I like it 50/50. They're brilliant in there, so friendly and nice.

Electronic cigarettes help create autonomy



When asked “What more can we (services) do to support you to cut down on your smoking” – M Considered and said forcefully “It’s not about you it’s in here” pointing to his head. In 3 months-time, you never know that morning cigarette I enjoy so much – it might be this instead (holds up his e cg) or it might not!

And when I believe in something I like to test it out myself and I have.

I used to walk past this shop and look in the window, but I never thought about coming in. Now I can walk in and point to exactly what I want from behind the counter.

Developing a supply chain



Specification

1 x Orca Solo Kit
1x Orca coil pack
15 x tobacco e-liquid 18mg
1x charger
1x Royal Mail delivery per user

Assess demand

Procurement

Liaison

Trouble shoot

Summary

- Conceptually: relationships, dispersed leadership and autonomy
- Extending the marketing of vaping extends the reach and impact of stop smoking support
- Operationally: procurement, invoice specification, instruction sheet

Summary

- Vaping is a popular, safer and cheaper alternative to smoking

and

- A popular, cheaper and more effective alternative to prescribed pharmacotherapy
- To do the most good for the most people with limited resource we need to fund whole populations to try vaping

Yearly Pharmacotherapy costs to Plymouth

- £326,000
- LWSW Stop Smoking Service Advisors
- GP based Community Advisors
- Pharmacies

Relative costs of nicotine

Typical 12 week NRT programme

Combination NRT based on:

21mg patch @ £ 9.97 per week
Nicorette mouthspray at £13.80 per week

=

£285.24

Vs

12 week Electronic Cigarette supply

Vaping start up kit and nicotine based on:

Innokin IO starter kit @ £6.64
charging plug @ £2

Replacement pod x3 @ £0.93
18 mg e-liquid x 36 @ £0.66

=

£42

What this could save Plymouth

12 week NRT	£285
12 week EC	£42
EC % of NRT	15%
Current (CCG +PH) NRT Bill	£326,000
Pharma bill if convert everyone on NRT to EC	£48,002
Saving	£277,998

What this could mean

- EC can reach people who traditional stop smoking services do not tend to reach
- Marginalised, heavily addicted smokers
- Smoking by default (not on their radar), want no strings attached, easy access, free, practical hardware, risk (cost) free
- People who do not want behavioural support and are not responding to concerns about their health – (not on their radar.)

Appreciative Enquiry

HOW LISTENING CHANGES EVERYTHING

“Appreciative Inquiry is a way of being and seeing. It is both a world view and a process for facilitating positive change in human systems”

(Centre for Appreciative Inquiry)

“Appreciative Enquiry attempts to use ways of asking questions and envisioning the future in order to foster positive relationships and build on the potential of a given person, organisation or situation”

(Wikipedia)

“It’s having an open and positive conversation with people”

(John Hamblin, Plymouth Alliance)

The 4 D's



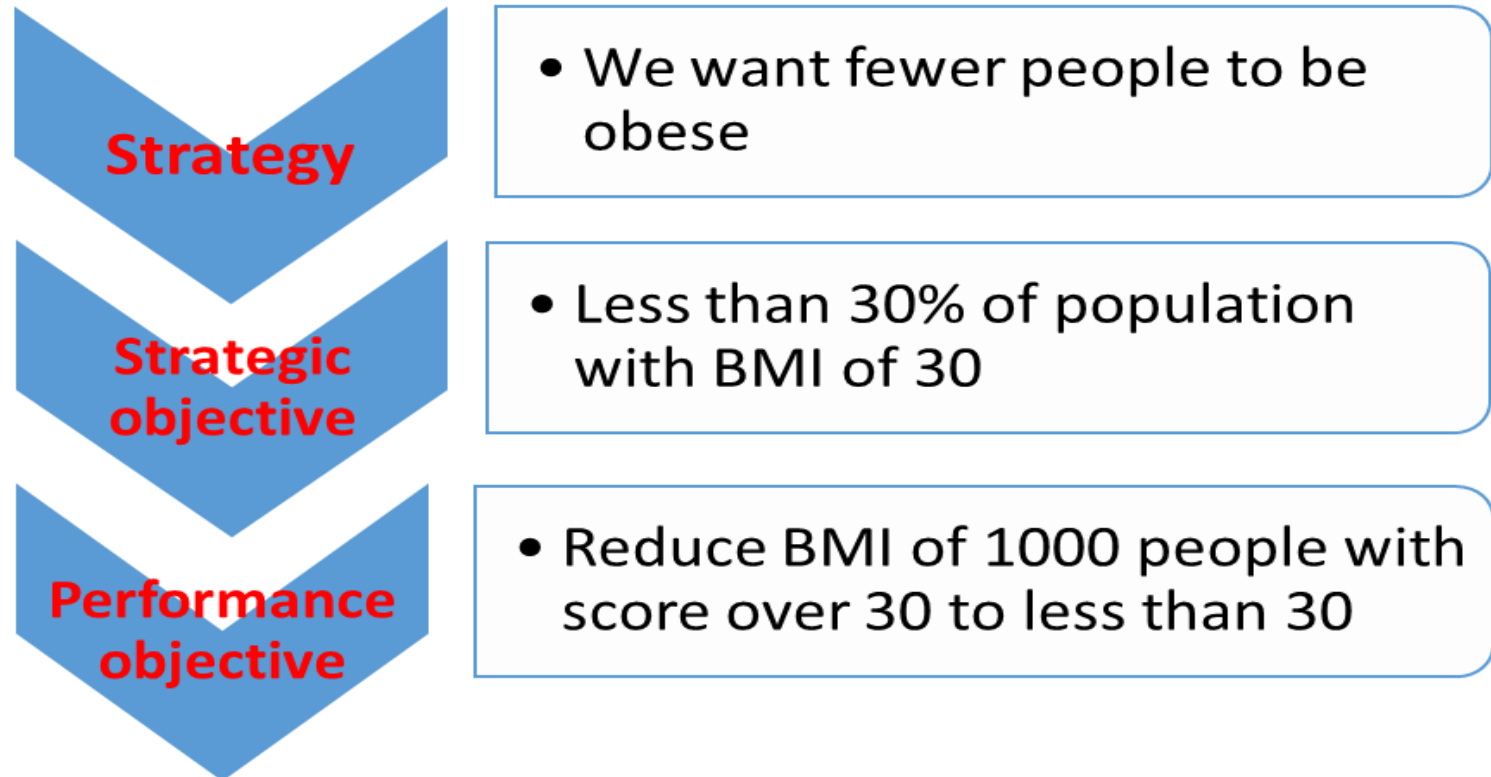
- Discover
- Dream
- Design
- Deliver
- Repeat

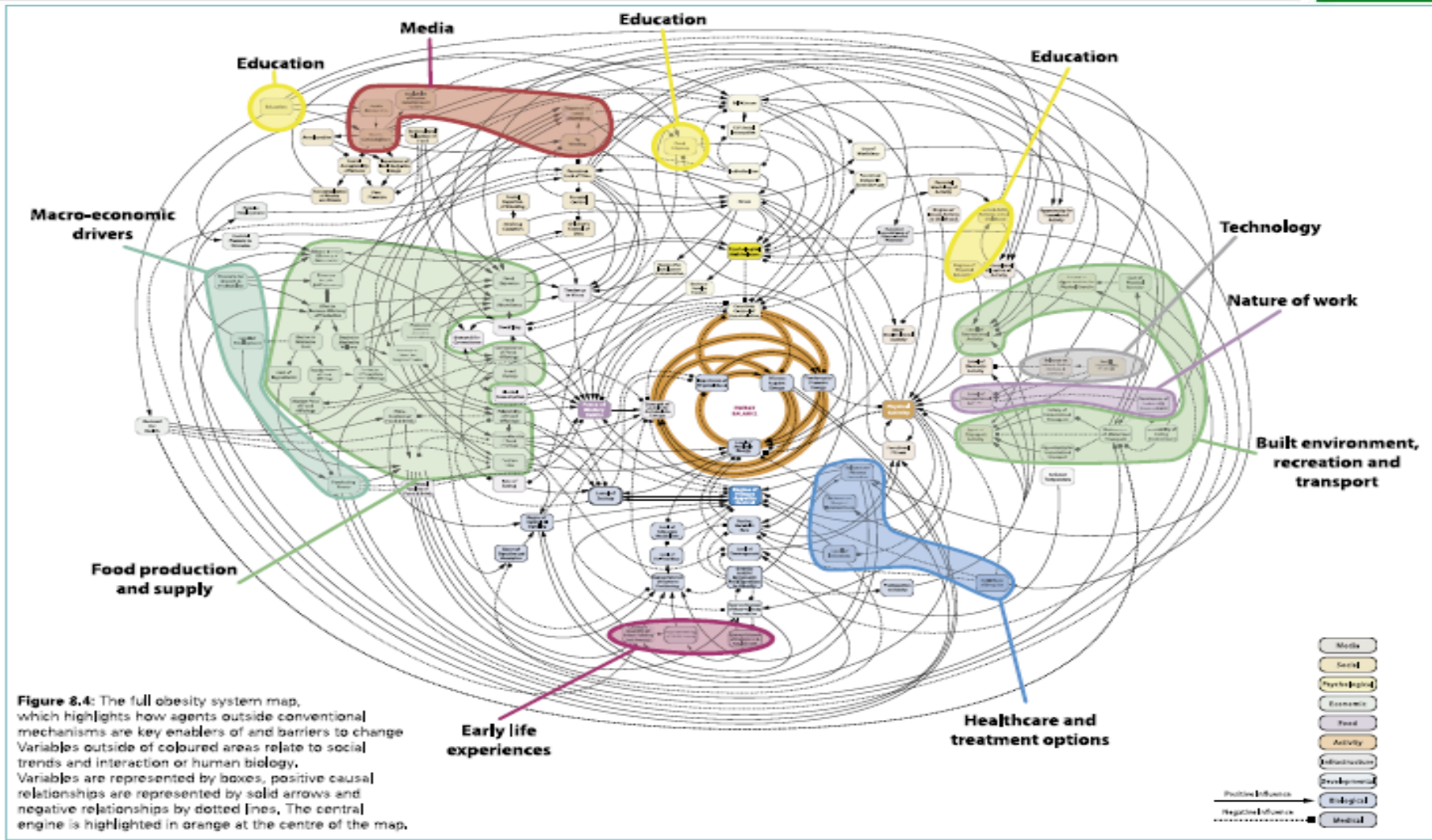
The process



- Co-producing open starting questions
- Fieldwork I – doing the AE in pairs (witnessing)
- Preparation work – turn into first person stories
- Group work
 - i) reading and listening to stories
 - ii) making sense of the stories
 - iii) planning the next AE questions
- Fieldwork II
- Etc until satisfied we fully understand the issues

Outcome-based performance management





Child Obesity



- 10 children 'morbidly obese'
- Concerned Paediatrician
- An assumption for more dieticians
- Trained school nurses and Health Visitors in AE
- Interviewed the 10 families
- Wrote them up in the first person
- Read them aloud in groups
- Agreed the answer was a 'whole family approach' across multiple services

The practice of learning through listening



- Builds understanding (because we do it together)
- Builds empathy (because we do it together)
- Builds trust (because we do it together)
- Gives legitimacy (because we talk to lots of people)
- Tells us what we need to do
- Is asset/strength based because it starts where people are

System Optimisation Group & Creative Solutions Forum

Gary Wallace
Office of the Director of Public Health
Plymouth City Council

System Optimisation Group



- Multi-agency, multi-commissioner forum
- Delegates have authority to act (mainly CEO level)
- Around 30 services and 5 commissioners
- A high level group tasked with finding and resolving 'system level' problems escalated from CSF and other learning
- Take collective responsibility and focus on the whole system

Membership



- Representatives from existing services supporting people who have single homeless, mental health, drug and alcohol and offending support needs
- Other representatives who have an interest and ability in improving the current system
- Commissioners from the Co-operative Commissioning Team and NEW Devon CCG
- Public Health Specialist
- Representation from User and carer groups (e.g. HealthWatch, SQIP, PiPs)

Purpose



- Success would include creating a whole system for whole people, preventing people from 'falling through the gaps' and reducing repeat revolving door referrals. The SOG will work collaboratively to deliver the system changes required to realise success.
- The System Optimisation Group will take responsibility for sharing ideas and perspectives in order to identify how the current system can work better for people with complex lives, regardless of current individual contracts and funding arrangements.

