NOTICE OF MEETING

Shadow Health and Well Being Board

TUESDAY, 23RD OCTOBER, 2012 at 14:30 HRS - CIVIC CENTRE, HIGH ROAD, WOOD GREEN, N22 8LE.

MEMBERS: Please see membership list set out below.

AGENDA

1. WELCOME AND INTRODUCTIONS

2. APOLOGIES

To receive any apologies for absence.

3. MINUTES (PAGES 1 - 6)

To approve the minutes of the meeting held on 11 September 2012.

4. EVALUATION REPORT FROM DEVELOPMENT SESSIONS (PAGES 7 - 42)

Report of Tavistock Consulting – stock take and evaluative review of development activity April – September 2012.

5. ANY OTHER BUSINESS

To raise any items of AOB.

6. FUTURE AGENDA ITEMS AND DATES OF FUTURE MEETINGS

Members of the Board are invited to suggest future agenda items.

The proposed dates of future meetings are as follows:

Tuesday, 4 December 2012
Tuesday, 5 February 2013
Tuesday, 9 April 2013

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River Park House
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Membership of the shadow Health and Wellbeing Board

Organisation		Representation	Role	Name
Local Authority	Elected Representatives	3	Cabinet Member for Adults and Community Services	Cllr Bernice Vanier (Chair)
			Leader of the Council	Cllr Claire Kober
			Cabinet Member for Children and Young People	Cllr Ann Waters
	Officers' Representatives	2	Director of Adult social Services	Mun Thong Phung
			Director of Children and Young People's Services	Libby Blake
NHS	Haringey Clinical Commissioning Group (CCG)	2	General Practitioner	Dr Helen Pelendrides
			General Practitioner	Dr Sherry Tang
		1	Accountable Officer	Sarah Price
		1	Vice chair Haringey NCL and Lay Vice Chair lead for public and patient involvement Haringey CCG (designate)	Cathy Herman
Joint Representation	Local Authority/NHS	1	Director of Public Health	Dr Jeanelle de Gruchy
NHS Commissioning Board	NHS	1	Tbc	Tbc
Voluntary and Community Sector	Link	1		Helena Kania

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Agenda Item 3

MINUTES OF THE SHADOW HEALTH AND WELL BEING BOARD
TUESDAY, 11 SEPTEMBER 2012

Board Members Present:	Cllr Bernice Vanier (Chair), Dr Jeanelle de Gruchy, Helena Kania, Dr Helen Pelendrides, Mun Thong Phung, Dr Sherry Tang, Cllr Ann Waters, Marion Wheeler (substitute for Libby Blake)
Also in Attendance:	Joan Badcock, Helen Chapman, Siobhan Harrington, Rachel Lissauer, Carmel McHenry, Helena Pugh, Dr Rebecca Viney
Apologies for absence:	Libby Blake, Debbie Haith, Cllr Claire Kober, Cathy Herman, Lisa Redfern and Jill Shattock

MINUTE NO.	**SUBJECT/ DECISION**
HSP01.	**UPDATES AND INFORMATION** **a) <u>BEH Clinical Strategy</u>** Siobhan Harrington gave an update on the BEH Clinical Strategy, which was now moving into the implementation phase. The update included details of links with primary care and community services and clinical service changes including: • The expansion and redevelopment of women's and children's services and an increase in the number of emergency admission beds at North Middlesex hospital • The development of urgent care, expansion of planned surgery and transfer of maternity, paediatrics and emergency services off-site at Chase Farm hospital • The expansion and redevelopment of women's and children's services and expansion of emergency capacity at Barnet General Hospital. It was anticipated that the related business cases would be approved by the end of November. It was reported that a clinical cabinet was overseeing the range of clinical workstreams, and a reference group and Chase Farm vision group had also been established as part of the implementation. Engagement with the Health and Wellbeing Board would also be important, and consideration of how this would be undertaken was necessary. In raising questions and discussing the presentation, the Board covered the following points: • It was planned that the new maternity unit at North Middlesex hospital would be completed by November 2013. • Communication of the changes to local residents and service users would be via existing engagement and communication channels, such as local authorities' communications departments. Communication would begin once the business cases were signed off. Thought would need to be given as to how to make the best use of the resources available for communications. • It was confirmed that no service would be closed until the replacement unit was operational. With particular reference to Chase Farm, it was confirmed

that there was some double-running of services planned to ensure continuity of service during the transition. Further information on this issue would be provided at a future meeting.

- In response to a question regarding how feedback would be captured, it was anticipated that the Health and Wellbeing Board would be represented on the Reference Group and that progress would continue to be reported to the Health and Wellbeing Board. Good communications were agreed to be essential to this process.

An update on this issue would be a standing item on the Health and Wellbeing Board agendas.

b) <u>Healthwatch Haringey</u>

Joan Badcock presented the report, circulated with the agenda, on progress with establishing Healthwatch Haringey by 1st April 2013. The following points were raised in discussion of the report:

- In considering the range of duties expected of Healthwatch and the budget available to it, it was not anticipated that all Healthwatch functions would be in place in full from 1st April 2013, but that the organisation would develop during its first year. It was important to engage with the community in a realistic way, and to focus on signposting and referral as key activities.
- A series of priorities had been generated from the local community, but the Healthwatch Board itself would take the decision on what the organisation's priorities should be, based on this information.
- The Board discussed PALS (Patient Advice and Liaison Service); it was confirmed that the community element of PALS would come within the Healthwatch budget, but that hospitals and the Mental Health Trust had their own PALS services, which would remain unchanged after 1st April 2013. It was confirmed that officers were working closely with the PALS manager to ensure continuity of service during the establishment of Healthwatch.
- It was recognised that working relationships were key to the success of the new system; as an example, Helena Kania advised that LINk had met with the MacMillan Trust to discuss providing Healthwatch with information and training on patient representation.

A further update would be provided at the next appropriate meeting of the Board, by which time more would be known about the preferred model and there would be some indicative results of the soft market testing exercise.

c) <u>NHS Haringey Clinical Commissioning Group – Vision, Values and Aims</u>

Dr Helen Pelendrides shared with the Board of the vision, values and aims agreed by the CCG governing body in June 2012 as follows:

<u>Vision statement</u>

"Enabling the people of Haringey to live long and healthy lives with access to fair, well-coordinated and high quality services".

<u>Values</u>

	• Engagement • Efficiency • Innovation • Openness • Quality • Inclusiveness Aims • To commission high quality, valued and responsive services, working in partnership with the public to make the best use of available resources. • To promote well being, reduce health inequalities and improve health outcomes for local people. • To improve the health and quality of life for people by commissioning integrated health and social care delivered closer to home.
HSP02.	**REVIEW OF ACHIEVEMENTS** **Joint Strategic Needs Assessment (JSNA)** Dr Jeanelle de Gruchy drew the Board's attention to this important and well-received piece of work, which was available online and was designed to be interactive, accessible and flexible in its use. Launched in June 2012, it was emphasised that this was a 'living' document, and is being updated on an ongoing basis. Members were encouraged to pass on any feedback and ideas on how the JSNA could be used in commissioning and strategic decision-making. It was also noted that more detailed needs assessments on a range of subjects were also available online, for example on domestic violence and child poverty, for when more in-depth information was required, as well as detailed needs assessments for all four GP collaboratives in the borough – the latter had been uploaded that week, and should inform the development of the primary care strategy.
HSP03.	**DELIVERING OUR HWB STRATEGY** **a) Integrated care commissioning update** Rachel Lissauer gave a presentation on the report, circulated with the agenda, on the integrated care commissioning update, which set out the definitions, rationale and evidence, programme overview and posed some questions around the role of the Health and Wellbeing Board in relation to this programme, and the monitoring of outcomes. The following points were raised by the Board in their discussion of this item: • It was noted that there was a risk that significant costs could transfer over to the local authority, and consideration would need to be given as to how to ensure services were sustainable. • It was hoped that joint working could reduce levels of hospital dependency and allow for increased investment in community services, but the Board recognised that discussions with partner agencies, including the acute trusts,

would be necessary in order to make it work. CCG-led QIPP boards would need to jointly articulate how hospital spends would be reduced and to set joint targets, and a similar process may be needed with local authorities in order to set out the expectations in respect of packages of care.

