Building Health Partnerships in Lancashire and South Cumbria: Wednesday 23rd January 2019

Partnership Meeting 2: Summary of Discussion

## Background

Building Health Partnerships is a programme of facilitated support designed to develop multi-stakeholder partnerships that create solutions to pressing local health and care issues.

At the first partnership session on 22nd November 2018 the group set out to identify the priorities for Lancashire and South Cumbria and to build consensus on what the group want to achieve (what themes and at what levels) through the process, as well as using the opportunity to hear about what’s going on in various ICP areas, to learn and to share.

The overall aim of the Building Health Partnerships programme in Lancashire & South Cumbria was concluded as: ***to look at ways to harness the leadership, power and capacity of our communities to improve their own health and wellbeing***. Through group discussions there was consensus that by ‘proving the value’ of new ways of working in partnership at a very practical, ICP level would bring benefit through shared experience and learning, and ultimately better decisions being made with communities.

## **Purpose of the workshop**

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| To plan and design a ‘test, learn and review’ approach that enables us to demonstrate what a multi- sector partnership at a neighbourhood level could look like and to prove the value of this way of working. |

## Key messages from the meeting:

**Good practice already happening**

* There were positive examples of **good practice** happening across Lancashire and South Cumbria.
* There was enthusiasm to **capture this evidence** in a meaningful way and to think on how to build on this in other areas. For example:
* The social prescribing programme being set up and running in East Lancashire.
* Sharing the report – Health as a Social Movement <https://www.thersa.org/discover/publications-and-articles/reports/health-as-a-social-movement-theory-into-practice> in particular ‘What Success Looks Like’

**Varied experiences across the areas**

Although, there were positive discussions about good practice happening, it was clear that this plays out in various ways and is at different stages across the areas.

This creates challenges in that the **areas have progressed at different rates** and are therefore starting at different places. That being said, neighbourhoods need to learn from one another about what is already happening, locally or more widely.

**How can we learn from what is happening in other areas or good practice?**

There is a strong appetite for areas to **learn from one another and share what works**.

There is enthusiasm to learn from the report ‘**Health as a social movement: theory into practice’,** in particular and apply the recommendations on what success looks like.

It was noted that **success could look different** depending on the neighbourhood and its level of development. One example, was that neighbourhood success could be about doing it for themselves rather than having a focus on services, as one person stated ‘services are not everything’.

One of the main problems is that individuals are **using complex language and jargon that excludes people**.

One way of learning from each area could be **to conduct a compare and contrast exercise**, if someone, or an area is ahead in building relationships and engagement with communities, what are the components that have informed this. How can other areas learn from what is happening? Or are there any commonalities or differences?

It would be useful to learn from all the Integrated Care Partnerships (ICPs), particularly around what is being done in practice might be different depending on the system. It is not just about demonstrating that things are being done differently but that they are **thinking** differently.

* *‘Knowing what you don’t know and needing to learn’* - need to go into the communities and systems and learn about what is happening*.*
* *‘How do we value what we know is happening and make the rest of the system work like that?’* - this will be done by identifying what is happening in other areas and bringing people to the same level.

**Thoughts about the programme design**

* Undertake a pilot in the 5 accelerator areas (*potentially could lead to more buy in to be involved, more resource, readier to test and support how aligned relationships are*).
* Potential to look at different approaches to engagement (at a neighbourhood level) in the 5 areas.
* Debate whether the neighbourhood should be picked first and then decide on the health topic, as it could depend on the local context.
* When selecting areas this needs to be done in a collective way and to ensure the work is not being duplicated in the areas.
* What is the offer for the areas to be involved? This group should provide an offer but also fine if they decline.
* There was some discrepancy about how areas/ neighbourhoods are/ will be defined.
* It is likely the accelerated areas will be up for sharing data, but not necessarily a consensus about taking part in a wider project.
* Could be better to work with a range of neighbourhoods to provide further reach and support.
* A common goal is that the programme should aim to improve the outcomes of everyday lives.

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| There was discussion about whether the approach should be reordered to **review, learn, test, review.** |

**Consensus for a bottom up approach**

There was a consensus that the neighbourhoods need to have ownership over what the BHP programme is focusing on and have a clear understanding of why it would be useful for them to be involved.

There was concern raised that that the programme might be driven from a top down agenda rather than a bottom up approach. Health partnerships need to be driven by co-production. There needs to be a push for an agreed involvement with the community and potential for individuals to go out and talk with the community.

*To have better health partnerships what can we do, what can we offer and what can we learn?*

**Engagement and relationships**

Discussion about the focus of our work and the ways the ICS and VCFS can work better together (relationships, engagement structures, decision making). Perhaps to unpick what are the different types of relationships and ways to engage with communities and neighbourhoods.

What success looks like at a neighbourhood level is important to understand what the culture is like between the VCFS and ICP, **what are the relationships and behaviours in the areas looking like now? What are the characteristics that make up a good relationship? What makes us want to be part of the community? And how can this learning be shared?**

That said it was agreed that there should not be a systems approach to relationships. Too often it is stated the voluntary sector has been involved in discussions and really only two individuals have been spoken with and is done on a tokenistic measure. This is not enough, there is not necessarily a systematic approach to engagement, yet. Instead it seems relationships need to be culturally established rather than on a personal basis. The latter can be problematic if someone leaves and relationships subsequently break down, therefore, it should not be about personal relationships but rather sector relationships.

**Things to follow up on:**

* More on the accelerator areas and their potential to support the BHP work
* Look at the Maturity Matrix
* Further data on the ICP areas required to ‘demonstrate’ or get started

**Group one:**

**Group two**

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| Important question to be asked of the ICS: Would the same decisions be made if the VCFS were not around the table? |

**Group three**