Functions



- Defining the issue; who are the people who fall between the gaps, what issues do they face, how many are in this cohort
- Problem solving; identify immediate solutions to meeting the gaps in our system
- Fixing what can be fixed now; members will be expected to make changes within their organisations
- Identifying other key stakeholders who are able to improve the current system and make changes
- Ensuring that service user and carer views are represented

Functions



- Sharing ideas, thoughts and suggestions in an open 'judgement free' environment
- Sharing pressures and hot spots with a view to improved understanding of each other's organisations
- Sharing Good Practice
- Ensuring that recommendations for system changes that cannot be implemented within the existing system are communicated to commissioners.

Behaviours



- Commit to making changes to their working practice
- Work together under the *Cooperative Commissioning Principles*
- Hold each other to account for agreed actions
- Meet formally at least once a month for six months but continue to communicate effectively at all times in order to succeed
- Build effective, strong and sustainable relationships within the group and with others as required
- Not focus on individual or organisational service interests, making decisions based on what is best for the service user.

Creative Solutions Forum



- Piloted for 6 months August 2016 to February 2017 (but now a permanent group)
- A forum of last resort comprising commissioners, practitioners and managers
- Deals with cases where multiple hand offs occur, where complexity means bespoke solutions are necessary, where risk is unacceptably high and needs to be shared and/or where thresholds and boundaries have become blocks to help

Membership



- Standing membership – MH, PH, ASC and community connections commissioners. Substance misuse, housing, MH, hostel providers
- Chaired and ‘owned’ by adult safeguarding
- Any other relevant service can attend by invitation on a case by case basis
- Ethos is permissive, collegiate, supportive and creative
- Hand offs are not permitted – no agency can abrogate responsibility

Purpose



- Full case discussion
- Development of bespoke multi agency, multi commissioner response
- Reduction of risk
- Elimination of 'gaming' and 'hand-offs'
- Reduced use of unplanned services
- Iterative production of an holistic and deliverable care plan

Creative Solutions Forum



- To encourage creative partnerships between providers and commissioners that place the person at the centre of planning and **share responsibility** for risks and outcomes
- To explore the current packages of support in place for people with highly complex presentations, to examine their effectiveness and identify any gaps in provision
- To propose solution focused suggestions for further support, both by making use of current services and in some circumstances by commissioning new packages of care.
- To influence and inform the Commissioning Strategy for people with highly complex presentations
- To share and encourage the development of learning, good practice, knowledge and skills across the city in both community and targeted services.

Prototype Cases



- 52 cases
- 27 women
- 25 men
- Referrers: police, substance misuse services, hostels, private landlords, social workers, nurses, GP's, hospital, neuro-rehab service, mental health services, environmental health (hoarding) and reablement services

Referral Reason(s)



- Complexity leading to multiple handoffs
- Imminent risk of death
- High risk to staff, public and of hate crime (perpetrator)
- Assessment of capacity and a permanent home
- Suicide, self neglect, overdose, BBV, high risk
- High risk of death, drinking and drug use
- Mental health, sexual health, self harm, overdose
- Risk to public, violence
- Retain accommodation, non payment of rent, MHA Act assessment
- BMI 13, sex worker
- drug and alcohol, ? Korsakoff's, unmanaged diabetes, Hep C
- End of Life care
- Eviction
- ?PTSD
- Self neglect
- Accommodation need

Range of Diagnoses



- Borderline Personality Disorder & Emotionally Unstable PD
- Pregnancy
- Psychosis
- Acquired Brain Injury
- Autism
- Anorexia
- PTSD
- End stage liver disease
- Anxiety
- Paranoid schizophrenia
- Depression
- HCV
- Alcohol related dementia

Typical Risks



- Suicide ++
- Self harm ++
- Accidental overdose ++
- BBV infection +
- Liver damage ++
- Neglect +
- Violence (victim and perpetrator) ++
- Anorexia

Results



- 47/52 cases presented with high risks
- All but 5 (lost to follow-up) cases reported risk reduced
- Workers carrying risky cases report feeling more supported in managing risks
- Big reductions of use of emergency services – one case from average 3x police/ambulance per DAY to none
- Reductions in B&B use
- Implemented end of life pathway for homeless person
- Housing – all achieved a housing option/plan they were satisfied with
- System learning - around half of these cases could have been avoided if services were 'joined-up'
- Benefits have been so broad we can't quantify them

Benefits



- The biggest benefit has been the transformation of culture across the health and social care system
- Relationships, integrated working, changes to practice, less bureaucracy, more collaborative work, removing administrative barriers and standardised approaches, a focus on the person and the return of bespoke approaches
- CSF rarely needs to invent it mainly gives permission for nurse, social worker, commissioner etc to have the freedom to act based on their professional knowledge and skill

“ I love coming to this meeting. It feels like I get to do all the things I thought I was going to do when I became a social worker”





Experimentation to help people to thrive in Gateshead

Putting People First – Part II

How health and care in Scotland
can be different

December 9, 2021

Mark Smith

SRO, Changing Futures Northumbria

Director - Public Service Reform, Gateshead Council

Summary of contents

Part One – Doing and Debriefing

- To prototype or not, and if not, what?
- Essential design features for any experiment
- Rules and principles
- Effective -> Efficient -> Sustainable
- From ADR to URM
- P.L.A.N
- Measures framework
- Debriefing, confirmation practices

[Q&A]

Part Two – Learning and Sense Making

- Learning-and-doing governance
- Designing for frequency
- Cost/consumption: history and trajectory
- The power of stories – telling and selling
- Legacy – points of leverage and taking action

[Q&A - BREAK]

A photograph of two people, a man and a woman, suspended in a complex web of ropes against a dark background. The man is on the left, shirtless, and the woman is on the right, wearing a dark top. They are both looking upwards. A single red rope runs diagonally across the frame. In the top left corner, there is a small orange rectangular graphic.