- The Board discussed governance for the work and the appropriate forum for setting the targets that would inform programme delivery; it was reported that alongside the Integrated Care Partnership Board, which involved both commissioners and providers but was commissioner-led, there was a need for pre-work between commissioners. It was important that the Health and Wellbeing Board was appraised of progress. Any executive decisions required would need to be taken by Cabinet. A further mechanism would be the HWB delivery plan, which would include this as one of the outcomes.
- It was confirmed that discussions around funding would be taken at the Integrated Care Partnership Board, and then reported up to the Health and Wellbeing Board with proposals.
- Discussions would need to be held between partners regarding how the integration of organisations with different thresholds of need may affect service users in practice; the Board expressed an interest in learning the outcome of such conversations.

The Board expressed thanks to Rachel and the team working on this programme for the speed with which this work had been mobilised, and asked for a further progress report at a future meeting.

b) <u>Draft HWB Delivery Plan</u>

Dr Jeanelle de Gruchy introduced the report, circulated with the agenda, on the draft Health and Wellbeing delivery plan. The Health and Wellbeing Strategy had been agreed and was moving to implementation; the draft delivery plan, while it would need further updating as a 'living document', was presented to the Board for its initial agreement. The delivery plan incorporated into a single, overarching document what had previously been a range of strategic delivery plans and was divided into the three outcomes of the HWB strategy. It was emphasised that this was a live document, to be updated on an ongoing basis. The following points were raised in discussion of this item:

- In response to feedback already received, job titles would be added under the 'by whom' column for clarity.
- It was agreed that guidance would be issued to ensure a consistent approach to RAG status and progress reporting.
- Monitoring of the delivery plan was agreed to be by exception reporting; consideration would be required as to how often the plan should be monitored, as the activities had different reporting cycles.
- As a live document, it was noted that some activities may have been removed or added when the document was next reported; changes would be made as work progressed.
- The Board questioned why the caseload of YOS was included as a measure, and it was agreed that this would be reviewed.
- It was reported that the clinical commissioning group was currently performance managed by NHS North Central London, but from October this responsibility would be assumed by the National Commissioning Board.
- It was agreed that the Board should consider setting its own targets for those

	measures where none was indicated; this was linked to performance monitoring and would enable local targets to be set for local priorities. • The Board discussed the approach to be taken where problems were flagged; it was suggested that the Board should make its own recommendations, check the action plans in place to address the issues and then receive reports to monitor progress against these action plans. It was also suggested that the Board could offer support and assistance in those areas where issues needed to be addressed. The Board thanks all those involved for the significant level of work this report represented, and noted that there would be continuing work to review and update the plan.
HSP04.	**ANY OTHER BUSINESS** **a)** From the next meeting onward (23 October) Board Members only would be invited to attend the meetings of the Board. **b)** It was agreed that the January and February dates proposed should be combined into a single date in early February.
HSP05.	**FUTURE AGENDA ITEMS AND DATES OF FUTURE MEETINGS** Tuesday, 23 October, 1.30pm Tuesday 4 December, 1.30pm February 2013 – date tbc Tuesday 9 April, 1.30pm The meeting closed at 15:35hrs.

Councillor Bernice Vanier

Chair

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Haringey H&WBB

Stock take and evaluative review of development activity

April – September 2012

September 2012

Tavistock CONSULTING

Haringey
H&WBB

Stock take and evaluative review of development activity

April – September 2012

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Executive findings and implications

In this sub section, we provide a summary of the main findings from the stock take and evaluation of the customer journey activity; and also reflect on some of the implications and challenges for the shadow H&WBB as it contemplates becoming a fully mandated partnership in April 2013.

We recommend that the *implications and challenges* in this sub section are discussed at future meetings of the H&WBB.

Finding one – the investment of time and energy in developing relationships has been worthwhile; but there is a need to push it to a next stage of clarity and depth of understanding soon.

Finding two – you are all pre-occupied with *what* value that the H&WBB will add; but there are wide-ranging views about *how* it will add value.

Finding three – the fact that part of what value the H&WBB might add, lies in the 'how' (for example in highlighting some crucial issues, or encouraging system-wide change) is in the discourse and thinking of Board members; but is not yet being explored – productively – together.

Finding four – there is real interest in prioritisation; but uncertainty about how to prioritise beyond what is in the H&WB strategy. And there is a risk that 'everything will be a priority'.

Finding five – there is an appetite for sorting out some kinds of operating protocols – but the kinds of things being considered tend to be 'procedural' (how often we will meet etc) rather than based on judgements about what would be fit-for-achieving-your-purpose.

Finding six – the focus on OD in these formative stages of the Board is of value; but there are likely to be some important changes in emphasis (of priority and of ways of working) in the future.

Finding seven – the board is learning about the system in which it operates, and beginning to appreciate the strengths and weaknesses of the evidence base. It could have a role in acting as the champion for high standards of use of evidence in the design and operation of the Haringey H&WB system.

Finding eight – accelerated learning took place by focusing on the customer journey and service user experience, although there was a tendency to privilege the experience of the provider in this process.

Finding nine – provider development and the link between that and commissioning is a neglected priority.

Finding ten – there is a major opportunity to co-ordinate a strategic approach to user and provider engagement across the whole of the H&WB system.

Implications and challenges

These findings suggest to us that the H&WBB could usefully consider the following implications and challenges:

Relationships are developed in order to achieve what?

You have made a good – even ambitious – start. Relationships are being built between important players in the system, and – by implication – this helps establish the goodwill, trust and resilience within which network, joint work can be done. All interviewees hold the view, however, that

- there is an urgent need to identify the purpose of the H&WBB, that may well go beyond what is in any guidance that may come out; and
- in any event your purpose could have a focus that was highly specific to Haringey.

Adding value to what, through prioritisation?

There is unanimity that the H&WBB exists in order to 'add value' to the system. But (beyond tasks like producing a H&WB strategy), there is not yet agreement about either the 'what' or the 'how' of adding value.

Interviewees can identify several major issues and opportunities for the 'what' – St Anns', dementia care, mental health services; but you have not yet developed a way in which you can explore the 'how'. The customer journey mapping – to the extent it has been taken up – was a simple example of a 'how' choice being exercised. Working together is not sufficient – decisions need to be taken about hat you will work on, and how you will both work, and lead work by others.

- What do you want to prioritise?
- How do you want to lead, intervene, inspire, encourage etc?

There is a risk that your terms of reference will cover merely functional considerations, and neglect the need to have an agreement about the type of strategic partnership that you intend to be.

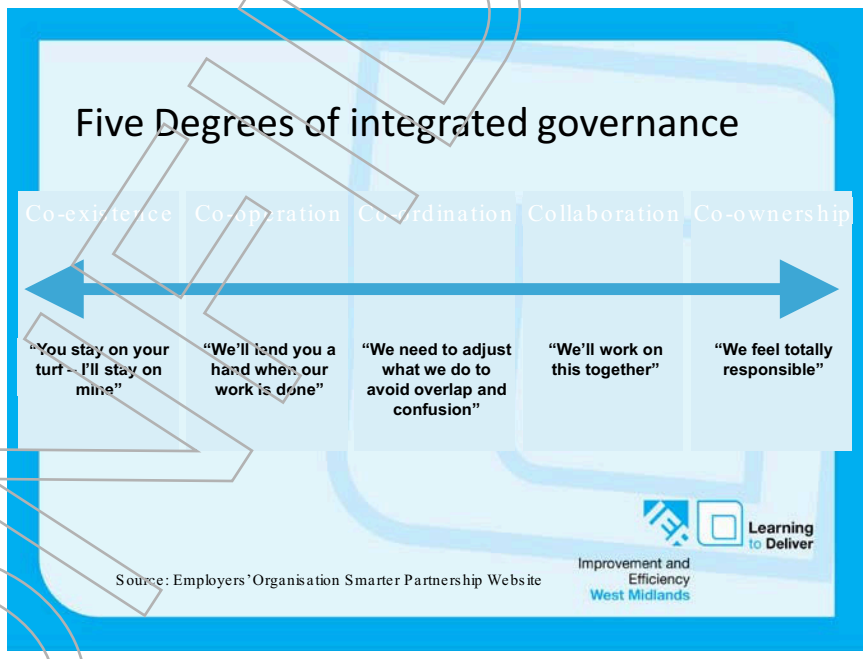
Your scope and your context – how do we you see it?

