Building Health Partnerships in Lancashire and South Cumbria: **Talking Points for VCFS leaders in ICPs**

Purpose:

To illustrate what a multi- sector partnership looks like at a neighbourhood level and to demonstrate the value of this way of working.

The aim is to explore the existing and new ways of working in partnership that are already being undertaken at a (practical) ICP level. To create better health partnerships we need to find out more about what things look like now, what can we learn so far and what needs to change or be developed.

1. How would you describe **the relationships** in your ICP? (E.g. what does engagement with the VCFS look like, how are decisions being made?)

   Too often it is stated the voluntary sector has been involved in discussions and really only two individuals have been spoken with and It's done as a tokenistic measure.

2. In your ICP area what kind of language is used during discussions? Is it accessible? Is there good practice/ bad practice? Can you provide an example?
   *Using **complex language and jargon** can exclude people and gets in the way of partnership working.*

3. Is the VCFS always at/ invited to the table when important decisions are being made? How regularly?

4. If the VCFS were not around the table do you think the same decisions would be made?

5. In your view and experience – what are the **characteristics** that make up a good relationship in this context?

6. Below are 8 principles from Health as a Social Movement to inform the practice of people working in healthcare – which of these are you seeing/not seeing?

7. As part of the Lancashire & South Cumbria Building Health Partnerships programme VCFS and ICS system leaders identified the following about ***thinking*** **differently**:

a. *Knowing what you don't know and needing to learn*

b. *How do we value what we know is happening and make the rest of the system work like that?*

Think about how both statements relate to current practice – are there opportunities/**ways to learn** and is that **respected and understood**? What can we share that works, from what we are doing?

8. What is in place in your ICP to **sustain** relationships? What can/ should be done in the future to sustain relationships?

   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.

The Health as a Social Movement Theory into Practice report states that:

We identify eight key principles which we hope to inform the practice of people working in healthcare, and crucially, support commissioners to understand the value of social models of health, whose interventions accrue better value for health care systems over time.

The 8 key principles are:

- **Act early** connect and mobilise citizens to develop a shared purpose and take collective action.
- **Shift control:** enable people to have more access to, and more control over, the resources in their community that impact on health and wellbeing.
- **Collaborate widely:** join forces with local anchor institutions, local CVS organisations and other public services.
- **Share power:** form partnerships between citizens and professionals, pooling different kinds of knowledge and experience.
- **Change culture:** work to change culture and practice within state and civil society organisations.
- **Growing from local:** make sure decisions and actions are rooted in local experience and build on the assets and experiences of the community.
- **Building momentum:** learn as you go and use every opportunity to spread good practice.
- **Bringing people together:** Connect and mobilise citizens to build knowledge, help each other, develop a shared purpose and then take collective action in their communities to help each other stay well