Experimentation to help people to thrive in Gateshead

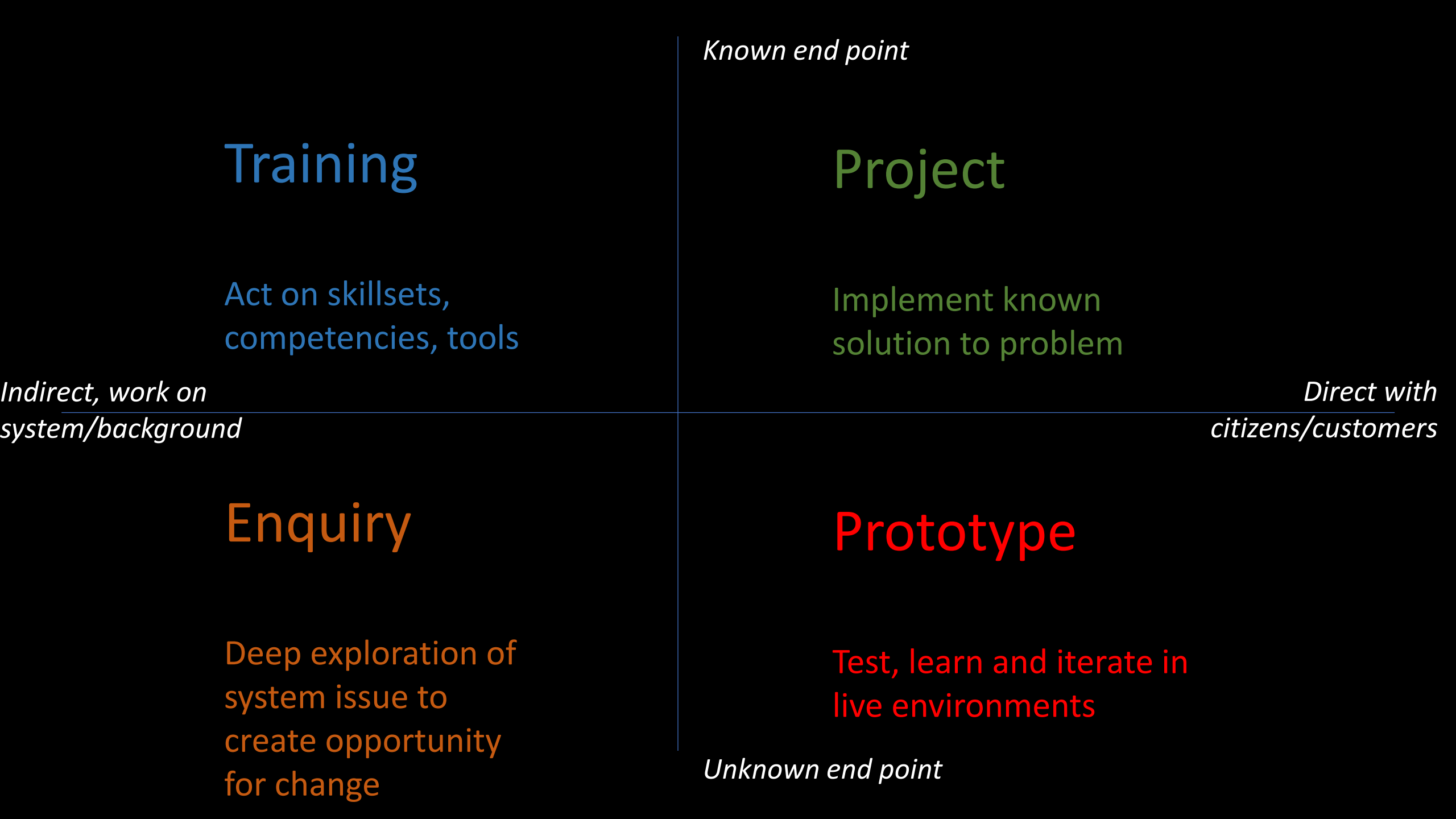
PART ONE

Doing experiments and
debriefing about them

Mark Smith

SRO, Changing Futures Northumbria

Director - Public Service Reform, Gateshead Council



Known end point

Training

Act on skillsets,
competencies, tools

*Indirect, work on
system/background*

Project

Implement known
solution to problem

*Direct with
citizens/customers*

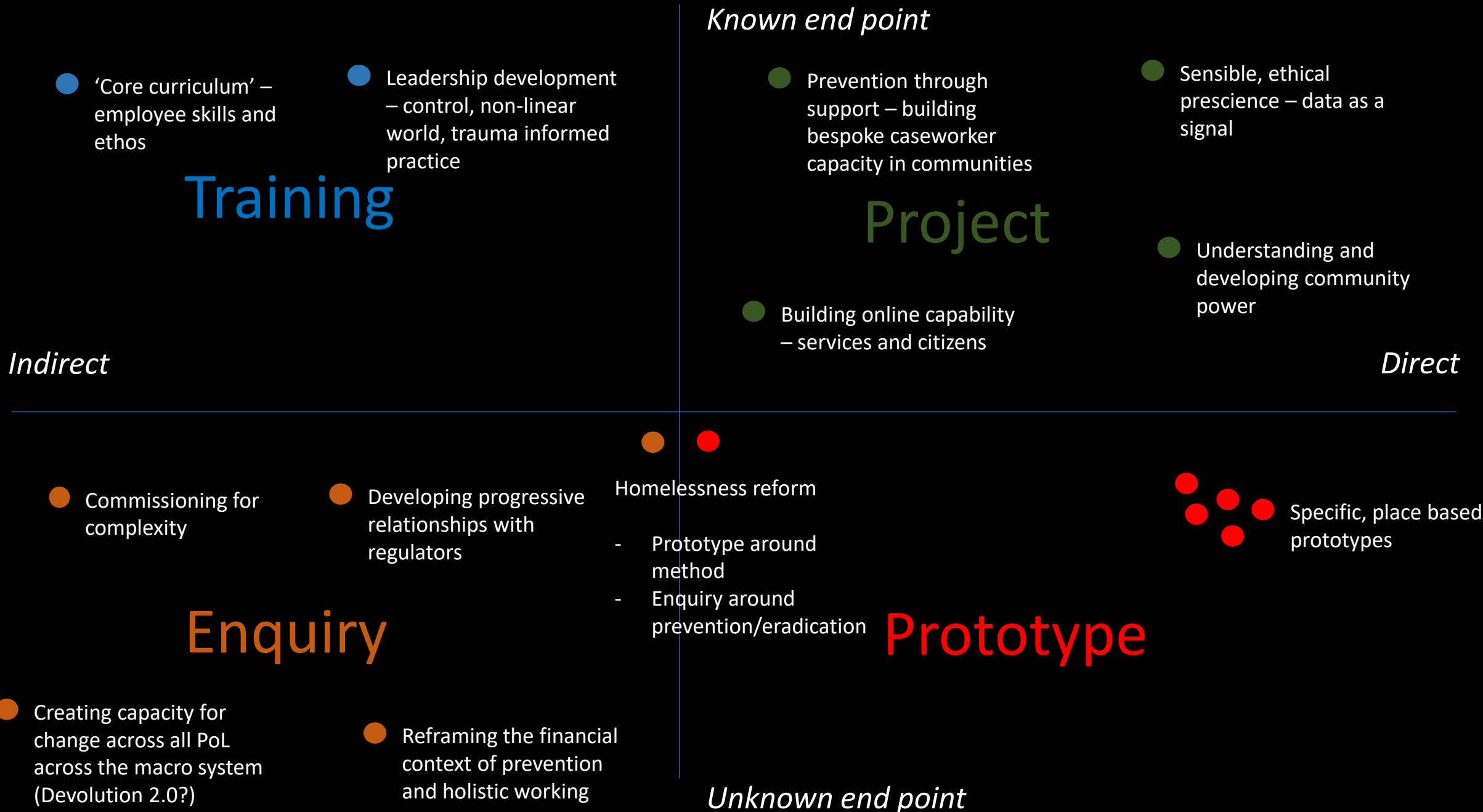
Enquiry

Deep exploration of
system issue to
create opportunity
for change

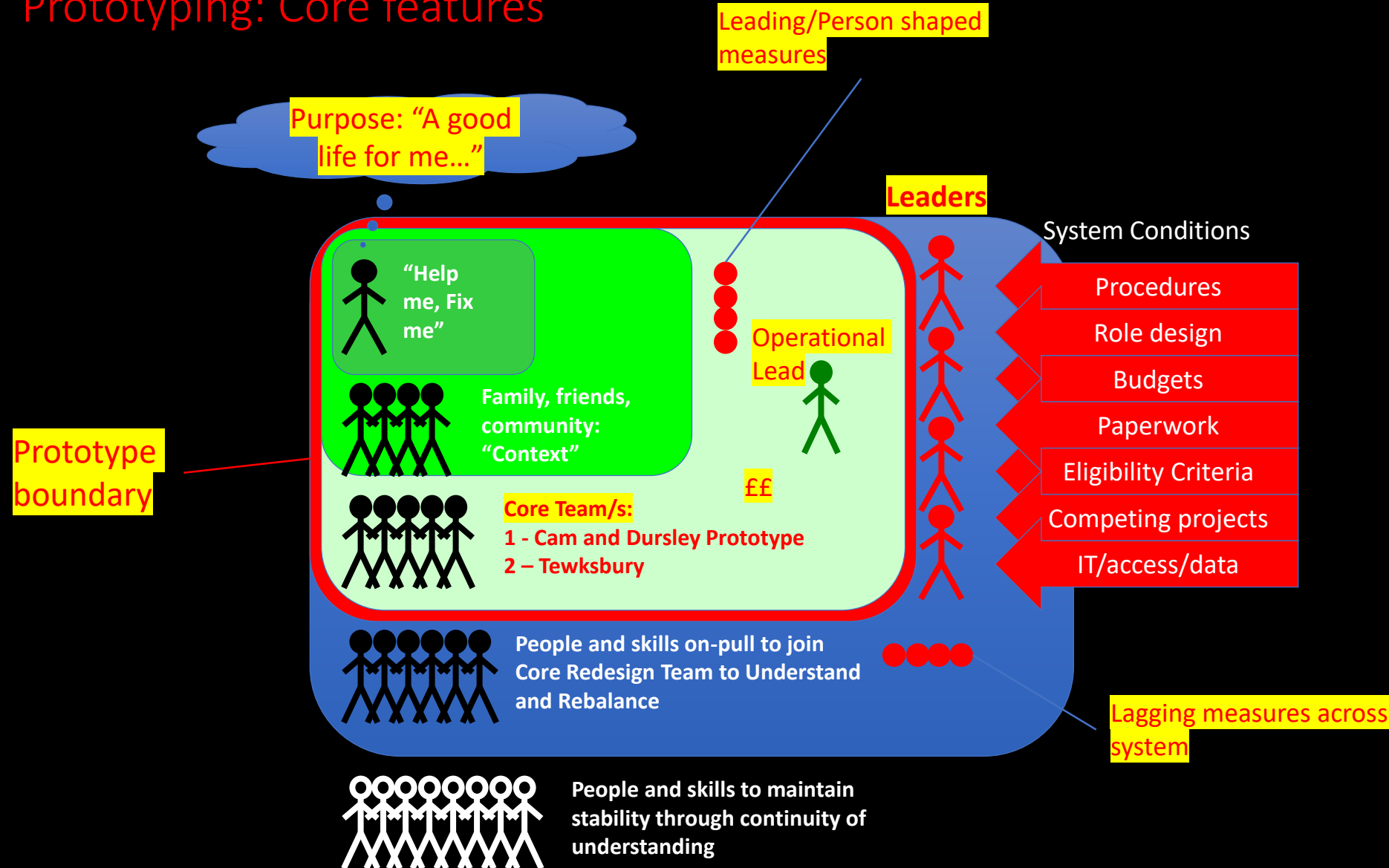
Unknown end point

Prototype

Test, learn and iterate in
live environments



Prototyping: Core features



Rules and Principles

- Second only in importance to PURPOSE
- Rules: binary, sacrosanct, unambiguous, means of control
- Principles: guiding, clear, multiple manifestations, up for negotiation
- Too many rules – stymie creativity and harder to absorb variety
- Too few/no rules – laissez faire, risky, learning unclear
- Develop these from experiences of staff and citizens – important groundwork

Rules and Principles

RULES

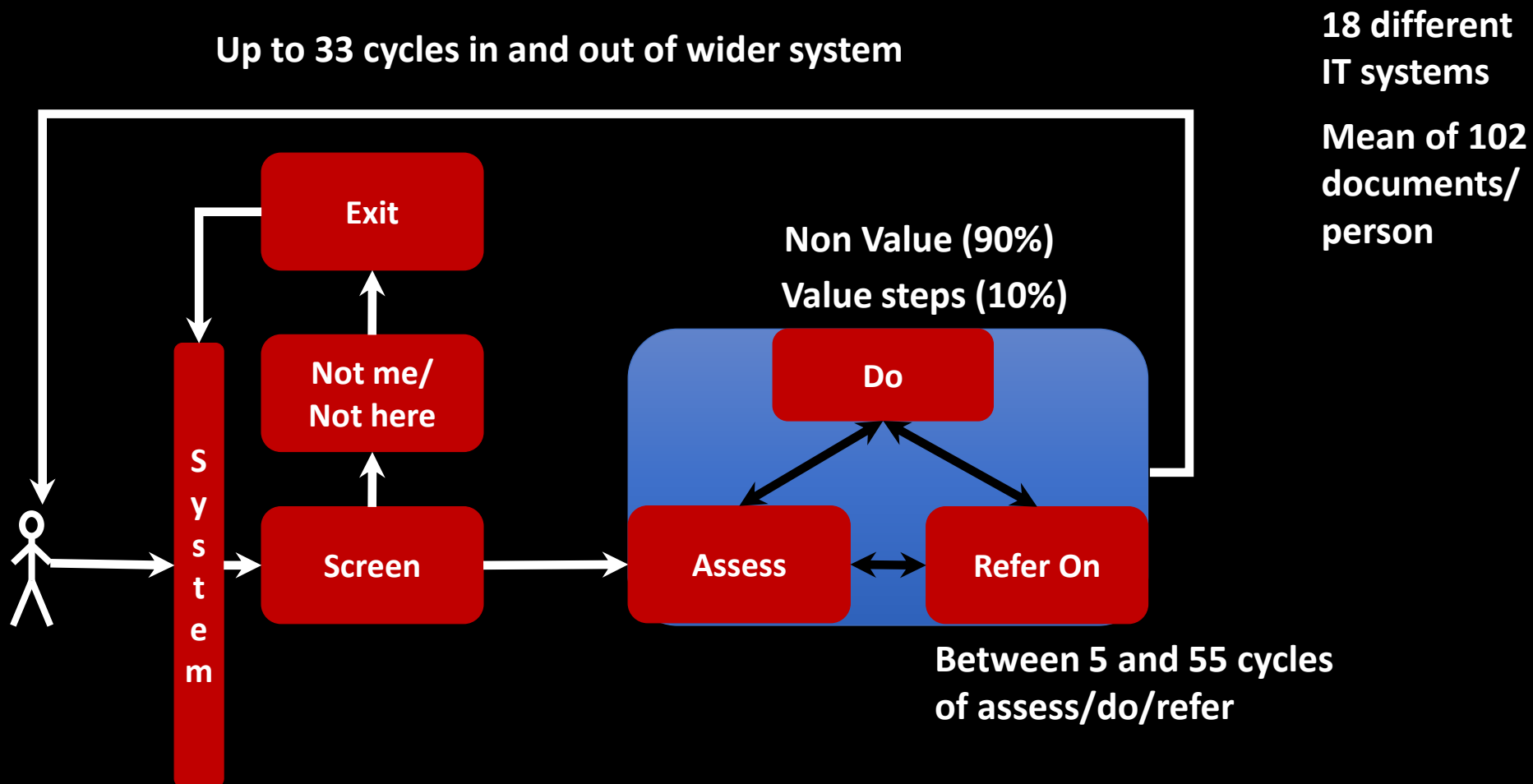
- Do no harm
- Don't break the law
- (Do IT last...)