As far as the evidence from this review shows, there is no expectation that the H&WBB will have 'executive powers'. However, there is a view that you expect to be an influential group – that you expect to have some kind of 'clout' (indeed, otherwise, how could you possibly add value). But there are assumptions about the here-and-now and your context that remain unexamined. For example:

- What is the scope of your power likely to be?
- Is there an issue of 'levels' here? For example, do you want to occupy a position that oversees/leads/develops the *system* of health & well being, rather than any one part of it?
- How will the executive groups in the health and well being system (the Council Cabinet, the CCG board etc) take on board your recommendations?
- What is the real nature of the operating context, and how is it likely to change in the next 3-5 years?

How will you organise yourselves?

All of you are – naturally – concerned about how you will organise yourselves; although it seems as though most of this pre-occupation is about how will we organise ourselves as a board, rather than how will we organise the governance system for health & well being in Haringey, with the H&WBB as part of it. This is a crucial distinction – that speaks to your purpose; and the 'what and how' of adding value.



- Where might you plan to stand on this continuum?
- Are questions of organisation and operating protocol essentially about the board, as a piece in the governance jigsaw? Or
- Are we concerned with the governance jigsaw, too?

Anticipating the future

Clearly, it is early days – and it might well be premature to dwell too much on the future. However, some of you argue that part of the purpose of the H&WBB could valuably be to have a trend watching interest in the future – from a vantage point and 'over view' that no other part of the governance system for health & well being can achieve.

The pace of change, the nature of systemic impacts from government policy, the cuts in resources that are certain for the next 3-5 years, and the escalating need in Haringey; all of these factors argue for 'holding the future in your gaze'.

- How might you do this?
- What 'shocks' do you anticipate?
- How resilient is the system?
- If a focus on the future is part of your purpose, what difference might this make to how you add value?

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Introduction and method

This briefing note serves two purposes. On the one hand it provides a stock take of the organisational development (OD) activity undertaken by the shadow Health & Well Being Board (H&WBB) between April and September 2012; and on the other hand it provides a 'snap shot' evaluation of the activity which took place (during this time) based on customer journey methodologies.

It is important to note that this was OD activity – or 'partnership development' – activity, rather than something else (like 'policy' development, or 'strategy' development). Even so, in this period, the Health & Well Being Strategy was developed; and when completed, it was adopted by the Board.

Part of the challenge of the OD focus was to identify (and focus in on) what exactly is the 'organisation' being developed? What is this Board for? As we will see in the finding, this dilemma has not been resolved – and may not be until (or even if) guidance is produced by the Government to scope the mandate and role of H&WBBs, generally.

So, some of the core assumptions being explored during this process of development included:

- That relationships need to be developed between the various members of the shadow Board;
- That shared understanding between individuals (and between differing 'sectoral' interests will help with the building of respect, which will (in turn) foster trust;
- That trust will help to promote resilience (with even more difficult times to come in over-seeing health & well being for the population of Haringey and those who provide services to them);
- That resilience will help to create the conditions under which 'joint' work is more likely to be possible – whether that is joint commissioning, decommissioning, or risk taking; and
- There is also a further assumption – not yet fully translated into the governance of the H&WBB – that we are stewards of the health and well being needs and outcomes for Haringey residents

These assumptions are the Haringey-specific equivalent of the recent framework produced by the Local Government Association, *A new development tool for health & wellbeing boards*[1] The concept of a maturity index (used in this publication) is similar to the notion of a life cycle in partnership working, or team building. In other

[1] http://www.local.gov.uk/web/guest/health/-/journal_content/56/10171/3638628/ARTICLE-TEMPLATE

words, as the capacity and resilience of the H&WBB develops, the partnership is more able to act decisively, because it is higher performing/more mature.

But the question of 'what *kind* of organisation are we developing?' remains.

The method used for the stock take was simple – a series of confidential phone interviews based around a series of topics, including:

- Assessment of H&WBB capacity – strengths & weaknesses
- Major obstacles & risks ref H&WBB strategy
- Major opportunities for H&WBB role & value-added
- View on OD support to date
- View on priorities
- AOB

Findings from stock take interviews

The stock take discussions took place over a 4 week period from late July 2012. These findings are presented as a series of 'voices' (to promote readability); and organised under a series of themes. They are not 'quotes' – no one 'said' any of the things in this section during any of the interviews; but they do represent 'points of view'.

The responses from interviewees were frank and wide-ranging. we have organised them into four sub sections, covering:

how to add value - directly and indirectly, the topic on which there is most interest, and on which there is a wide range of opinion; and
prioritisation - as a strategic process of the board, rather than a set of priorities as such (we discuss priorities under the sub section dealing with 'added value'); and
operating protocols - in which there is a discussion of the points of view on 'how we will work together' (mainly in the future). This is where issues to do with terms of reference and the like are relevant; and
future scenarios - where the interviewees conjecture about what 'might' happen; and some of the direction of travel that they anticipate.

Adding value

There is universal agreement that the purpose of the H&WBB is to 'add value'. This is its rationale - if it does not add value to what is already happening, then it is - itself - of no value. How will the Board 'add value' in reality; and to what? and in which ways? and when? and through whom? There is no doubt that there is a vortex of questions, conjecture, excitement, hesitancy, sense of risk, hope, regret etc in relation to this topic.

There is a direct connection in interviewees' minds between the OD work and how to add value...

'Perhaps some of the development time has been premature – since we do not yet know what our powers will be. There is a real challenge – since we do not know our mandate and accountabilities – in deciding how to really add 'strategic value'.'

...and having to have a purpose. Indeed, most interviewees implied that the purpose of the H&WBB *was to add value*. This is the 'holding position' on purpose - our purpose is to add value (and we will work out the how, soon, in the light of the guidance.)

But there is also a view - that we could be much more consciously thinking about this - and ourselves weighing up how we (in Haringey) define our purpose in ways which are consistent with outside imperatives (like guidance), but which take account of our own sense of what value needs to be added - where and how.

'We have to have a purpose – the OD work has helped with this to some extent; but we have not yet made our purpose explicit. The options include:

> *'waiting for the guidance' to provide us with a purpose*
> *Generate our own purpose*
> *Maintain and deepen the current 'holding' position*

We could appraise these options.'

One of the 'adding value' dilemmas is to do with 'scale' and 'ambition'. Some members of the Board can identify concrete instances of large scale need-for-change in the system. Others have a much more transactional view of where value might be added.

'There is a rhetoric around the H&WBB about 'transformation' – it is like a 'noise' in the system – and yet we have not yet identified what it is we would like to 'transform' …..or even if there is anything that is open to transformation. We need to get some kind of agreement around this. What might we be able to make a very significant difference to – or are merely agents of government policy? We could spend a lot of time just 'tweaking' things.'

The re-development of the St Anns site - and the impact it will have on commissioning appears to some as a 'no brainer' - where the credibility and clout of the H&WBB will be linked to its policy and actions in relation to St Anns' (experience from elsewhere suggests that all commissioners will have a vested interest in making sure that whatever is agreed for St Anns, succeeds - so either by decision or by default, it will be a major priority).

'A massive – indeed the massive strategic priority – is the development of the St Anns' site – this is a once in a generation opportunity…very rare…this is the focus for the biggest investment in the potential health and well being of the population of Haringey that we can realistically imagine. It can act as a focus for and catalyst of

the development of a 21st century system of services and infrastructure for health and well being.'

But in relation to adding value, there is also a question of 'direction setting' and leadership, especially for the Council and the CCG. There is recognition that the timings for decisions by these leadership groups may not yet be right - but the absence of a clear position by either or both of them may well prolong a sense of limbo in which the H&WBB is felt to be essential, but it is unclear what it hopes to achieve.