PRINCIPLES

- Understand, not assess
- Pull, not refer
- Decisions in the work, not the leader's office
- No such thing as 'out of scope', no eligibility criteria
- Measures to learn and improve (rather than to keep score)

What do we really want to know?	The focus of the measures?	What measures should we learn how to develop and use?
Is it effective?	Citizens	<ul style="list-style-type: none"> - “What matters to me?” - “Is this helping me to lead a better life?”
Is it efficient?	Services Employees Volunteers	<p>How easy/difficult was it for me to do the right thing for the person I am trying to help?</p> <p>What helps? What hinders? Why?</p>
Is it sustainable?	System Resources Structures Culture/Power	<p>How might what hinders be removed? Can it be?</p> <p>How might what helps be increased? Can it be?</p> <p>What features of the system need the most work? (e.g. commissioning, regulation, roles?)</p>

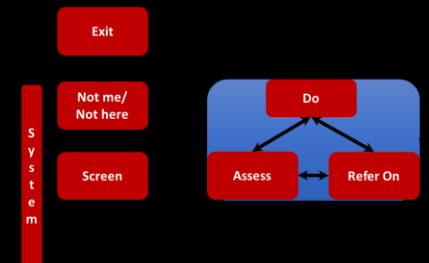
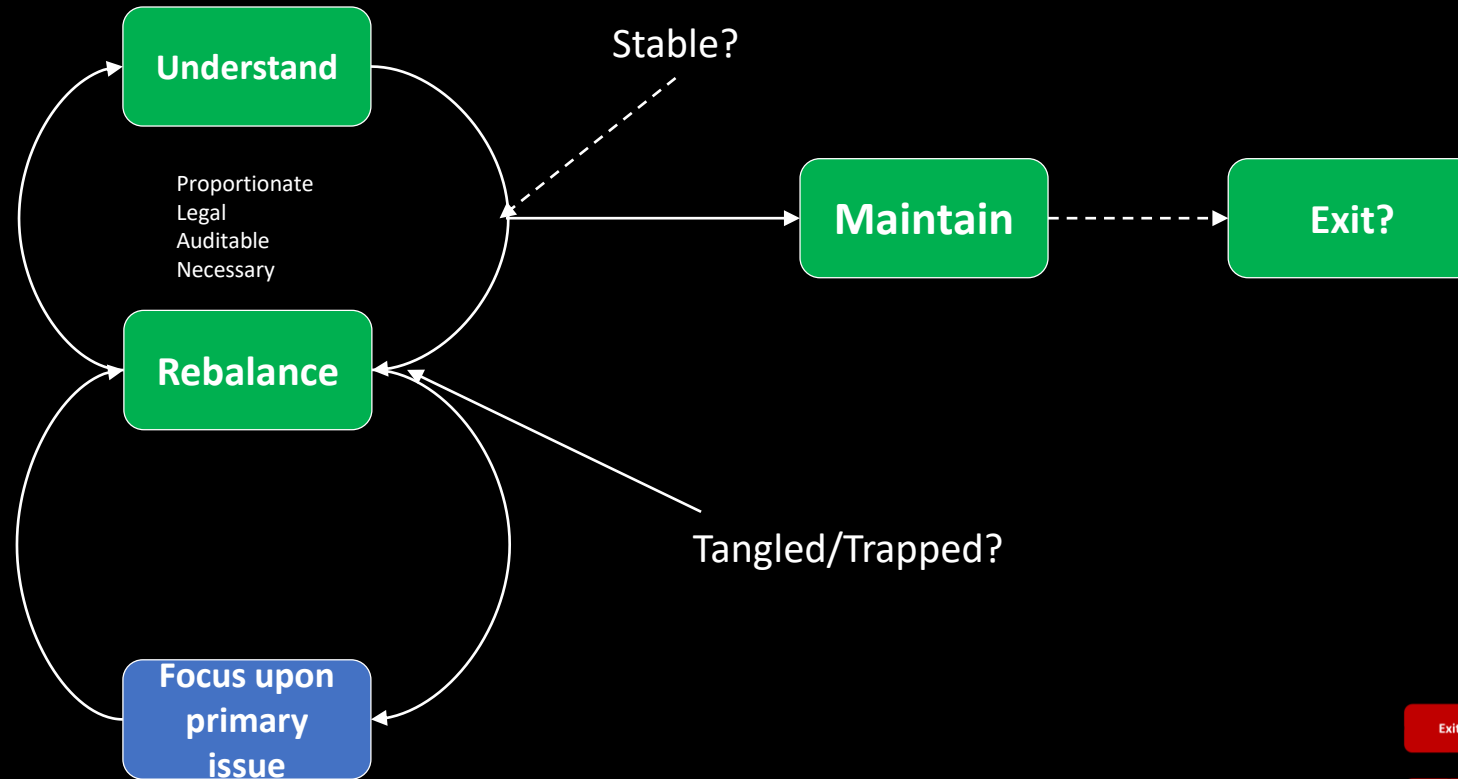
Starting with efficacy...



Three years back story....

Do things better ✗

Do better things ✓

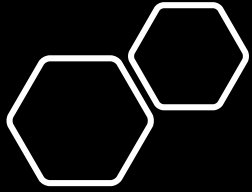


Good measures come from good questions...

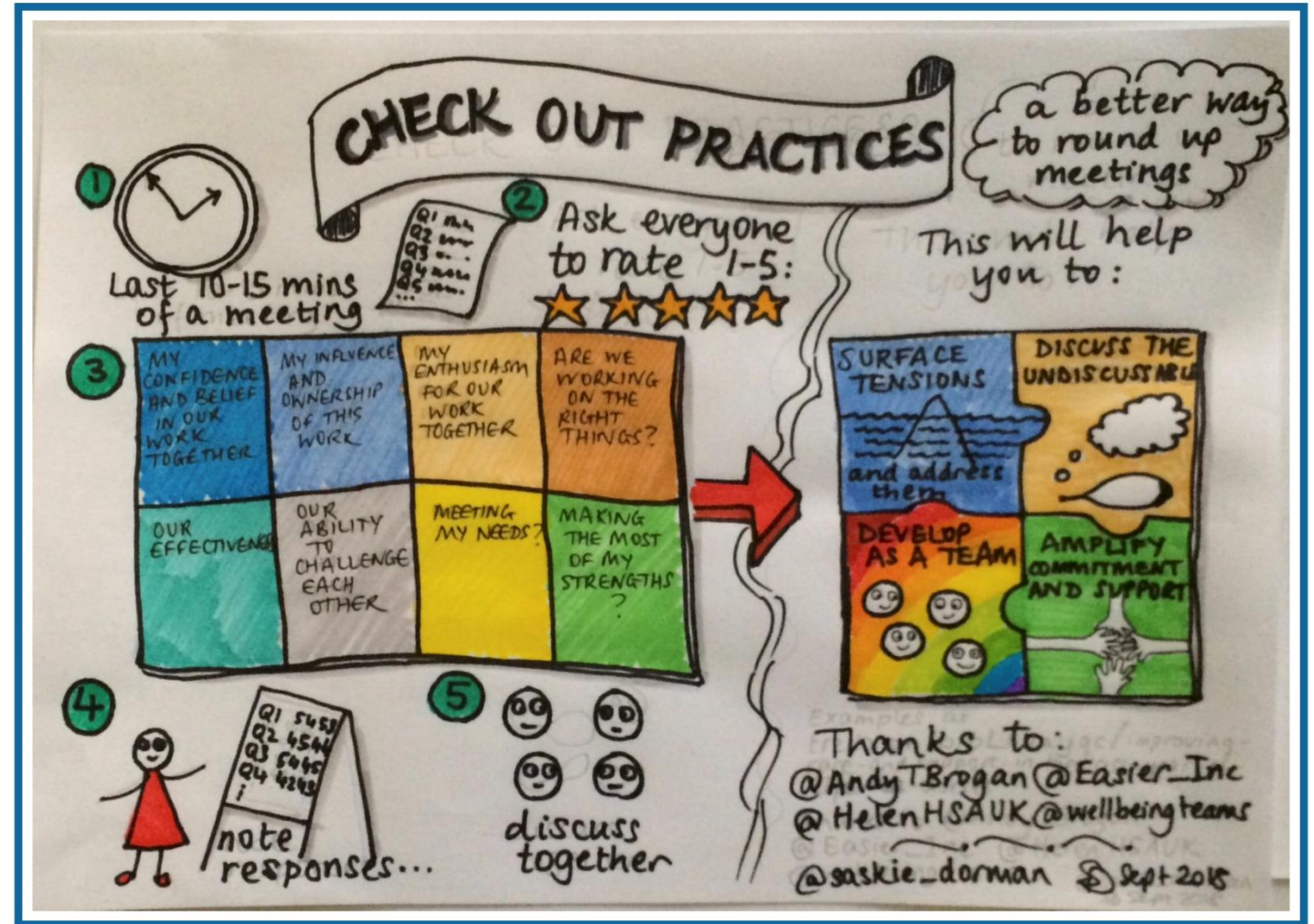
Central Questions	Impact on Citizens	Efficiency	Cost	Morale	
Teams	What will have the best impact upon those we're supporting?	How easy/difficult is it to work upon what matters to people?	What has it already cost to get to where as citizen is now?	What would make this work great to do for staff and volunteers?	This is information required to focus work done in locality teams, aka <i>leading measures</i> . They are 'leading' as they guide the work but do not assess it.
Leadership	How well is our work working for citizens? Why?	What makes it difficult and how can we change that? What good can we build upon?	What has it cost to do what we're doing? What cost did this potentially prevent?	What impact is what's happening having on staff and volunteers? Why?	Information required to focus work for system leaders, aka <i>lagging measures</i> . They are 'lagging' as they evaluate the consequences of the work after the fact, so improvement and focus is where it is needed.