'What does the Council want to do with the H&WBB? What does the Council want to do through the H&WBB?' Equally, 'what does the CCG want to do with the H&WBB, or do though the H&WBB?'

Interviewees are not short of suggestions on what could be on a long list of those things to which the H&WBB could add value. In the main, these are based on a view of the Board that is strong, with powers of investigation, intervention and recommendation; but in a non executive capacity.

'Develop a strong partnership board with clear delegated powers – but where partners retain executive powers. What could the delegated powers consist of? Potentially consist of powers such as:

> *Making recommendations to Cabinet and to the CCG Board over commissioning;*
> *Joint design of programmes of work eg on integration of services, or implementation of dementia strategy, or the local implementation framework for 'No Health Without Mental Health'*
> *Workforce development for health & social care in Haringey*
> *A campaign to promote understanding of (and the need to extend and embed) self management of conditions*
> *A drive to inspire, push, and encourage all partners to extend their practical commitment to prevention – which could have a very practical focus to it eg in supporting the 'early help' drive from Children's Services*
> *Driving for co-location of services (which make sense from service users point of view)*
> *Catalyst for health and well-being work in support of the 850 'troubled families' in Haringey*
> *Championing a process under which we significantly improve our organisational and systems' capacity to 'learn from experience'*
> *In relation to the decline in resources we are all experiencing, could the H&WBB develop a strategic view of likely changes in need over the next 3-5 years, and relate changes in our resource base to that? This would be a uniquely valuable objective for this group that no other group (arguably) could fulfil.'*

Prioritisation

There was lots of discussion of prioritisation, in particular of prioritisation as a process - a business process for a partnership such as the H&WBB. But in the process of prioritisation, there is a significant dilemma - how to prioritise a few things on which to concentrate, when there is so much to do.

'Our priorities are so many and so pressing, the trouble is that if we prioritise within our priorities, it is as if we are neglecting some issue that is – equally – a priority. The consequence of this is that we make no difference to everything; because we could not address the issue of making some difference to a few things.'

There are also real constraints on time and capacity, which - in themselves - add to the pressure to prioritise. Recognising the practical constraints on joint work is both one of the drivers of prioritisation, and also - itself - a priority (in the sense of an essential operating principle, or basis for engagement).

'There are likely to be around four meetings per annum – so the capacity to 'transact business' will be very limited – we will need to develop some kind of 'seminar' activity to promote shared understanding and develop the basis for change eg. on

Service integration
Joint commissioning
Risk sharing'

Thinking about prioritisation has led some of the members of the board to think about the 'purpose' of the partnership - and the ways in which priorities in the use of time, and in the design of the agenda will constrain purpose.

There is a widespread interest in getting the 'purpose' question 'locked down' sooner rather than later - since this the basis on which the fitness-for-purpose of the partnership will be judged.

'In practice, all that the H&WBB is likely to be able to do is scrutinise – since it will only ever be able to 'dip-in-and-out' of agenda items. But even in scrutinising, it will need to prioritise.'

Operating protocols

We have discussed the link between priorities, operating principles, and purpose; in this sub section, we touch on the range of views on 'operating protocols'. These concern the day-to-day governance questions and choices that the H&WBB face - in effect these are questions about 'how-we-do-things-round-here'.

There is a clear concern about the scope to act - and at what point this may become clearer, if in fact it ever does.

'We cannot define our discretion to act – this is a systemic weakness – which might get cleared up when guidance is issued; but might not. It can make things 'sound' like a talking shop – when what we are doing is sharing perspectives on the uncertainty. Bits of the system jigsaw are still missing.'

What kind of power or authority do you have, and how does this connect to 'purpose'? This is a familiar challenge in the formative stages of establishing partnerships - especially 'strategic' ones; since

- it can be so difficult to grasp something real on which to act
- there is a tendency for the members of the partnership to be way more comfortable dealing with (relatively speaking) operational matters
- there is a dilemma over 'who will make the first move' - unless it is mandated by Government, one of the members of the partnership needs to agree to subject themselves to the authority of the partnership

In the appendices, we include a summary of a view on this governance dilemma, developed seven years ago when Local Strategic Partnerships faced the same dilemma. They decided that there were four modes of operation that they moved between - each of which had differing strengths and weaknesses. This may be a pragmatic example from which you could learn - you could identify the 'modes' under which you operate, and their conditions for high and low performance.

'We do have more than moral power – but we shrink back from naming some vital issues, as if we only wanted to have moral authority. I have a sense of us developing a sensitivity to 'what might we be getting into' if we went further…? And yet it will only be if we 'go further' into something or other that we will get any where. Inherent in our role is ruffling some feathers, it seems to me.'

There is a view that conventional approaches to 'terms of reference' could miss this important question of how you intend to operate together.

'We speak of our terms of reference in a round about way, in my view. It is as if we need some kind of 'terms of operation' under which we liberate ourselves to grasp some things – inevitably, by exception.'

There is likely to be a crisis - of confidence, of sense of agency, of goodwill and commitment - relatively soon, if this question of operating protocols is not dealt with transparently.

'Everyone wants it to do well – there is great good will – there is a perception that a well functioning group of this kind (bringing these parties together) can be 'very useful'. Yet we are not quite sure what we are trying to achieve; somehow, it keeps on eluding us…'

Members of the shadow board are clear about the nature of the issues:

'How are we really going to operate 2 or 3 years down the line?
How do we 'raise' things on other people's agendas – in ways which are authoritative and timely? It is all very well 'having influence' – but there is some 'real politic' to making things happen.
How do we make 'it different'? We seem sure that there is a need to make some things different, but we do not seem to – yet – have discussed how we might do this
How will we connect-things-up – and which sets of 'disconnected things' will we choose for this treatment?
How are we each held to account for the actions we might take up on behalf of the H&WBB when all of us have primary accountabilities elsewhere?

We could easily tip from goodwill into cynicism, if we do not start to achieving some things'

The question of operating protocols extends to membership and expectations or participation....

'Working together as a Board is a real challenge – how do we draw in other people?

To what extent are we a collective, or do we expect people to turn up – as and when required? There is a real depth of understanding of the care we will have to exercise in navigating the context we are operating within'

And - of course - thinking about operating protocols loops round into the use that is made of plans and the link with priorities. Some Board members see the delivery plans as the key to how you will operate.

'Focus on priorities – the H&WB strategy is very clear – stick to delivery plans when they are developed'

This is a minority view. The majority of the members of the Board are unlikely to be directly involved in the delivery planning of the H&WB strategy, itself; and there is a risk that their understanding and ownership of the delivery plans (one for each priority is expected) will mean that they make confident use of them. Arguably, the Board needs a 'delivery plan' or an 'annual cycle' of business (or something similar) to shape its own activity, especially in the light of the discussion of 'how to add value'.

Future scenarios

The interviewees provided some conjectures about the future of the H&WBB - mainly in terms of 'policy' (rather than development, which we cover elsewhere in this report).

There was a clear point of view about the importance of 'scope' and - by implication - realism about how the system is changing, and how much more inter-dependent partner decisions and services are becoming (irrespective who provides them).

'It is very very important that the H&WBB straddles the two sides of the health and social care economies – and also straddles the provider and service user points of view. The inter-dependence of the different parts of the system are becoming more marked all the time.'

And there is a very important area of potential to add value - as mentioned earlier - around finances and risk.

'At the moment risks are unevenly shared – at least the risks in relation to finances are unevenly shared - and this gets more the case over the next few years.'

A significant proportion of the interviewees have very clear views about what the H&WBB *will not be* - and by inference what it will therefore need to become; in not being executive, it is likely to be advisory, or have powers of scrutiny....

'It is not (going to be) an executive body.'

Part if the sense of the future also includes a recognition that there is a leadership challenge in recognising the *type of vital issue* that the H&WBB needs to be concerned with.

'We really need to push for a shared understanding of what are the vital issues in Haringey – partly in terms of 'outcomes' and baselines – that is part of what the H&WB strategy does; but also what we think the vital system-development issues might be. This is a different type of priority – less to do with the kinds of priorities in the H&WB strategy, but more to do with our 'shared agreement' about how you make a real difference to something….so, on the work we did on the St Anns' site visit, where it became clear that there was no effective crisis support, and that the services' provided were very fragmented ….what do we think needs to be done in response to that? And how do we exercise our clout with those who need to do things differently?'

Part of the value of the OD work to date has been in the focus on particular conditions and treatments. However, in the future, there is a need to broaden the focus of the H&WBB to bring its power and influence to bear on 'whole population' needs, informed by what is know about particular groups' needs.

'In the future, we will need to develop ways of understanding the 'whole population' picture, while bearing in mind health inequalities; rather than think of prioritisation as a form of targeting.'

Some see this as extending to a much better focus on trends and making sense of them - in relation (for example) to future demand.

Review of customer journey activity

The customer journey activity was a specific component in the OD activity, focusing on the customer experience of health & well being services. The diary of activity included sessions on a series of themes identified in the Health & Well Being Strategy[2]. The sessions[3] covered:

- Under Outcome 1: Every child has the best start in life, we explored the potential contribution of the H&WBB to priorities 1 and 2 – reducing infant mortality; and reducing teenage pregnancy;
- Under Outcome 2: a reduced gap in life expectancy, we explored the potential contribution of the H&WBB to priority 7 – reducing alcohol misuse; and
- Under outcome 3: improved mental health and well-being, we explored priorities 13 and (indirectly) 12 – supporting people with severe and enduring mental health needs; and addressing common mental health problems among adults.

The themes were chosen because they were priorities – and because they represented particular types of complex challenge. For example:

Under Outcome 1: Every child has the best start in life, we explored the potential contribution of the H&WBB to priorities 1 and 2 – reducing infant mortality; and reducing teenage pregnancy
The *particular complexity* of which included: ▪ The need to understand highly diverse cultural attitudes to pregnancy ▪ The need to respond to apparent changes in performance (on rates of teenage pregnancy) and service provisions ▪ The challenge of co-ordinating de-commissioning of services (where reductions in the provision of services by one partner increase demand elsewhere in the system) ▪ The need for the H&WBB to anticipate and plan for recovery actions in anticipation of (and response to) de-commissioning actions

Under Outcome 2: a reduced gap in life expectancy, we explored the potential contribution of the H&WBB to priority 7 – reducing alcohol misuse
The *particular complexity* of which included: ▪ The challenge of co-morbidity, and the tendency for services to expect that service users and their carers 'pick up' the costs of alignment of services

[2] See Appendix for a model, summarising the strategy
[3] See Appendix for a project plan summary of the events and the related lines of inquiry

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▪ The challenge of pronounced (but hidden) needs in segments of the population who are often 'below the radar'

Under outcome 3: improved mental health and well-being, we explored priorities 13 and (indirectly) 12 – supporting people with severe and enduring mental health needs; and addressing common mental health problems among adults
The *particular complexity* of which included: ▪ The challenge of developing a H&WBB position on commissioning, especially changing commissioning priorities in relation to secondary providers ▪ The challenge of responding the evidence from service users and carers in relation to fragmented service delivery (when experienced from the point of view of their own condition management)

Each of the activities was based on a simple process of co-design under which

- We agreed a theme, based on priorities within the Health & Well Being Strategy;
- We worked with a lead officer from within the partnership on the design of the activity;
- Briefing and orientation materials were prepared – often based on related needs' assessment work, or summaries of some of the evidence that had fed into the Joint Strategic Needs Assessment (JSNA);
- A 'cohort' or 'type' of service-user and/or carer was identified, and a method of engagement agreed – either through direct involvement (as in the session for people with severe and enduring mental health needs); or documented (as in the activity focusing on alcohol misuse; or teenage pregnancy)
- After the session with the shadow board, a note of decisions[4] and reflections on future development was drawn up and circulated

The work on customer journey mapping was based on the following assumptions:

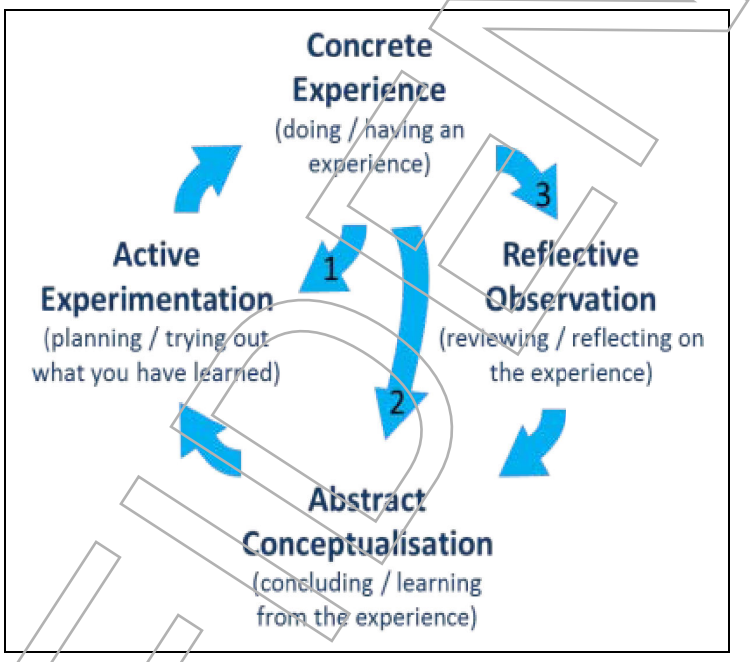
- Most effective learning and development will take place when partners work on real-life problems and challenges, together;
- Changes in the health and social care economy mean that we need to find ways of addressing system-wide changes in commissioning and de-commissioning;
- The challenges of governance in integrated care services are mainly ones of horizontal governance, operating across organisational, budgetary and service boundaries (rather than hierarchical governance challenges of oversight, and assurance);
- Joint work is more likely to be productive if there is an element of co-production between the interested parties, especially if a degree of self management of care is part of the vision for service change. In this respect, we need to get the 'patient experience' in-the-room; and

[4] Sample from activity on 11th July is in Appendices

- Make explicit the assumptions about likely changes to patient demand and experience over the forthcoming years

In the activity, there were two leadership roles – one facilitating the development activity; and one providing an 'observer' and 'challenge'. The method used for each of the strands of activity helped the system-players to develop their own capacity to fulfil these leadership roles in explicit and flexible way.

All of the activity was designed around developing joint solutions to real-world problems, centred around 'triple-loop' learning, an approach under which one of the things we want to learn about (as a partnership) is how we most effectively learn & work together.



Findings from the customer journey mapping activity

The customer journey mapping activity in which the H&WBB has been involved in the period April - July 2012 has added to capacity, and helped to inform the experience that generated the evidence reporting in the stakeholder interviews. As such, the customer journey mapping activity is part and parcel of the evidence we have been discussing; the findings to date are based on this OD activity.

However, there are some findings that *very clearly relate* (specifically) to the customer journey mapping. These are discussed in this sub section, under five headings.

- Relationships – in which we discuss the developing relationships between the members of the H&WBB;

- Use of evidence – is an explicit concern (both the use of existing evidence and the access to evidence that is kept in the system, but not visible);
- Learning – about each others' worlds, about the system, about the service user experience: all of these are of crucial importance;
- Provider development – is a very significant area of interest and need, linking closely with commissioning;
- The H&WBB has an opportunity to make a significant difference to the ways in which engagement (with service users and providers) is organised, and enhance the impact which it has.

Relationships

There is - near - unanimous recognition amongst interviewees that the customer journey mapping experience and methodology enhanced and deepened relationships between the members of the H&WBB.

'Enjoyable…worthwhile…useful learning…good, deep relationships…cordial rapport….crucial basis for trying to work together effectively…it is highly significant that there has been a willingness to work on developing the capacity of the partnership to work together'

The energy and focus of the start that they have made in shadow form is seen as a welcome investment by most - but some struggle to fulfil the expectations that this places on them.

'There is real value in us starting in shadow form with some drive and ambition.'

However, the investment in deepening and strengthening relationships is not starry-eyed; most of the interviewees recognised that there are real, pragmatic benefits to investing in more resilient relationships in the current conditions.