Debrief

- Regular and planned – daily at first
- ‘Hot’ debriefs for major learning that cannot wait – single issue, callable by anyone
- Sandwich structure : pragmatic, reflective, pragmatic
 - Where are you up to/what’s happening?
 - What do you need?
 - How’s it going for you, those you’re helping, colleagues?
 - What did you learn? What needs to be figured out?
 - RIP AOB – Your belief in the mission, the experiment, your contribution
 - What happens now? Staff, Op Lead, Leaders, others?
- Specific role needed to record this and to populate the measures
 - Specific 1:1 debriefs key for measures and welfare issues too



Debrief



Next section...

- Learning-and-doing governance
- Designing for frequency
- Cost/consumption: history and trajectory
- The power of stories – telling and selling
- Legacy – points of leverage and taking action

The background of the slide is a dark, atmospheric photograph of two people, possibly a man and a woman, suspended within a complex web of thick, light-colored ropes. The ropes are draped and knotted, creating a web-like structure. A single, vibrant red rope stands out against the dark background, running diagonally across the upper right portion of the image. The lighting is dramatic, highlighting the textures of the ropes and the figures within them.

Experimentation to help people to thrive in Gateshead

PART TWO

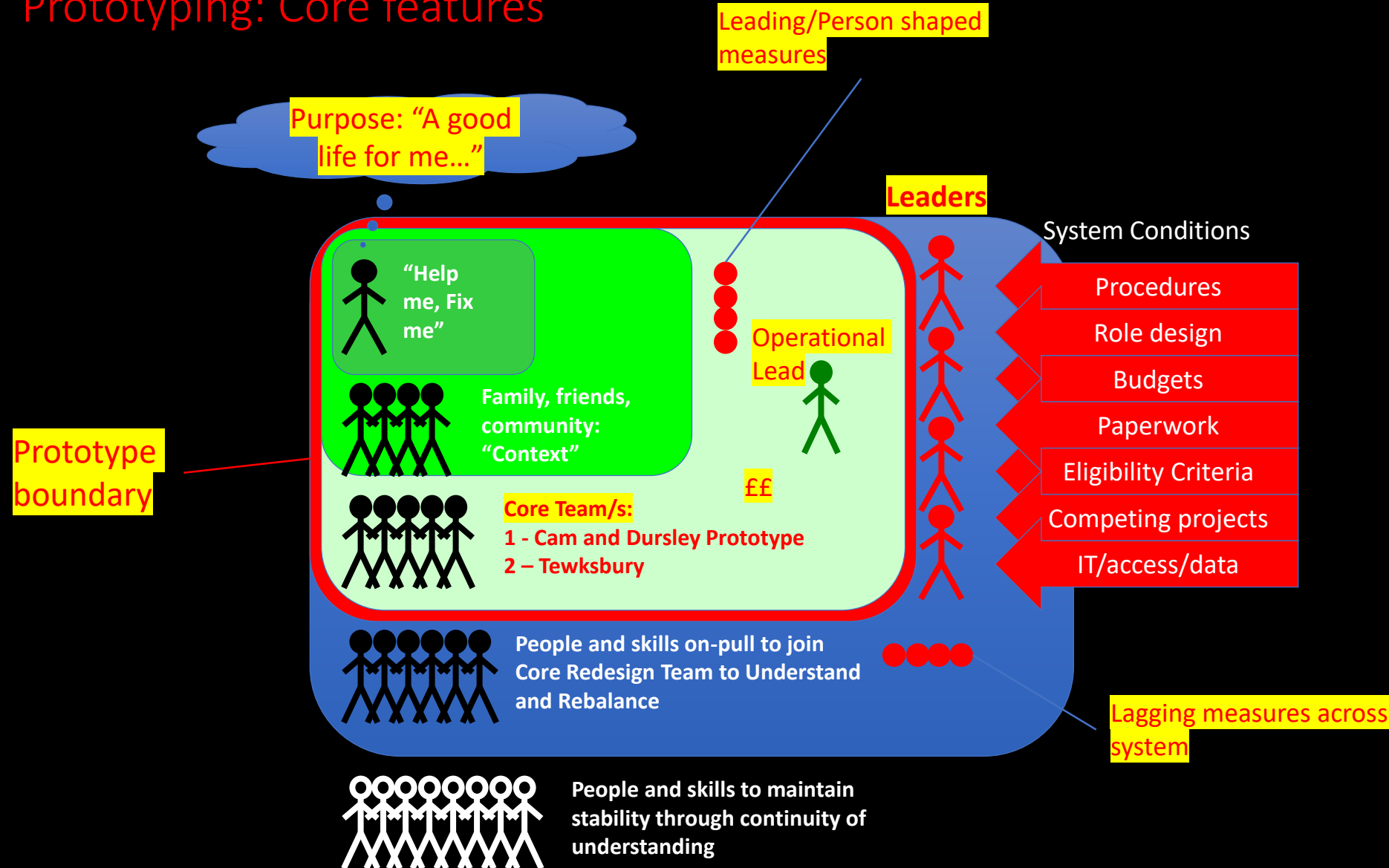
Learning and sense making

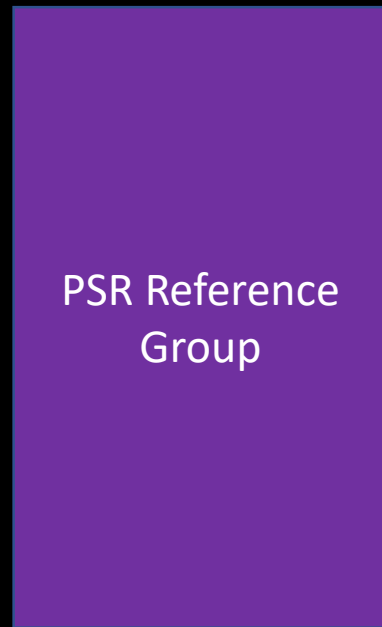
Mark Smith

SRO, Changing Futures Northumbria

Director - Public Service Reform, Gateshead Council

Prototyping: Core features





Provide helpful scrutiny and external perspective



Learn how to help people to thrive

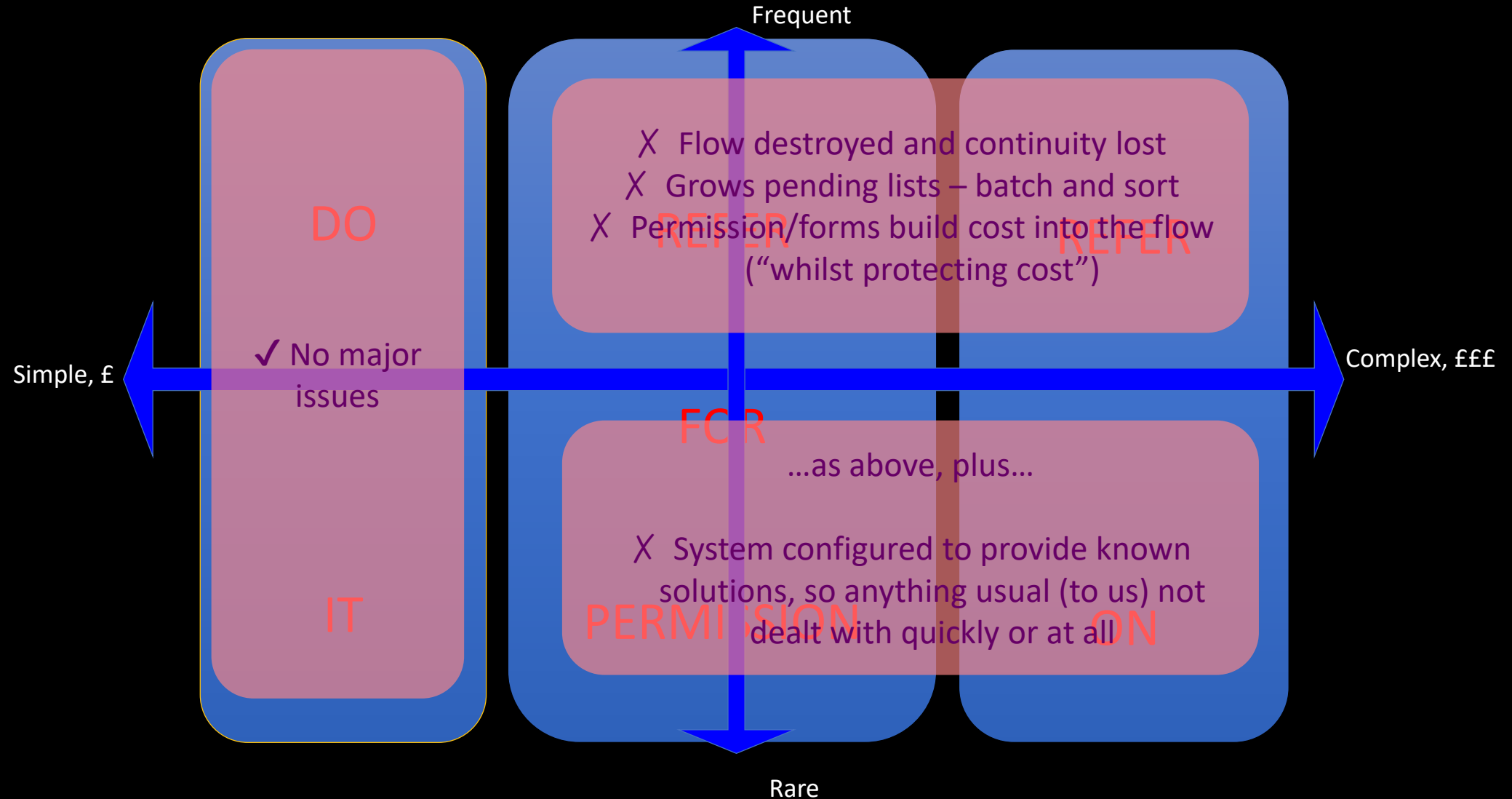
Evaluate the implications of what the Core Team are learning