'We are in the middle of several years of extensive turbulence in the system – so it makes good strategic sense to focus on building and maintaining relationships, since it mitigates risk under such conditions.'

The calibre and clout of individuals on the board is also seen as a real source of potential benefit.

'Very good Cabinet members involved…the GPs we have involved are good, too …. three out of eleven GPs from the CCG are involved… 2 councillors are involved (out of a Cabinet of eight), but they include the Deputy Leader of the Council...'

Use of evidence

The experience of the customer journey mapping encouraged member of the H&WBB to consider evidence from differing points of view. They recognised the

significance of different types of evidence, and also how significant some of the evidence gaps were in understanding the customer experience.

'How do we act as an 'advocate for evidence?' In all of the activities we have been involved in, the evidence has been partial – and in particular, we have not been able to get information on the performance of providers on the basis of which we can get a sense of relative quality, or the link between supply and demand.'

The work made clear that whilst those officers centrally involved in its production understood the JSNA and could see how it applied to service re-design and prioritisation, the general awareness of, and systemic use of the JSNA was limited.

There were clear opportunities for developing both transactional and systemic understanding of the JSNA - promoting the productive use of the JSNA could become part of the role of the H&WBB.

'I wonder how really well understood the JSNA is across the board….or indeed across the Board? One of our priorities for influencing should be to make sure that all of the relevant commissioning boards are fully informed about the critical evidence in the JSNA – and we should be pushing to find further evidence and raising the bar in terms of information sharing and comparability. We could make a massive difference over the next few years on this front.'

However, the customer journey mapping activity also revealed that the Board has a patchy grasp of the economics of customer experience - about the risks and benefits of how we do it now; and what could be improved. There is a particular gap in data about the relative performance of difference providers, without which - in fact - it is difficult for the H&WBB to make well-informed commissioning decisions.

'We need to use comparative data about our resource utilisation and the performance of other providers in other boroughs to help us get to more strategic 'take' on things.'

One of the features of customer journey mapping that really struck a number of interviewees was the need to develop a wider understanding of customer experience, that went beyond any one treatment, or episode of treatment; but which was - for a high proportion of people - a 'throughout-the-life-of-their-condition' treatment experience.

'We need to gather data on the 'through life' experience of using services for patients and carers.'

Learning

Members of the H&WBB have learnt form the experience of being involved in the customer journey mapping, but they have also learnt about some of the 'gaps' in their knowledge - and some of the assumptions that need to be tested and

addressed. Induction - and orientation, as the system changes and develops, is a very high priority, that many feel has been neglected (or at least addressed in an ad hoc way, as a by-product of other things happening eg. in another role, a member of the board may learn important information about what another sector values - but it is not part of a shared understanding across the whole H&WBB)

'All board members need an induction into the system players – who is who; what purposes they work to; what constraints they operate within. We need to make this explicit – rather than assume you 'pick it up' somehow. There is a high likelihood that you pick up misunderstandings as much as accurate understanding – and it also means that those who know the system best (because of their role, or their history) end up having a kind of 'mystery' influence at the board. The induction should be didactic – a clear briefing. It is still needed.'

There were differential views of the extent to which different parties were becoming aware of the context from which each other was operating – the focus on particular pathways had helped provide tangible base for the learning

'The focus in on particular treatment areas and cohorts of service users has been really helpful – especially in developing a shared understanding of the issues; it is as if it short-circuited the time that it would have normally taken for us to get to know one another, and also gave a bonding sense that something needed to be done…'

Provider development

The activity revealed the need for thought-through approaches to provider development; but also highlighted a lack of evidence, and – perhaps – some incapacity.

'One of the areas to which we need to pay attention that we have neglected is 'provider development'. We haven't really addressed the fact that commissioning largely boils down to changing the ways in which existing providers act in the future – both in how they provide what we want them to continue providing; and in how they provide different things in the future.'

Thinking about commissioning is unsophisticated.

'Perhaps there is a tendency for commissioning to be thought of as doing new things with new money. There needs to be some kind of up-skilling around the nature of commissioning – we need to develop a sense of direction and a development trajectory for providers.'

In particular, understanding of national and London-wide commissioning trends and drivers needs to be developed

'What is our thought-through position on 'provider development'? Do we want to promote a 'mixed economy' in Haringey?'

Engagement

The Board stance on engagement – in micro terms (such as through the promotion of customer journey mapping) and in system-wide terms (through shaping the design of the engagement system in the borough) – is an opportunity.

'The Board needs to give the theme of 'engagement' a good thinking through…with the development of HealthWatch, and the CCG patient and practice panels, and the interest the H&WBB will have in service user perspectives – there is an opportunity for developing some kind of strategic co-ordination of public and user dialogue and engagement.'

This could be an 'early win' for the H&WBB.

'This could be systemic, rather than ad hoc. How does patient engagement really feed into the system? There is an emerging annual cycle of strategic commissioning and engagement – quality feedback through high quality engagement will be critical to making this worthwhile.'

This could be a good example of where a policy priority and a process priority overlap – in making sure that something that is going to happen is done in a way which has the greatest impact.

'The H&WBB taking an interest in 'how strategic engagement could work best' would be in everyone's interests. The clout of the engagement activity would be significantly enhanced.'

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Appendices

These appendices include:

Project plan for development activity
Decisions and actions from 11th July activity
Sample materials from journey mapping
'Types' of strategic partnership
Summary of H&WB strategy

Project plan for development activity

Tasks April – July 2012

This is based on the specification, proposal and subsequent conversations between Jeanelle de Gruchy and Andrew Harrison

Action	When by	Dependency & issues for planning/execution
Set up Contracting	5th April	
Session 1 – 12th April Focus on alcohol outcomes Choose a particular cohort (probably 'Irish men' where prevalence of alcohol misuse is high) Follow the established format for the session – with the kind of questions outlined in the adjacent column as a guide. This could be a prototype for the next session/s We recommend that the focus in all of these discussions is on the *systems of support* and the *culture of responses* on H&WB issues; rather than hold the focus on this particular project or this particular service decision. Inevitably – and appropriately – there will be discussion of the specific, but we need to relate that to the wider system The output from this session could be a short paper (no	Planning by 5th April Deliver on 12th April	*Presentation and scene set* • Make sure we include data on need and demand, trends, comparators • Consider scale of cohort known to the treatment services in relation to the absolute numbers • Consider the nature and range of services; the scale of demand that they can accommodate *Customer/user journey* • What is the experience of service users when they encounter and travel through services? • What are the factors that appear to explain this issue – both apparent and under-lying? • What do we understand about the cause and effect pattern in these particular cases? • What does this tell us about the culture of health & well being in Haringey? What does it tell us about service & community responses? To what extent can we think into the future on this? *What do we think?* • What are the different views we have about this issue?

Action	When by	Dependency & issues for planning/execution
more than 2 sides of A4) describing: – The scale and nature of the problem – Current need and service demand – Strengths & weaknesses of our systems of services' & community responses (culture, values, assumptions etc) – What we need to more of/less of – What the H&WBB thinks needs to change – Risks to the H&WB of Haringey's population if there is not action of this kind, on this scale – What the H&WBB will do, if anything – Who else needs to lead on what		• What use can we make of the differences to think differently and more effectively about this issue? • What are our areas of consensus? • What are our constraints? • What does this discussion tell us about the health & social care system? *H&WBB response* • What are the specific areas for action that we could take on (in relation to this issue) that are consistent with our purpose? • What does this case tell us about our purpose and role? • What does this instance tell us about the future of commissioning for Haringey residents? • Who else do we need to engage with? Why? • What value can we add to what is already happening?
Session 2 – 21st May Perhaps conduct it on site at the proposed Health Campus Adapt/apply Lansley's four tests – but explore the difference between applying these tests to this one investment; and applying them to this part of the H&WB system in Haringey/this part of London	Planning by 27th April Deliver on 21st May	The focus of this session is on the provision of mental health services for children and adults with severe and enduring mental health conditions. Subject to the experience of the session on the 12th April, we recommend using the same model, but apply it to this theme.
Session 3 – move to 11th June, *to combine with the stakeholder event* Stakeholders working through antenatal targets performance Followed by H&WBB development session	Date change by 27th April Invites	We can continue to use a similar method. In relation to the stakeholder event, we need to make a decision about who is invited. The choice seems – essentially – to be between trying to involve the 'whole system' (or as much of the system as we can); or some critical sub systems – eg the