Support the Core Team with Method Issues

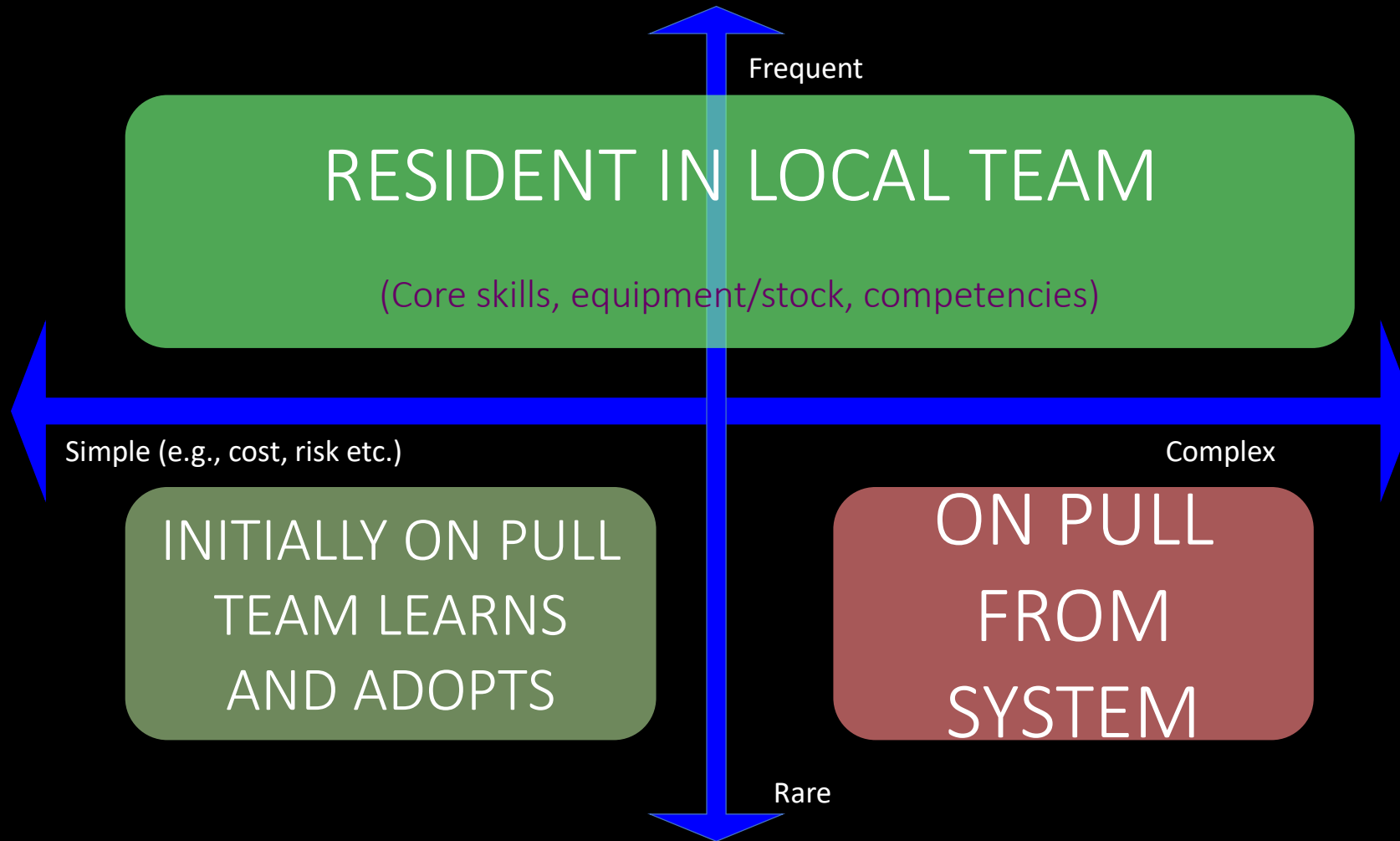
Engage the Leadership Team with System Issues

Change the system based upon evidence and learning

Roles: Managing complexity and cost

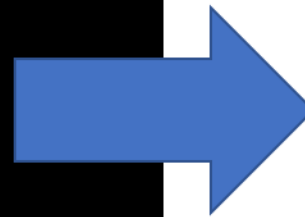


Designing for frequency

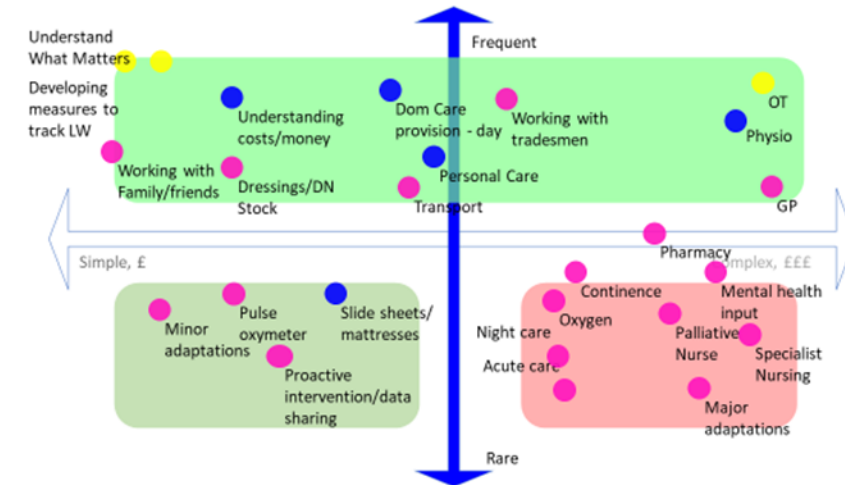


Designing for frequency

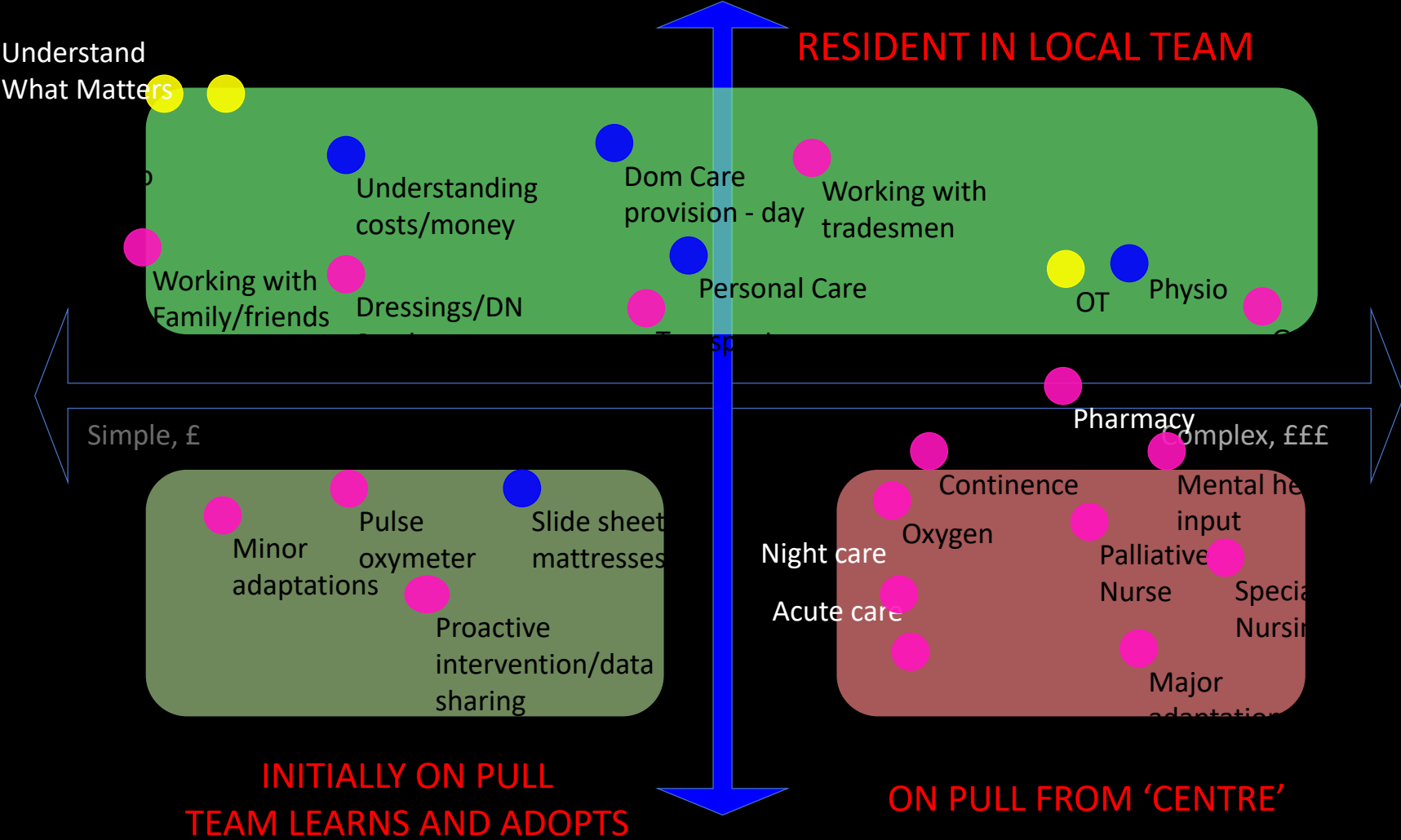
Activity	Frequency	Complexity



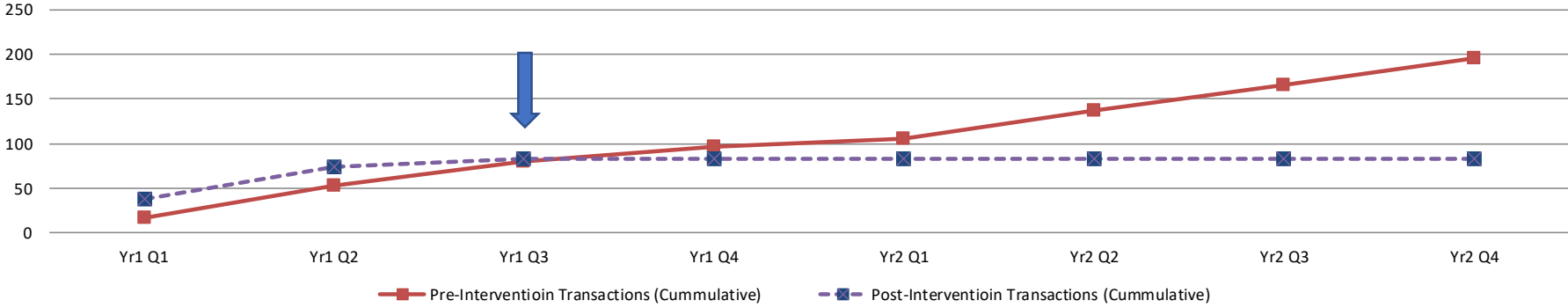
Learning from our cases



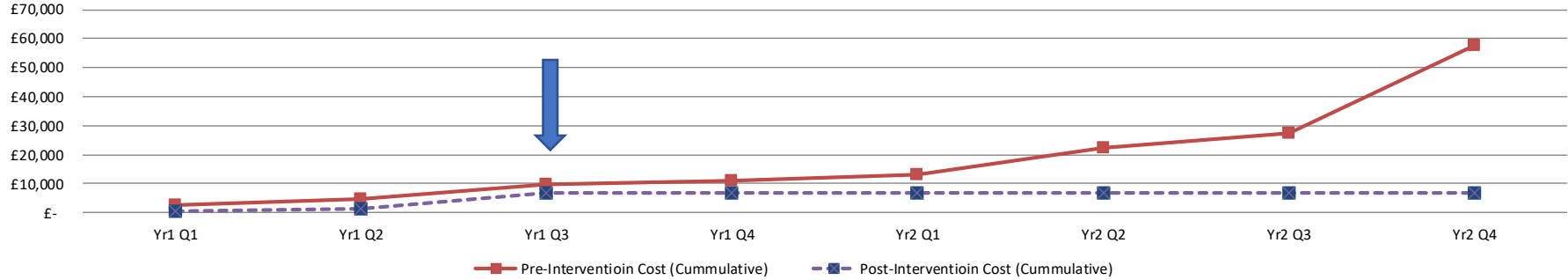
Learning from cases



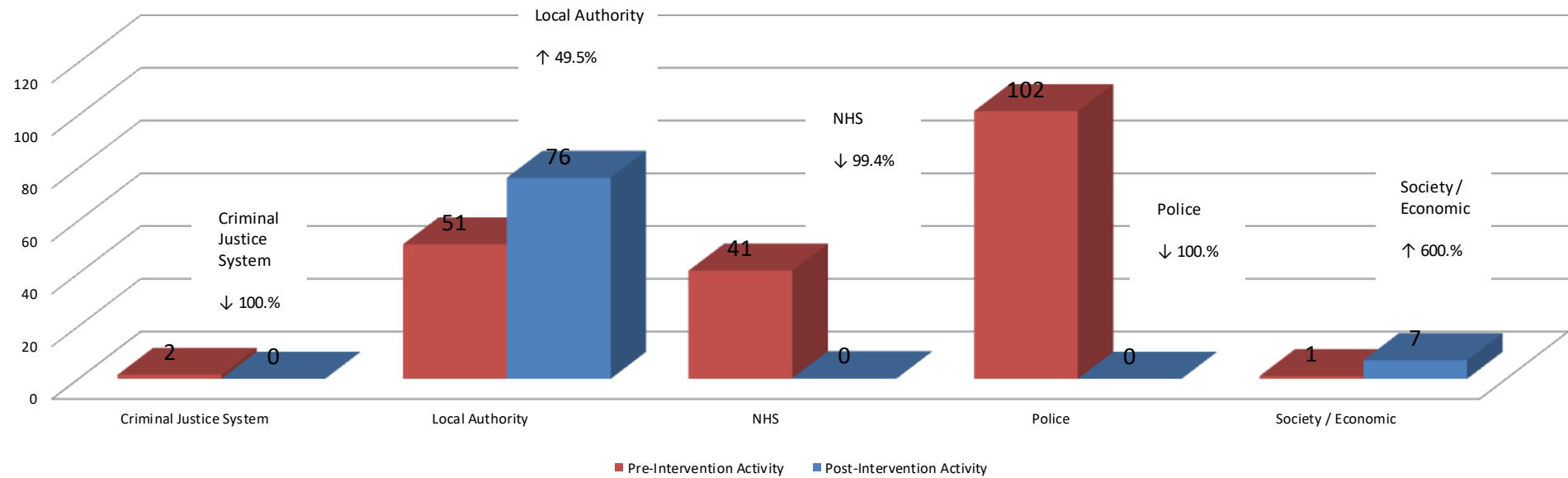
Cummulative Comparison of Pre and Post-Intervention Total Activity: Kelly



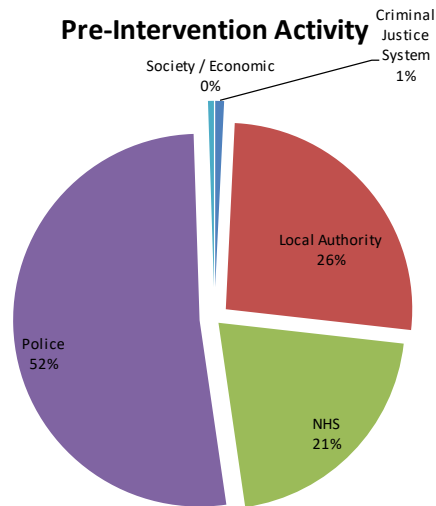
Cummulative Comparison of Pre and Post-Intervention Costs: Kelly



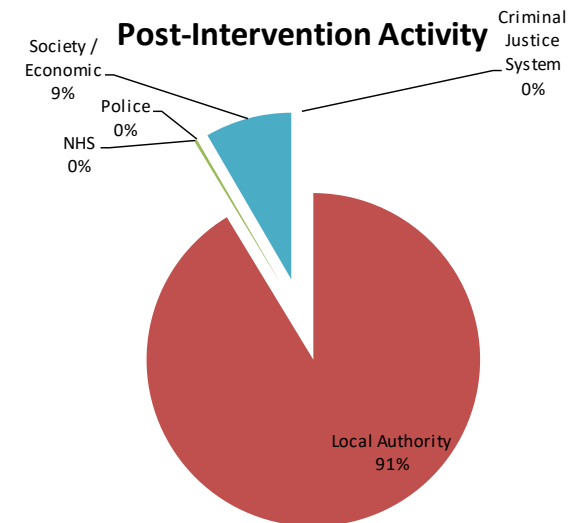
Demand Analysis: Number of Pre and Post-Interventions by Agency: Kelly



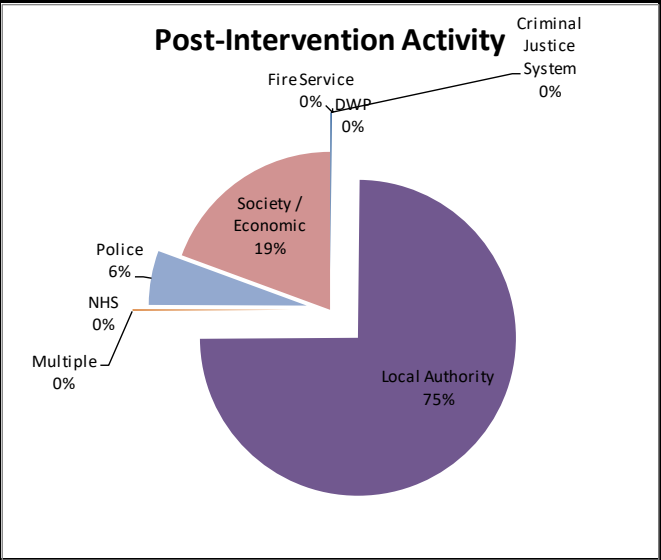
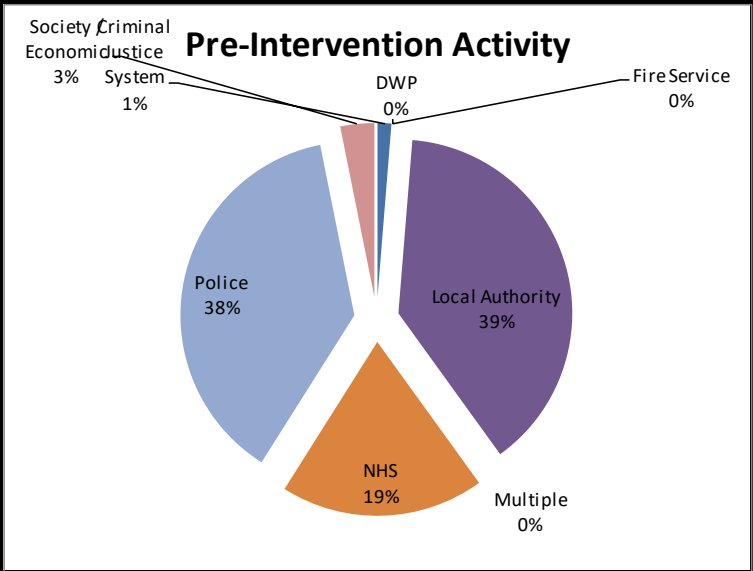
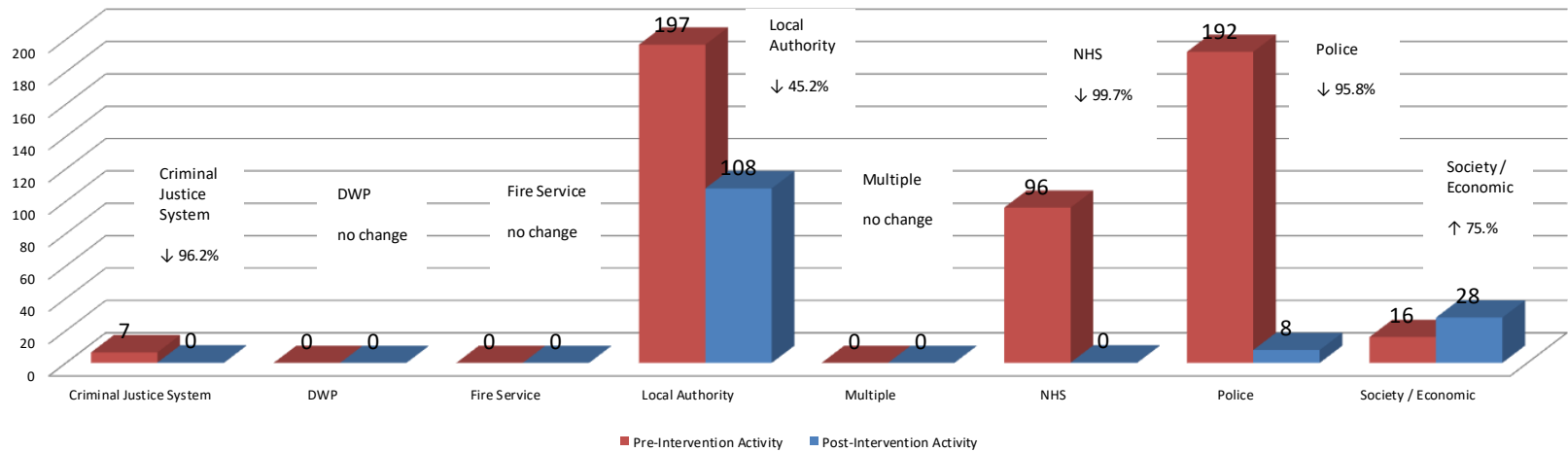
Pre-Intervention Activity