Action	When by	Dependency & issues for planning/execution
	out by 27h April Planning of session by 11th May Deliver on 11th June	combination of current and future commissioners, service users and practitioners who are the stewards' of 'flow' in the system. If the earlier activity you have done on this has established a good sense of the 'customer/user journey' through services; where that works well; and where it works badly, then work with the sub-system is likely to be productive. If you have not established a shared understanding of the flow in the system, then a wider system event will be needed in order to achieve this. It is only likely that you will be able to re-design the system (or parts of it), it there is this shared understanding.
Session 4- 23rd July (action planning) Session on the issues around Teenage Pregnancy followed by workshop on developing action plan for next 18-24 months	Planning by 6th July Deliver on 23rd July	We can plan this nearer the time, depending on the work of the task force looking at the variability in 'performance' around Teenage Pregnancy. Some of the principles we are applying in the design of these sessions could apply to the work of that group. Action planning will be achieved through a facilitated discussion – building on the work done prior to April 2012, and the decisions/judgements made in each of these development sessions.

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Decisions and actions from 11th July activity

Actions noted

This session considered the following priority and other issues arising from it:

Outcome 3: improved mental health and well being
Priority 13: support people with severe and enduring mental health needs

Objectives

The objectives of the session were:

- To explore the customer journey experience of making use of services for people with severe and enduring mental health needs, from the point of view of someone for whom the service was effective; and from the point of view of someone for whom the service was ineffective.
- To assess the underlying causes of service fragmentation and agree ways in which fragmentation can be reduced and service integration improved
- To outline a series of short and medium term actions which will make a difference to the quality and resilience of service integration
- To identify what the specific value might be that the H&WBB can add to this
- To reflect what lessons might be generalised from this theme to help identify how the H&WBB might approach (and add value to) other planning a delivery challenges where integration is a major issue

Actions agreed

The following actions were agreed:

Action	Who by	When by
Web based local information service – establish what is happening	Helena K	September
Commissioning opportunities (including CAMHS) – plan in how to synchronise commissioning across different contract opportunities	Nicole, Lisa and CCG contact	End of July
Estimate of current total spend, and the use to	Same as above	End of July

Action	Who by	When by
which it is put; plus projected savings and growth plans		
Update on the nature of IAPT provision in the borough	Nicole	End of July
Check the JSNA for 'gaps' on this theme, and the next theme (teenage pregnancy)	By all	For the next meeting, as part of the habit-forming use of the JSNA to inform discussion and decisions
Scoping exercise to improve data quality and data availability	To be confirmed – but likely to be Sinead (Lisa to check)	Sept
Strengthen and specify links with other strategic, partnership grouping eg CSP	Jeanelle Lisa Helen	ASAP and on going
Investigate relationship between MH Trust and QUIP board	Nicole to clarify	Sept
Develop the concept of 'challenge' and 'risk' investment as part of the future TOR of the Board	By all	To come up as a theme in future sessions

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Sample materials from journey mapping

Shadow Health and Wellbeing Board Development Session
11th July 2012

Briefing paper

Outcome 3: improved mental health and well being
Priority 13: support people with severe and enduring mental health needs

This briefing paper is based on the notes of the site visit and workshop session which took place at St Anns' on 21st May 2012. It is intended to help inform the 2nd development session on this issue – taking place on 11th July 2012.

The purpose of this briefing paper is to remind the members of the shadow H&WBB about some of the background issues to this topic; and also stimulate some thoughts as part of the 'tuning in' to the theme for the session on the 11th July.

Reflections on the site visit

Members of the Board discussed their reflections on the tour of the St Ann's Hospital site and heard the viewpoints of Tamara, someone with experience of in-patient care at St Ann's; and Sarah, a carer for her son, who had a severe and enduring mental health condition and had been a patient at St Ann's.

The following views were expressed by Tamara, a user of mental health services at St Ann's:

- Staff were trying to do their best with the limited facilities available;
- She felt that there was significant pressure for patients to be discharged into the community;
- Her personal experience was that workloads of professional mental health workers were such that they had very limited time to spend with each patient; she expressed frustration with 'the system', rather than individual members of staff;
- She felt that many people would not go to their GP or use the out of hours service when they were in crisis – the Alexandra crisis unit helpline (now closed) had provided the most helpful service; and there was a need for this model of service to be reinstated, as other service providers were not felt to be competent or experienced at dealing with crisis situations and their inexperience could escalate the level of intervention required;
- Her experience had been that, in a time of crisis, she was not confident that GPs / locums / out of hours services would be able to respond appropriately; people

needed to be able to make a single phone call to get the support required and not be referred elsewhere;
- Tamara suggested that service users who may have a fear of being sectioned might be reluctant to go to a GP who might not know them well, might not trust that they were okay and might call the police; and
- She felt that the ER experience for service users could be improved, as the atmosphere could be very intimidating, with lots of other people waiting, staff at reception too busy to give a proper welcome and the experience of have a door closing behind you.

The following views were expressed by Sarah, from a carer's perspective:

- Carers always needed to take the initiative in seeking information. While CPAs were allocated in theory, in practice this did not always happen and no one person took the necessary responsibility;
- Carers and people who use services needed to be treated as equals in the team responsible for people's care, and had to be treated with respect;
- Carers were often not taken seriously when raising concerns at an early stage, and patients would (often) not be admitted to hospital until they were referred by the Police, which was felt to be a significant problem; and
- There was a focus on the medical model (for example, prescribing pills) when treating mental health, with other treatments seen as 'add-on's rather than integrated parts of the treatment package.

Considerations for the H&WBB

- What does this evidence lead use to think about how the service system needs to develop?
- What are our thoughts about 'access' and 'flow' through the system?
- What about fragmentation of services? What about the interface between primary and secondary care?
- What about the role of carers? And the quality & extent of our communication with them?
- What is the balance of our view about the effectiveness of our services in providing support, and in responding to crises?
- What our thoughts and feelings about the potential for change and improvement?
- Are we hopeful – clear on the scope and direction of travel and our 'clout'? or what?
- What role *could* we have as a Board in leading such changes?
- What role *will* we have?

The local context, demand and trends

Dr Nicole Klynman gave a presentation on severe and enduring mental illness, with information and statistics in relation to Haringey. In relation to wider health issues affecting people suffering from mental illness, it was noted that incentive schemes for

stopping smoking and physical healthcare were being launched this year and that there was an opportunity to link these in to ensure they were available for the right people.

Medication, unemployment, depression and the consequent effect on self-esteem were all noted as having a negative contribution on the health and wellbeing of people with mental illness. Feedback from service users was that they would appreciate better communication about what services were available to them.

After a brief break, the group discussed their impressions from the previous discussion and tour, and where they felt that the work of the Health and Wellbeing Board could make a difference. The following points were raised:

- The service models at Camden and Islington (both in terms of commissioning and provision) were felt to represent good practice, and it was suggested that these be looked at to identify lessons that could be learned in order to improve services in Haringey, particularly as they were working with similar populations;
- The fragmentation of commissioning and less fragmented provision of mental health care services needed to be addressed; there was a need to identify what was working well and what could be refined. It was suggested that the Board should look at the pathways from a commissioning perspective, and pay closer attention to co-ordination of services;
- Concern was expressed at the unacceptable experiences reported by service users, for example having nowhere to go when in crisis and GPs not meeting their patients in person;
- It was suggested that the Board should look at the system from the perspective of a patient journey, and identify where there were issues, and which of these could most quickly be addressed;
- Customer care issues were felt to be one of the areas that could be addressed quickly, for example addressing issues around the first impression and welcome service users received. Concern was expressed that professionals were communicating to service users how busy there were, and that it was unacceptable for professionals to be conveying this impression;
- Communications and PR were also felt to be potential ‘quick wins’, for example, producing an accessible, up to date map of services online, and taking action to keep the relevant information up to date;
- It was suggested that the possibility of a joint post between agencies be explored, to update information on an ongoing basis and circulate this updated information to all of the other relevant agencies in order to address data quality issues;
- The group was struck that Tamara had been unaware of personal budgets, and that there was clearly an issue around raising awareness that needed to be addressed;
- It was noted that there was a replacement service for Alexandra Road Crisis Unit, the loss of which people who had used the service had expressed concern about, and that more clearly needed to be done to communicate to service users the existence of this replacement service.
- Progress was being made with addressing people’s physical health as well as mental health issues, but there was more to do. It was noted that frequently

people who had a mental health issue had their physical health issues overlooked. More needed to be done to involve people who used mental health services in the health checks programme, and there was a need for primary care service providers to think about how to link up mental and physical health care.

- The Board would need to consider how 'brave' it wished to be in its commissioning model;
- It was suggested that referral pathways and care pathways be explored, and what difference there would be between models where care was the driver as opposed to ease of referral;
- While service users had raised no complaints regarding frontline care staff, and had instead raised concerns regarding the 'system' instead, it was felt that there must be a workforce development dimension to the work that needed to be done, of which customer care was one aspect;
- It was agreed that hearing directly from service users and carers was useful and highlighted issues that might not otherwise be picked up, but the importance of hearing from a full range of service user perspectives was emphasised. It was felt that there should be direct input from service users in all such sessions, as otherwise the Board would be basing its views on assumptions, and not what was really happening within the system

Considerations for the H&WBB

- What do we think about the trends and trajectories in Haringey –in terms of differentiated needs? Demand? Resources? The responsiveness and resilience of services?
- How well and widely understood are the issues and the trends?
- Which other services do we need to connect up with? How will we do this?
- What role *could* we have as a Board in leading the development of wider/deeper understanding of these issues?
- What role *will* we have?

Engagement with service users

One example of ways in which the Board could engage with service users would be to link in with established user groups / forums on issues where this was appropriate, such as the Mental Health Partnership Board and Mental Health Carers Association, and ensure that there was a solid relationship between these groups and the Board. The quality of any such link would be critical, and it was suggested that having regular shared experiences with key groups of service users might have the potential to alter the way in which these groups and the Board related to one another;

- Consideration would be needed as to how to address the 'them and us' impression, and to enable user groups to engage with the Board; it was agreed that it was important for whatever emerged from this meeting, for example, to be fed back to the Mental Health Trust, and to maintain communication in both

directions. It was also agreed that the Board should write to thank Tamara and Sarah for their involvement;

- There was a need to demonstrate to user groups the impact that their involvement had, and to show that they had been listened to at a point when their feedback could make a real difference;
- The extent to which the care system was reliant on family members to provide care was noted, reducing the need for patients to access resources. Self-care and self-management were key for acute provision as these helped to regulate demand for services; and
- There was current transformation from an in-patient model to a community care model, with service users empowered to access support and services when they needed it, and there was need to think about how this could be achieved without overloading carers.

Considerations for the H&WBB

- How do we keep the experience of service users more fully in mind as a Board?
- The particular experiences of *this* service user, and *this* carer made an impression on us. How can we develop our understanding of the *particular* needs and experiences of more service users and carers, and service user & carer groups?
- What changes do we think are needed to help the people working in the system keep service users and carers more fully in mind?
- What role *could* we have as a Board in leading such changes?
- What role *will* we have?

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'Types' of strategic partnership

This extract is a summary of four modes of LSP working (b*ased on Evaluation of Local Strategic Partnerships National Evaluation Governance: A briefing note for LSPs by LSPs. (May 2004).* It is from another era of partnership working (so to speak). However, the choice-of-position implied in these four distinctions is of value in thinking about H&WBBs – especially since the assumption is that the H&WBB is either likely to operate in 'advisory' (scrutiny) mode, or commissioning mode.

Mode 1: Advisory

In this mode, the LSP acts as a consultation and discussion forum and often forms the basis for consensus building, but has no independent power to act. It draws its accountability and legitimacy entirely from member organisations, particularly the local authority. An advisory LSP

- Signs off and wins agreement for strategy
- Has a role in identifying best practice
- Recommends actions to others
- Comments on draft documents and proposals
- Monitors and reviews progress
- Doesn't make major decisions
- Doesn't hold budgets
- Tends not to vote - consensus based influence
- Doesn't employ staff
- Has no separate power or desire to act - decisions are implemented through the partner bodies

Strong version - high influence	**Weak version - low influence**
○ Members can wield their organisation's authority ○ Capable of making choices ○ Clear about limitations ○ Effective at building consensus	○ Not listened to ○ Not able to resolve disputes or build consensus ○ Simply rubber stamps council or other agency decisions ○ Talking shop or a cosy club

Mode 2: Commissioning

In this mode, the LSP has its own staff and authority[5], is able to implement decisions and commission projects and therefore has to create its own forms of accountability and legitimacy. This is a far less common model and we are not yet sure there are any strong examples, but many LSPs have a limited commissioning capacity to run small projects or take action on a small scale. In some cases, commissioning partnerships based around regeneration work are

[5] Even if this is only achieved by proxy – by secondment, or through some kind of co-ordination arrangement

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Mode 2: Commissioning

returning to advisory mode as they become LSPs. A commissioning LSP has:

- Delegated authority and capacity to act in its own right
- Ability to make and implement decisions
- Its own staff
- Its own budget – or influence over 'pooled' budgets
- Ability to enforce decisions - agreement about mutual accountability
- Legal status - PLC? Formal partnership status?
- Formal and transparent decision-making arrangements
- Joint commissioning arrangements to allocate resources and commission services
- Contractual relationships between partners
- The power to monitor implementation

Strong version - key people attend	**Weak version - in-fighting between partners**
○ Effective decision making ○ Radical commissioning decisions ○ Resources used effectively ○ Able to prioritise ○ Gets things done	○ Challenge to the legitimacy of decisions ○ Decisions not implemented ○ Large amounts of energy spent on spending tiny sums of money ○ No measurable results ○ No clear accountability - a cosy 'club' of key agencies

Mode 3: Laboratory

Many LSPs will occasionally act in 'laboratory 'mode. Here the emphasis is on drawing on the combined thinking of senior managers and community leaders to create a breakthrough and think radically about the way resources are currently configured. Without some 'laboratory mode' the LSP may be relatively unexciting and pedestrian in its work. This model is one where the prime focus is on generating new ideas and ways of designing local services. However, unless the laboratory mode LSP is closely linked to decision-making power, the ideas may never be implemented.

In a laboratory LSP:

- Power depends on the quality of thinking
- Space is created to explore new ideas
- Participants work together as a 'think tank'
- Members are chosen for expertise/creative thinking
- Work is evidence-driven
- New ways of working are pursued
- Innovation is encouraged

Mode 3: Laboratory	
Strong version - new ideas ○ Creative process ○ Views are respected ○ Change happens ○ Reconfiguring resources ○ Linked to decision making	**Weak version - poor ideas** ○ No-one listens ○ Ideas never get implemented ○ Old thinking ○ Talking shop

Mode 4: Community empowerment	
This is not a common model. Here attention is focused on creating strong networks within the community rather than on the public agencies involved. A community empowerment LSP has: ○ Community dominated membership ○ Strong neighbourhood presence ○ Links to community ○ Emphasis on being formally or informally inclusive ○ An independent chair ○ Fewer senior managers ○ Focus on process and consensus building ○ Time for dialogue	
Strong version - strong links to Community ○ High local awareness ○ Difficult for politicians to challenge	**Weak version - cliques** ○ Rule bound ○ Backbiting and hidden politics ○ Not in tune with public views ○ Too idealistic ○ Confused and chaotic

Summary of H&WB strategy

The model on the next page is an extract from the Haringey H&WB strategy. It provides a summary of the policy and outcome context for the work of the Health & Well Being Board and illustrates some of the challenges. For example:

What does the Health & Well Being Board add to the key supporting strategies? These are depicted as the foundation to the H&WB strategy – yet it is unclear

- What the H&WBB will add to these strategies, either by increasing their likelihood of success; or reducing their risk of failure; or
- How the H&WBB membership will lead, or instigate leadership initiatives, in support of these strategies?

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