Post-Intervention Activity

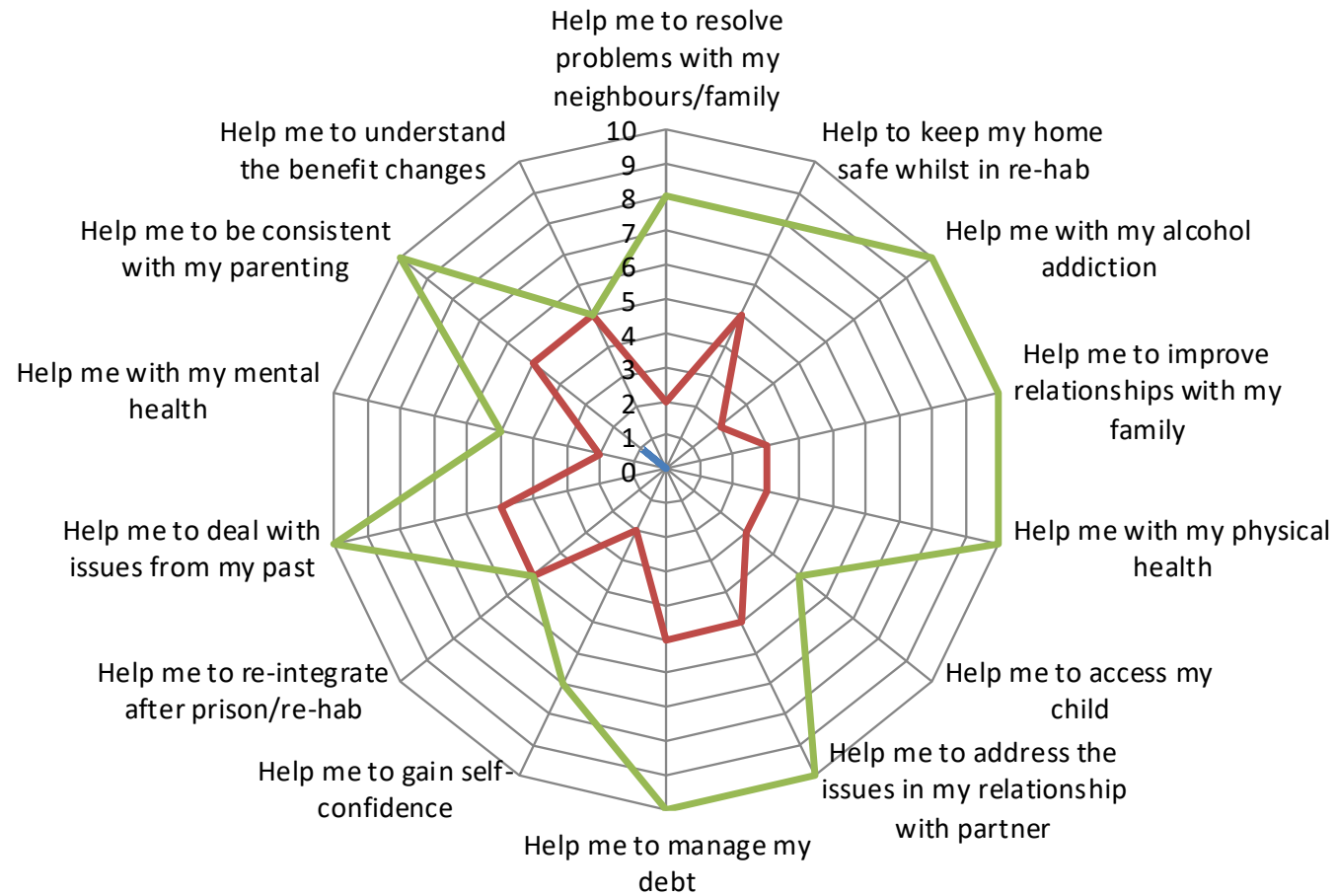


Economic Outcomes, Number of Pre and Post-Interventions by Agency: All Cases

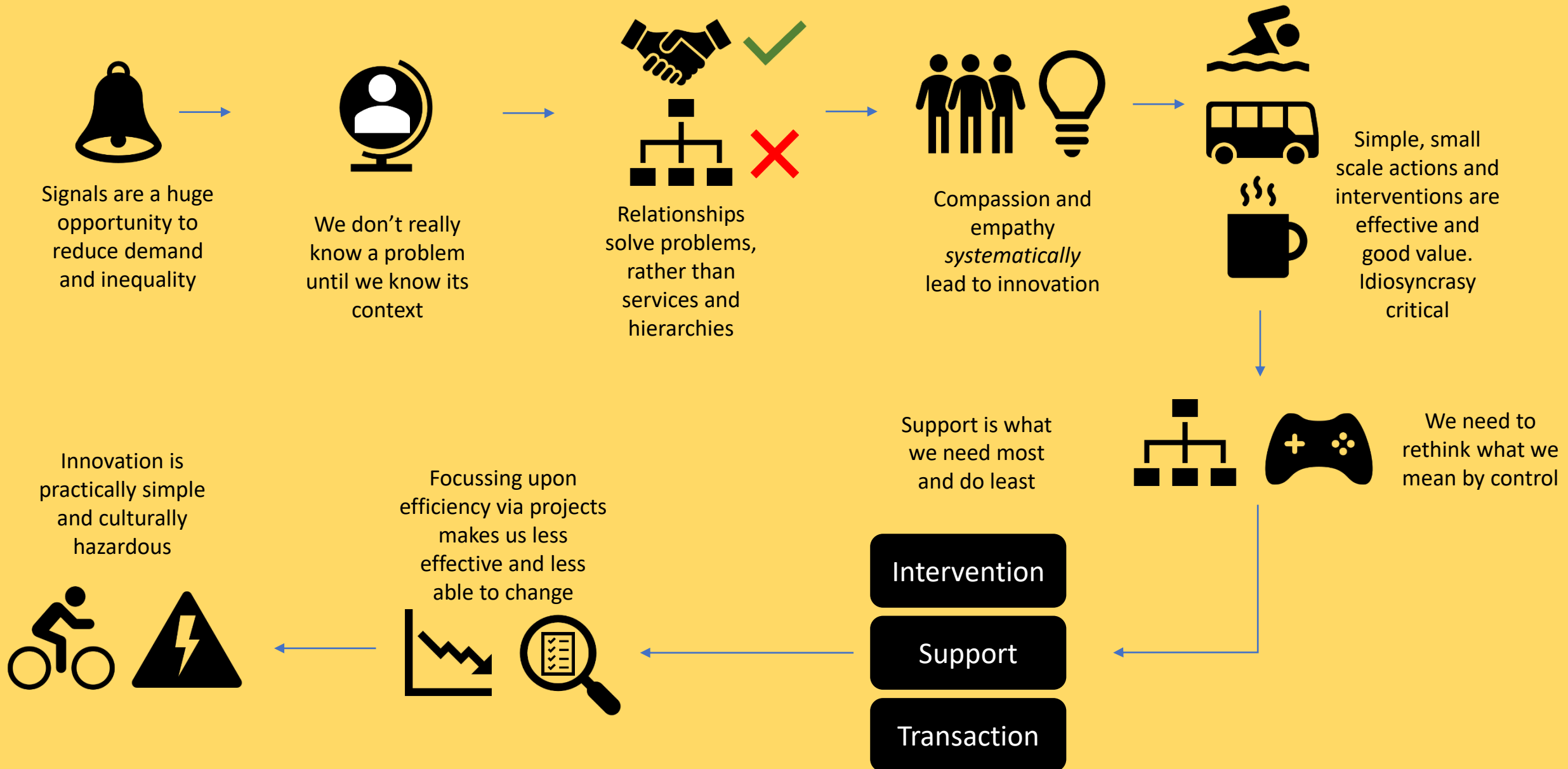


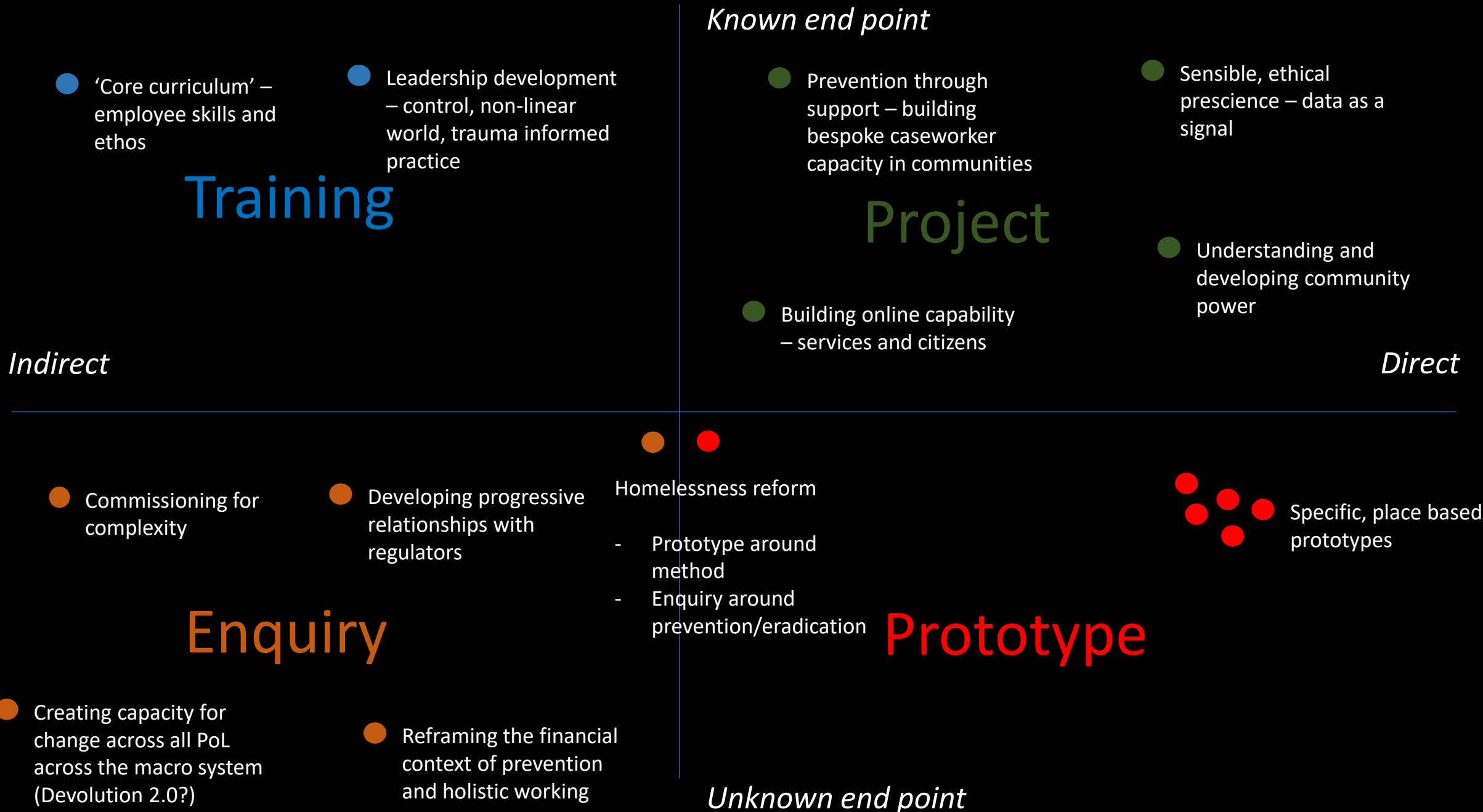
Capturing the learning from *issues*

Issue Description	Level			Status (open/ closed)	Owner			Action required	
	Ind	Sys	Macro		Team	L'ship	Govt	Countermeasure (now)	System Change (new normal)



What did we learn?





Q&A

Putting people first - Part II: practical insights of how to use Human Learning Systems

website: ihub.scot

email: his.collaborativecommunities@nhs.scot

twitter: @ihubscot

